

Proposals for revisions to PRS/2
and the Victorian Admitted
Episodes Dataset (VAED) for
1 July 2008

November 2007

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Executive Summary

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

This document has been produced to invite comment and stimulate discussion on the proposals outlined below. If you would like to comment on any of the proposals, please see the introduction section on how to do so.

In order to be accepted into the VAED proposals need to demonstrate clear business justification and be fully costed, meaning funding streams will need to be identified and confirmed. Final acceptance of all proposals is dependent on the Executive Director, Metropolitan Health and Aged Care Services (based upon recommendations by the Data Management Advisory Committee (DMAC)).

For further information on the revisions process and timetable contact the HDSS Help Desk on 9096 8141.

The proposed revisions for the Victorian Admitted Episodes Dataset (VAED) for 1 July 2008 are summarised below. They include (but are not limited to) the:

1. Addition of the Palliative Care Consult flag.
2. Addition of Date of Birth Accuracy Flag.
3. Addition of Impairment codes for sub-acute episodes.
4. Addition of Admission and Separation FIM Scores.

Included also are proposed developments for which feedback is sought from the field.

Introduction

The VAED proposals consultation process

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

The Proposal document is being distributed to all Victorian hospitals, to patient management system suppliers known to have Victorian clients, and to a range of industry bodies. It outlines *proposals* for changes to PRS/2 and the VAED as at the time of its release in November 2007. This should not be regarded as a complete list of changes to be made for 2008–09. Items in this publication are not guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate it will not change from 1 July 2008. Confirmed changes will be published in the document '*Specification for Revisions to PRS/2 and the VAED for 1 July 2008*', expected to be published in February 2008.

It is expected that release of these proposals will stimulate discussion within the health industry.

Prompt feedback is sought on these proposals. Hospitals and software suppliers should review this document and assess the feasibility of the proposals. All are invited to provide written feedback to DHS by completing the proforma provided as an Appendix to this document, and forwarding it to HDSS as indicated **by 30 November 2007**. Copies of the proforma may also be obtained from the HDSS web site located at <http://www.health.vic.gov.au/hdss>.

Orientation to this document

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

- New values and definitions relating to existing items are highlighted in orange.
- Changes to existing items are highlighted in green.
- Redundant values and definitions relating to existing items ~~are struck through~~.
- Comments relating only to the proposal document [*appear in square brackets and italics.*]
- Page numbers representing cross referencing to another section of the VAED Manual are represented by a #.
- Edits that are proposed to change are marked when listed as part of a Data Item or after an Edit Table with a * after the edit number. New proposed edits will be shown with an edit number of ###.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Admitted Episodes Dataset (VAED 17th Edition, 1 July 2007)*.
 - Specification*: details the reporting requirements for the item.
 - Administration*: provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each proposal is provided.

Abbreviations

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
ACHI	Australian Classification of Health Interventions
AHCA	Australian Health Care Agreement
AIHW	Australian Institute of Health and Welfare
AIMS	Agency Information Management System
AR-DRG	Australian Refined Diagnosis Related Group
DHS	Department of Human Services
ERC	Expenditure Review Committee
FIM	Functional Independence Measure
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
KHSU	Koori Human Services Unit
NHDD	National Health Data Dictionary
NICU	Neonatal Intensive Care Unit
NIV	Non-invasive Ventilation
NMDS	National Minimum Data Set
PRS/2	Patient Reporting System, Version 2
SCN	Special Care Nursery
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VICC	Victorian ICD Coding Committee
WIES	Weighted inlier Equivalent Separations

Symbols

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

Proposed revisions/additions to data items

Proposal 1 – Addition of Palliative Care Consult flag

It is proposed to Add a flag to the episode record to indicate whether the patient was seen by the hospital's palliative care consultancy team.

Proposed by Jackie Kearney
Manager, Palliative Care
Cancer and Palliative Care Unit
Programs Branch
Metropolitan Health and Aged Care Services
Department of Human Services

Implementation Date 1 July 2008

Background This change will assist in determining the level of activity undertaken by the palliative care consultancy teams by counting the number of patients receiving a consult during their admitted episode.

