

**Specification for Revisions to the
Victorian Emergency Minimum Dataset
(VEMD)**

for 1.7.2001

February 2001

**Acute Health Division
Department of Human Services**

Contents

EXECUTIVE SUMMARY OF CHANGES	I
INTRODUCTION.....	II
ABBREVIATIONS	III
DOCUMENT CONVENTION	III
VEMD REVISIONS 1 JULY 2001	1
DEPARTURE STATUS.....	1
DESCRIPTION OF INJURY EVENT	5
ESCORT SOURCE.....	8
PROCEDURE.....	10
REFERRED BY.....	11
CONCEPT DEFINITIONS.....	15
MEDICAL ASSESSMENT AND PLANNING UNIT.....	15
SHORT STAY OBSERVATION UNIT	16
REFERENCE FILE UPDATES	17
POSTCODE FILE	17
HOSPITAL CODE TABLE.....	17
FILE FORMAT	18
DATA SUBMISSION	18
METHOD FOR REPORTING ‘REMAINING INS’ ON 30 JUNE 2001	19
FILE STRUCTURE	Appendix A
AMENDED, DELETED AND NEW EDITS	Appendix B

Executive Summary of Changes

The Victorian Emergency Minimum Dataset (VEMD) specification for 2001-02 comprises the VEMD manual, Version 5.0, 1 July 2000 (as amended by HDSS Bulletins 16 and 19) with the following amendments as detailed in this document:

Data Item Revisions

Departure Status

Modification of Code 2, and addition of code 3

Description of Injury Event

Clarification of the reporting guide and the addition of software prompts

Escort Source

Item collection made optional

Referred By

Clarification of code 7

Procedures

Item collection made optional

New Data Items

No New Data Items

Updated Reference Files and Corresponding Data Items

- Postcode File: *Postcode and Locality*
- Hospital Code Table: *Campus Code, Transfer Source, Transfer Destination*
- VEMD ICD-10-AM Library File: *Diagnosis Codes*

Edits

A range of VEMD edits have been revised in accordance with the changes to data items outlined in this document.

Introduction

The need for VEMD modifications:

Comments made by hospitals and software suppliers on the content of the *Preliminary Proposals for Revisions for 1.7.2001* document, have been considered by the Department of Human Services (DHS) and the Emergency Department Information Systems (EDIS) Review Committee. Where possible suggestions have been accommodated and dataset changes kept to a minimum.

For further reference, please see the *Notes of VEMD Forum held on Friday 17 November 2000*, and the minutes of the EDIS Review Committee meeting held 29 November 2000.

From 1 July 2001, changes to the VEMD will be necessary to:

- Further refine and align current terminology and code sets with the Victorian Admitted Episodes Dataset (VAED), the National Health Data Dictionary (NHDD) and source data systems.
- Include and revise applicable edits to promote data integrity.
- Update relevant reference files.

Distribution and components of this document:

This document outlines new and amended VEMD definitions, fields, business rules, edits, and current and revised file structures. It has been distributed to: Emergency Directors, VEMD Submission Officers, software suppliers, a range of industry associations, and is also accessible on the website of the Health Data Standards & Systems Unit (HDSS) at DHS (www.dhs.vic.gov.au/ahs/hdss).

Hospitals should request that suppliers modify their software in accordance with the revised specifications. Information on the method of dealing with patients who are remaining in hospital at the end of 30 June 2000 is also included in the *Specifications for Revisions*.

The existing file format for VEMD data transmissions will continue from 1 July 2001: **Tab delimited ASCII format** (modified VEMD format).

The changes noted in this document will be incorporated into the VEMD Manual, Version 6.0, 1 July 2001. Software suppliers and hospitals are advised to work from this document in conjunction with the VEMD Manual, V5.0, 1 July 2000, and the amendments notified in HDSS Bulletin Issues 16 and 19, until the Version 6.0 Manual is released.

Abbreviations

DHS	Department of Human Services
DWH	Data Warehouse
MAS	Metropolitan Ambulance Services
RAPID	Redevelopment of Acute and Psychiatric Information Directions Project
RAV	Rural Ambulance Victoria
ODS	Operational Data Store
HL7	Health Level 7
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10 th Revision, Australian Modification
MAPU	Medical Assessment and Planning Unit
NHDD	National Health Data Dictionary
SOU	Short stay Observation Unit
VEMD	Victorian Emergency Minimum Dataset
VAED	Victorian Admitted Episode Dataset (formerly VIMD)
VIMD	Victorian Inpatient Minimum Database

Document Convention

- * New and amended edits are identified in the ‘VEMD Revisions 1 July 2001’ section of this document by an asterisk (*) appearing on the left hand side of the corresponding edit number and descriptor. These edits are detailed in Appendix B.