Palliative Care Consultancy Flag (*New*)

Specification

Definition Indicates whether the patient received a consultation from the Palliative Care Consultancy team.

Datatype Numeric **Form** Code

Field size 1 **Layout** N or spaces

Location Episode Record

Reported by Public hospitals.

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set

Code	Descriptor
0	Not seen by Palliative Care Consultancy team
1	Seen by Palliative Care Consultancy team

Reporting guide

This information must be reported:

- When the patient's Care Type is not 8 *Palliative Care*; and
- Where the patient receives one or more consultations from the Palliative Care Consultancy team; and
- Where the Palliative Care Consultancy team is 'approved', i.e. funded by DHS.

Private hospitals and episodes where the care type is 8 report a space.

Edits ### Palliative Care Consultancy mismatch

Related items Section 9:

- Codes Lists *Palliative Care Consultancy teams*.

Administration

Purpose To count the number of patients who receive a consultation from the Palliative Care Consultancy team during their admitted episode.

Principal data users Palliative Care Unit, DHS

Collection start 2008-09

Definition source DHS **Code set source** DHS

Palliative Care Consultancy mismatch (New)

Effect

REJECTION

Problem

E4 Episode Record's Palliative Care Consultancy Flag must be space, 0 or 1 and must comply with the rules below:

If = 1

- Hospital Type must be Public; and
- Care Type must not = 8 Palliative Care; and
- Hospital must have a DHS-funded Palliative Care Consultancy team.

If = 0

- Hospital Type must be Public.

If = space

- Hospital Type must be Private; and/or
- Care Type must be 8.

Remedy

Check the Palliative Care Consultancy Flag, the Care Type of the episode and the Hospital Type.

Refer to:

- Section 9: Palliative Care Consultancy teams

Proposal 3 – Addition of Date of Birth Accuracy Flag

It is proposed to Introduce a new field to record the accuracy of the Date of Birth.

Proposed by Health Data Standards & Systems
Funding Health and Information Policy
Metropolitan Health and Aged Care Services
Department of Human Services

Implementation Date 1 July 2008

Background This change is proposed to improve the quality of the Date of Birth data item in the VAED by reducing the incidence of defaulted values when dates are unknown or estimated and improving the quality of statistical analysis.

The current method of indicating an estimated Date of Birth requires 0000 to be reported for DDMM and an estimated year of birth. This method may not pass date validation processes in some systems.

The change will also bring the VAED into line with the NHDD and other DHS data collections, such as VINAH and the Mental Health CMI/ODS.

Date Accuracy and its code set is a National Standard Data Element:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/294429>.

However DHS is aware that many IT systems, if they flag date accuracy at all, do so in a binary manner, i.e. that the date is accurate, or not. DHS endorses the idea of explicitly flagging estimated or unknown dates, rather than using sentinel values such as 1/1/1900, as a quality of care and patient safety issue. However, while DHS believes that the Date of Birth Accuracy code set as presented is useful and encourages its adoption, DHS will accept mapping a known accurate date as 'AAA' and a date other than accurate (e.g.: Where a binary flag may be set on the date) as 'EEE'. DHS expects that for all dates of birth transmitted with an 'EEE' value, some attempt using visual cues and other available information has been made to make as accurate an estimate as possible.

Date of Birth Accuracy Code (*New*)

Specification

Definition	A code representing the accuracy of the components of a date - day, month, year.		
Datatype	Alpha	Form	Structured Code
Field size	3	Layout	AAA
Location	Episode Record		
Reported by	All Victorian Health Services (public and private).		
Reported for	All admitted episodes of care.		
Reported when	The episode record is reported.		
Value domain	This data element's value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:		

Code	Descriptor
A	The referred date component is accurate
E	The referred date component is not known but is estimated
U	The referred date component is not known and not estimated.

This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported *Date of Birth*.

Component	Descriptor
1st – D	Refers to the accuracy of the day component.
2nd – M	Refers to the accuracy of the month component
3rd - Y	Refers to the accuracy of the year component

Reporting guide Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

Example 1: A date has been sourced from a reliable source and is known as accurate then the date accuracy indicator should be reported as 'AAA'.

Example 2 (assuming full code set implementation): If only the age of the person is known and there is no certainty of the accuracy of this, then the date accuracy indicator should be reported as 'UUE'. That is the day and month are "unknown" and the year is "estimated".

A Year component value of *U – Unknown* is not accepted.

Where possible, report the accuracy of each date component. However, where software systems allow the collection of a binary value for Date of Birth Accuracy, values such as 'AAA' and 'EEE' will be acceptable.

Edits ### Invalid Date of Birth Accuracy code

Related items Section 2: *Age*
Section 3: *Date of Birth*

Administration

<i>Purpose</i>	Required to derive age for demographic analyses and for analysis by age at a point of time.		
<i>Principal data users</i>	Multiple internal and external research users.		
<i>Collection Start</i>	2008-09		
<i>Definition source</i>	NHDD (DHS modified)	<i>Value Domain source</i>	NHDD 294429

Date of Birth (*Amended*)

Specification

Definition	The date of birth of the person.		
Datatype	Numeric	Form	Date
Field size	8	Layout	DDMMCCYY
Location	Episode Record		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care.		
Reported when	The Episode Record is reported.		
Code set	A valid date.		
Reporting guide	The Date of Birth must be on or before Date of Admission.		

Century (CC) can only be 18, 19 or 20.

If unknown, estimate the year of birth and enter 0000 [zeros] in DDMM and the estimated year in CCYY. Date 00MMCCYY will not be accepted.

If the Date of Birth is unknown or has been estimated, the appropriate value should be reported in the Date of Birth Accuracy field.

Remainder of table unchanged.

Invalid Date of Birth Accuracy code (*New*)

Effect	REJECTION
Problem	The E4 Episode Record's Date of Birth Accuracy code is null or invalid.
Remedy	Check Date of Birth Accuracy for valid format and values.

Proposal 4 – Addition of Australian Impairment Codeset

It is proposed to Introduce the Version 1 Australian Impairment codeset for Sub-Acute episodes.

Proposed by Health Data Standards & Systems
Funding Health and Information Policy
Metropolitan Health and Aged Care Services
Department of Human Services

Implementation Date 1 July 2008

Background The Australasian Rehabilitation Outcomes Centre (AROC) collects rehabilitation data from a number of Victorian hospitals. AROC currently collect Australian Impairment which is a variation of the Clinical Sub-Program codeset.

It is proposed to continue to collect the Clinical Sub-Program codes but also to introduce the Australian Impairment codeset. Note that Clinical Sub-Program will continue to be used for funding purposes. This will enable DHS to ensure CRAFT funding is not affected while assessing the effect of introducing the new codeset.

The intention of this proposal is to align the VAED with other data collections such as AROC and HCP, and thereby to reduce the reporting burden on hospitals.

Please note that this proposal has been included to gauge the level of support from the field so feedback is encouraged.

Impairment

Specification

Definition	The diagnosis, based on the body system manifesting the reason for rehabilitation.		
Datatype	Numeric	Form	Code
Field size	6	Layout	NNNNNN Left justify, leading zero.
Location	Sub-Acute Record		
Reported by	Public hospitals.		
Reported for	Care Types P, 2, 6, 7 and K. For Care Types 8, 9, F and E, report spaces.		
Reported when	A Separation Date is reported in the Episode Record.		

Code set

Code Descriptor

Stroke

011	Left Body Involvement (Right Brain)
012	Right Body Involvement (Left Brain)
013	Bilateral Involvement
014	No Paresis
019	Other stroke

Brain Dysfunction

Non-traumatic brain dysfunction:

0211	Sub-arachnoid haemorrhage
0212	Anoxic brain damage
0213	Other non-traumatic brain dysfunction

Traumatic brain dysfunction:

0221	Open injury
0222	Closed injury

Neurological Conditions

031	Multiple sclerosis
032	Parkinsonism
033	Polyneuropathy
034	Guillain-Barre Syndrome
035	Cerebral Palsy
038	Neuromuscular disorders (include motor neuron disease)
039	Other neurological disorders

Spinal Cord Dysfunction

Non-traumatic spinal cord dysfunction:

- 04111 Paraplegia, incomplete
- 04112 Paraplegia complete
- 041211 Quadriplegia incomplete C1-4
- 041212 Quadriplegia incomplete C5-8
- 041221 Quadriplegia complete C1-4
- 041222 Quadriplegia complete C5-8
- 0413 Other non-traumatic SCI

Traumatic spinal cord dysfunction:

- 04211 Paraplegia, incomplete
- 04212 Paraplegia complete
- 042211 Quadriplegia incomplete C1-4
- 042212 Quadriplegia incomplete C5-8
- 042221 Quadriplegia complete C1-4
- 042222 Quadriplegia complete C5-8
- 0423 Other traumatic spinal cord dysfunction

Amputation of Limb

- 051 Single Upper Amputation Above the Elbow
- 052 Single Upper Amputation Below the Elbow
- 053 Single Lower Amputation Above the Knee (includes through knee)
- 054 Single Lower Amputation Below the Knee
- 055 Double Lower Amputation Above the Knee (includes through knee)
- 056 Double Lower Amputation Above/below the Knee
- 057 Double Lower Amputation Below the Knee
- 058 Partial Foot Amputation (includes single/double)
- 059 Other Amputation

Arthritis

- 061 Rheumatoid
- 062 Osteoarthritis
- 069 Other Arthritis

Pain Syndromes

- 071 Neck pain
- 072 Back pain
- 073 Extremity pain
- 074 Headache (includes migraine)
- 075 Multi-site pain
- 079 Other pain (includes abdominal/chest wall)

Orthopaedic Conditions

Fracture: (includes dislocation, excludes neurological involvement)

- 08111 Fracture of hip, unilateral (includes #NOF)
- 08112 Fracture of hip, bilateral (includes #NOF)
- 0812 Fracture of shaft of femur (excludes femur involving knee joint)
- 0813 Fracture of pelvis
- 08141 Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
- 08142 Fracture of lower leg, ankle, foot
- 0815 Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
- 0816 Fracture of spine (excludes where the major disorder is pain)
- 0817 Fracture of multiple sites (multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum Excludes with brain injury or with spinal cord injury)
- 0819 Other orthopaedic fracture (includes jaw, face, rib, orbit or sites not elsewhere classified)

Post Orthopaedic Surgery: (includes secondary to fracture or arthritis)

- 08211 Unilateral hip replacement
- 08212 Bilateral hip replacement
- 08221 Unilateral knee replacement
- 08222 Bilateral hip replacement
- 08213 Knee and hip replacement same side
- 08232 Knee and hip replacement different sides
- 0824 Shoulder replacement or repair
- 0825 Post spinal surgery (includes nerve root injury (laminectomy, spinal fusion, discectomy; excludes spinal cord injury or caudaequina)
- 0826 Other orthopaedic surgery

Cardiac

- 091 Following recent onset of new cardiac impairment (AMI, heart transplant, cardiac surgery)
- 092 Chronic cardiac insufficiency
- 093 Heart and heart/lung transplant

Pulmonary

- 101 Chronic Obstructive Pulmonary Disease
- 102 Lung Transplant
- 109 Other pulmonary

Burns

- 11 Burns

Congenital Deformities

- 121 Spina Bifida
- 129 Other Congenital

Other Disabling Impairments

- 131 Lymphoedema
- 132 Other disabling impairments

Major Multiple Trauma

- 141 Brain and spinal cord injury
- 142 Brain and multiple fracture/amputation
- 143 Spinal cord and multiple fracture/amputation
- 149 Other multiple trauma

Developmental Disabilities

- 151 Developmental Disabilities

Re-Conditioning/Restorative

- 161 Re-conditioning following surgery
- 162 Re-conditioning following medical illness
- 163 Cancer rehab

Reporting guide

Impairment codes should be assigned by the treating clinician. Code assignment must be supported by the appropriate ICD-10-AM codes reported in the X4/Y4 Diagnosis/Extra Diagnosis Records.

The Australian Rehabilitation Outcomes Centre (AROC) provides guidelines for coding Impairments:

http://chsd.uow.edu.au/aroc/documents/aroc_aicv1_coding_guidelines.pdf

Edits

- 253 Rehab Invalid Clin Sub-Prog
- 258 Sub-Acute: No Sub-Acute Record

293 Clin Sub-Prog Present
405 Inapplic Clin Prog For Care Type 2
454 Incompat Fields for Interim Care

Related items Section 2: *Rehabilitation Care*.

Section 4:
• *Yet to be determined.*

Administration

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

Principal data users Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).

Collection start 2008-09

Definition source DHS **Code set source** DHS

Proposal 5 – Addition of Admission and Separation Functional Independence Measure (FIM Scores)

It is proposed to Introduce Admission and Separation FIM Scores for rehabilitation episodes.

Proposed by Health Data Standards & Systems
Funding Health and Information Policy
Metropolitan Health and Aged Care Services
Department of Human Services

Implementation Date 1 July 2008

Background The Australasian Rehabilitation Outcomes Centre (AROC) collects rehabilitation data from a number of Victorian hospitals. AROC currently collect FIM scores rather than Barthel Index Scores.

It is proposed to continue to collect Barthel Index Scores but also to introduce the FIM Scores. Note that Barthel Index Scores will continue to be used for funding purposes. This will enable DHS to ensure CRAFT funding is not affected while assessing the effect of introducing the new codeset.

The intention of this proposal is to align the VAED with other data collections such as AROC and HCP, and thereby to reduce the reporting burden on hospitals.

Please note that this proposal has been included to gauge the level of support from the field so feedback is encouraged.

FIM Score on Admission (a)

FIM Score on Separation (b)

Specification

Definition	(a) FIM Score, as assessed on admission. (b) FIM Score, as assessed on separation.		
Datatype	Numeric	Form	Score
Field size	18	Layout	NNNNNNNNNNNNNNNNNNNN or spaces. Right justified with leading zeros.
Location	Sub-Acute Record		
Reported by	Public hospitals.		
Reported for	Care Types F, E, 2, 6, 7, 9 and K. For Care Type 8, report spaces.		
Reported when	A Separation Date is reported in the Episode Record.		
Code set	Report a score for each measure (i.e. 1 digit score for 18 measures):		

FIM Scores

Score Sequence	Motor Subscale	FIM Scores
1	Eating	No Helper
2	Grooming	7 = Complete Independence
3	Bathing	6 = Modified Independence
4	Dressing Upper Body	Helper
5	Dressing Lower Body	5 = Supervision or setup
6	Toileting	4 = Minimal assistance
7	Bladder Management	3 = Moderate assistance
8	Bowel Management	2 = Maximal assistance
9	Transfers – Bed/Chair/Wheelchair	1 = Total assistance
10	Transfers - Toilet	
11	Transfers – Bath/Shower	
12	Walk/Wheelchair	
13	Stairs	
	Cognitive Subscale	
14	Comprehension	
15	Expression	
16	Social Interaction	
17	Problem Solving	
18	Memory	

Reporting guide

Assessment of FIM Scores is required at admission and separation for all S4 Records (excluding Palliative Care).

Statistical separations:

- From episodes with Care Types F, E, 2, 6, 7, K or 9 to episodes with Care Types F, E, 2, 6, 7, K or 9:
Separation FIM of the prior episode may be repeated as the Admission FIM of the subsequent episode.
- From episodes with Care Types F or E to episodes with Care Types F or E:
Admission FIM of prior episode may be repeated as both the Separation FIM of the prior episode and the Admission FIM of the subsequent episode.

The FIM on Admission should be assessed within 72 hours of admission.

The FIM on Separation should be assessed on the day on which the decision is taken to cease the Care Type.

The FIM on Separation for patients who die in hospital is 18 (i.e. a score of 1 for each measure).

- Edits**
- (a) *Yet to be determined.*
 - (b) *Yet to be determined.*

- Related items**
- Section 3:
- *Functional Assessment Date on Admission*
 - *Functional Assessment Date on Separation*
- Section 4:
- *Yet to be determined.*

Administration

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

Principal data users Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).

Collection start 2008-09

Definition source DHS **Code set source** FIM

Proposed Revisions in Record Structures

Episode Record

Episode Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	E4
M	Unique Key	9	3	Hospital-generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
M	Campus Code	4	22	0, 1, 2, 3, 4, 5, 6, 7, 8, 9
M	Medicare Number	11	26	NNNNNNNNNNNN or spaces
M	Medicare Suffix	3	37	AAA or A-A
M	Sex	1	40	1, 2, 3, 4
M	Marital Status	1	41	1, 2, 3, 4, 5, 6
M	Date of Birth	8	42	DDMMCCYY
M	Postcode	4	50	NNNN Refer to Section 3
M	Locality	22	54	Refer to Section 3
M	Admission Date	8	76	DDMMCCYY
M	Admission Time	4	84	HHMM
M	Admission Type	1	88	S, Y, M, C, L, O, X
M	Admission Source	1	89	S, Y, T, B, N, A, H
1	Transfer Source	4	90	NNNN or spaces Refer to Section 3
	Leave With Permission Days MTD	2	94	NN or spaces
	Leave With Permission Days Financial YTD	3	96	NNN or spaces
	Leave With Permission Days Total	3	99	NNN or spaces
	Status Segment Occurs 7 times			
2	Account Class	2	102, 115, 128, 141, 154, 167, 180	AA or AN Refer to Field specification
2	Accommodation Type	1	104, 117, 130, 143, 156, 169, 182	1, 2, 3, 4, 6, 7, 8, B, C, M, S
2	Qualification Status	1	105, 118, 131, 144, 157, 170, 183	N, U, X
2	Patient Days MTD	2	106, 119, 132, 145, 158, 171, 184	Must be present if other Status details are present

Note	Data Item	Field Size	Record Position	Layout/Code Set
2	Patient Days Financial YTD	3	108, 121, 134, 147, 160, 173, 186	Must be present if other Status details are present
2	Patient Days Total	4	111, 124, 137, 150, 163, 176, 189	Must be present if other Status details are present
3	Separation Date	8	193	DDMMCCYY
3	Separation Time	4	201	HHMM
3	Separation Mode	1	205	S, D, Z, T, B, N, A, H
1	Transfer Destination	4	206	NNNN or spaces Refer to Section 3
4	Separation Referral	4	210	F, P, M, L, B, U, C, S, D, G, I, A, K, T, R, X or spaces Left justified, trailing spaces
5	Carer Availability	1	214	1, 2, 3, 4, 5, 6, 7, 8 or space
3	Account Class on Separation	2	215	AA or AN Refer to Field specification
3	Accommodation Type on Separation	1	217	1, 2, 3, 4, 6, 7, 8, B, C, M, S
M	Care Type	2	218	F, E, 1, 2, 6, 7, K, 8, 5x, 9, 0, 4, U Refer to Section 3
M	Country of Birth	4	220	NNNN Refer to Section 3
M	Indigenous Status	1	224	2, 5, 6, 7, 8, 9
M 6	Criterion for Admission	1	225	B, N, U, O, E, C, S
M	Intended Duration of Stay	1	226	1, 2
M	Health Insurance Fund	3	227	Refer to Section 3
M	Hospital Insurance Status	1	230	2, 4, 9
3	Mental Health Legal Status	1	231	1, 2, 9
7	Funding Arrangement	1	232	1, 2, 4, 5, 6 or space
8	Contract Type	1	233	1, 2, 3, 4, 5, 6, 7 or space
8	Contract Role	1	234	A, B or space
9	Contract/Spoke Identifier	4	235	NNNN or spaces Refer to Section 3
10	Contract Leave Days - MTD	2	239	NN or spaces
10	Contract Leave Days - Financial YTD	2	241	NN or spaces
10	Contract Leave Days - Total	2	243	NN or spaces
	User Flag	1	245	Optional field, free text
12	Preferred Language	4	246	NNNN Refer to Section 3
12	Interpreter Required	1	250	N Refer to Section 3
13	ACAS Status	1	251	N or space Refer to Section 3
15	Mental Health Statewide Patient Identifier	10	252	ODS generated or spaces Refer to Section 3
	Leave Without Permission Days MTD	2	262	NN or spaces
	Leave Without Permission Days Financial YTD	3	264	NNN or spaces

Note	Data Item	Field Size	Record Position	Layout/Code Set
14	Leave Without Permission Days Total	3	267	NNN or spaces
14 16	Palliative Care Patient Days	3	270	NNN or spaces
3	Intention to Readmit	1	273	0, 1, 2, 3, 4, 9
M	DOB Accuracy Flag	3	274	AAA
12	Palliative Care Consultancy Flag	1	277	0, 1, or space
		Total		
		274		
		277		

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 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 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, K, 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.
- 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.
- 12 Mandatory for all public hospitals. Private hospitals report codes or spaces.
- 13 Mandatory for public hospitals when Care Type is 1, 2, 4, 6, 7, K, 8, 9, F or E, and patient age is greater than or equal to 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.
- 14 Where a field at the end of a record has a value of space, the record can be ended at the last field where a value is not space(s).
- 15 Mandatory for all public hospitals with an approved Mental Health Service when Care Type is 5x. Private hospitals report spaces.
- 16 Mandatory for all public hospitals when Care Type is 8.

Data Items**Transaction Type**

The value identifying the Extra Diagnosis Record is 'Y4'.

Sub-Acute Record

Sub-Acute Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	S4
M	Unique Key	9	3	Hospital generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
1, 2, 4	Barthel Index Score on Admission	3	22	Range 000 to 100 or spaces
1, 2, 4	Barthel Index Score on Separation	3	25	Range 000 to 100 or spaces
1, 6	Clinical Sub-program	3	28	From code list or spaces
1, 6	Onset Date	8	31	DDMMCCYY or spaces
1, 6	Admission/Re-admission to Rehabilitation	1	39	0, 1 or space
5	User Flag	1	40	Optional field, free text
3 5	RUG ADL on Admission	2	41	Range 00 to 18 or spaces
3 5	RUG ADL on Separation	2	43	Range 00 to 18 or spaces
3 5	Source of Referral to Palliative Care	2	45	Range 01 to 09 or spaces
1, 2, 4	Functional Assessment Date on Admission	8	47	DDMMCCYY or spaces
1, 2, 4	Functional Assessment Date on Separation	8	55	DDMMCCYY or spaces
1, 6	Impairment	6	63	NNNNNN or spaces
1, 2, 4	FIM Score on Admission	18	69	NNNNNNNNNNNNNNNNNNNN or spaces
1, 2, 4	FIM Score on Separation	18	87	NNNNNNNNNNNNNNNNNNNN or spaces
		Total 62 104		

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

M Mandatory

1 Mandatory if Care Type = 2, 6, 7 or K *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*

5 Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s).

6 Mandatory if Care Type = P *Designated Paediatric Rehabilitation Program/Unit*

Reported by Public hospitals.

[Private hospitals: Do not report S4s.]

Reported for Care Types F, E, P, 2, 6, 7, K, 8, and 9 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 (marked with an * in the table below) 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 or K	Palliative Care Type 8	GEM Care Type 9	Interim Care Type F, E	Paed Rehab Care Type P
Transaction Type	S4	S4	S4	S4	S4
Unique Key	*	*	*	*	*
Patient Identifier	*	*	*	*	*
Barthel Index Score on Adm	*	Spaces	*	*	Spaces
Barthel Index Score on Sep	*	Spaces	*	*	Spaces
Functional Assessment Date on Admission	*	Spaces	*	*	Spaces
Functional Assessment Date on Separation	*	Spaces	*	*	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	Spaces
RUG ADL on Separation	Spaces	*	Spaces	Spaces	Spaces
Source of Referral to Palliative Care	Spaces	*	Spaces	Spaces	Spaces
Impairment	*	Spaces	Spaces	Spaces	*
FIM Score on Admission	*	Spaces	*	*	Spaces
FIM Score on Separation	*	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.

If an episode that was previously reported with a Sub-Acute Care Type is amended to report a non-Sub-Acute Care Type, the Sub-Acute data will be deleted from the database and a Warning edit will be printed on the Control Report.

Data Items

Transaction Type

The value identifying the Sub-Acute Record is 'S4'.

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.

Potential Changes and Developments – Feedback Sought

This section identifies future developments and possible changes that will not be introduced for 2008-09 but are being considered for the future. Your feedback is sought so that we can evaluate the implications of introducing these changes.

Replacement of SLA with mesh blocks – Geocoding addresses

The ABS plans to implement a new National statistical geography framework to overcome a number of issues; pertinent to health data collection are problems related to Statistical Local Areas (SLAs). SLAs do not integrate well with postcode and electoral boundaries, and are not proportional with population distribution, particularly in rural areas. They are not common to all data collections and therefore statistical analysis of health data in comparison with other social or economic data is problematic.

Currently, DHS is required to report SLA-level data from the VAED as part of Victoria's National reporting obligations. At this time, SLA is derived in VAED from the postcode and locality data items based on conversion information sourced from the ABS.

The ABS is proposing to introduce mesh blocks which will not only provide more equitable population ranges within statistical areas but also enable the integration and comparison of health data with other statistical data.

Mesh blocks are a spatial unit containing a relatively small number (between thirty and sixty) of households. They can be used as a building block for, or to approximate, larger geographic areas. Mesh block boundaries are designed to remain stable over time. In areas of growth, mesh blocks will be split.

Thus mesh blocks greatly improve the ability to create, disseminate and analyse geographically referenced data both spatially and over time. They provide a stable basis from which to build boundaries and provide the ability to recast data on different geographies.¹

It is expected that in future, Commonwealth reporting requirements will be changed away from SLA-level data. The ABS will no longer be supporting SLAs, and the conversion tables currently used by DHS to derive SLA from postcode and locality will be discontinued.

It is proposed that the VAED either collect or derive mesh blocks. There are two options:

1. The patient's street name and number is reported to the VAED and the mesh block is then calculated by DHS; or

2. The hospital reports the mesh block identifier.

Option 1 would place the least burden on hospitals but will raise concerns regarding patient privacy. There may also be issues around common and reliable reporting of rural addresses.

Option 2 would require hospitals to have the facility to calculate mesh blocks from address information.

HDSS is seeking your comments and highlighting of possible issues in order to decide the best way to implement this change.

¹ Review of the Australian Standard Geographical Classification, 2007
Australian Bureau of Statistics
<http://www.abs.gov.au/ausstats/abs@.NSF/papersbycatalogue/43C8836095D76DA1CA2573380019D946?OpenDocument>

Redevelopment of PRS/2

Over the next twelve months, DHS will be developing a plan for the redevelopment of PRS/2 and the VAED. The redevelopment will include a review of all data items collected to ensure their collection is still valid, and a review of business rules and validation edits. It is intended that the collection be altered to allow greater transactional detail of patient activity to be reported rather than the current method of collecting the patient's status 'as of midnight'. This would also allow a number of items that are currently derived to be replaced with 'start/stop' indicators and should reduce the number of reported data items and the complexity in derivation and validation of many items.

Although we are in the very early stages of planning, HDSS welcomes any comments and suggestions from hospitals and suppliers.

Appendix: Feedback Proforma