VEMD Revisions 1 July 2001

The following pages provide an outline the revisions to VEMD data fields.

Text for addition to the 'Version 5.0 VEMD Manual' is underlined.

Text for deletion from the 'Version 5.0 VEMD Manual' is ~~struck through~~.

For complete details of existing formats, codes and edits, reference should be made to Version 5.0 of the VEMD Manual, July 2000 and the relevant HDSS Bulletins (16 and 19).

Departure Status

Revision Summary Add new Departure Status code 3 and modify code 2.
--

Specification

Definition	Patient status and/or destination at departure from the Emergency Department.		
Datatype	Alpha/numeric	Form	Code
Field size	One	Layout	N
Reported for	Every emergency department attendance (Mandatory item).		

Code set

Code	Descriptor
0	Departure and transfer to aged care residential facility (Includes nursing home and hostel)
1	Discharge to home (Includes return to nursing home, mental health residential facility)
2	<u>Admission to ward (Includes HITH and Medical Assessment and Planning Unit; Excludes registered Short Stay Observation Unit) /return to inpatient ward</u>
3	<u>Admission to registered short stay observation unit (Includes Chest Pain Evaluation Unit; Excludes Medical Assessment and Planning Unit)</u>
4	Transfer out of this hospital campus to another hospital campus (also record Transfer Destination)
5	Left at own risk, after treatment started
6	Left before being seen by doctor (or definitive service provider)
7	Died within ED
8	Dead on arrival
9	Departure and transfer to mental health residential facility (Includes psychogeriatric nursing home and community care unit)

Reporting guide

0-Departure and transfer to aged care residential facility (includes nursing home and hostel)

Departure and transfer to an aged care residential facility (includes nursing home and hostel). Does not require a Transfer Destination code.

Excludes: Patients returning to the aged care residential facility in which they live. Use code 1 - Home in these instances.

2- Admission to ward (Includes HITH and Medical Assessment and Planning Unit; Excludes registered Short Stay Observation Unit) ~~/return to inpatient ward~~

Includes patients who are admitted to the ward after attending the ED at the same hospital (and HITH), and those patients who attend the ED from an inpatient ward at the same hospital and then return to the ward.

Excludes: patients admitted to a short stay observation unit, (use Code 3 – Admission to short stay observation unit). See also Concept Definitions, Medical Assessment and Planning Unit, page 15.

Any change in ‘Campus code’ in multi-campus transfers is considered a transfer and requires a ‘Transfer destination’ code.

3-Admission to short stay observation unit (Includes Chest Pain Evaluation Unit; Excludes Medical Assessment and Planning Unit)

See also Concept Definitions, short stay observation unit, page 16

9-Departure and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit)

Departure and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit). Does not require a Transfer Destination code.

Excludes: Patients returning to the mental health residential facility in which they live. Use code 1 - Home in these instances.

Armed Forces and Prison Hospitals:

These are not recognised by Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

If a patient is transferred from the ED to an Armed Forces or Prison hospital, Departure Status = 1- Discharge to home (includes return to nursing home, mental health residential facility)

Edits

E137 : Transfer / Destination Source = Campus Code

E142 : Type of Visit Combination Invalid

E182 : First Seen By Treating Nurse / Doctor Date & Departure Status Combination Invalid

E188 : First Seen By Treating Nurse / Doctor Time & Departure Status Combination Invalid

E230 : Departure Status Blank

E231 : Departure Status Invalid

E232 : Transfer Departure Status Code Combination Invalid

* E233 : Unregistered Short Stay Observation Unit

E242 : Referred to on Departure & Departure Status Combination Invalid

E260 : Primary Diagnosis Blank

E320 : Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid

E339 : Inpatient Bed Request and Departure Status Combination Invalid

Related items

Escort Source, Transfer Destination, Referred to on Departure, Reason for Transfer, Departure Transport Mode

Administration

Purpose To identify and monitor the status and location of patients on departure from the ED. It is also used in the measurement and analysis of a variety of performance measures, including the calculation of admission block.

Principal data users Monash University Accident Research Centre; Access Unit, Quality Branch, DHS

Collection start	1 July 1995	Version	1 (Effective 01.07.95)
			2 (Effective 01.07.00)
			<u>3 (Effective 01.07.01)</u>

Definition source	NHDD, V9.0	Code set source	DHS
--------------------------	------------	------------------------	-----

Revision Background

Patients presenting to an acute hospital who require treatment beyond the initial hours of assessment, treatment and observation, have traditionally been admitted to the hospital in-patient ward for ongoing management. In recent years there has been a move to the use of Short Stay Observation Units (SOU) and Medical Assessment and Planning Units (MAPUs) as alternatives to traditional in-patient admission for specific patient groups. The reason for this change relates to the need to provide a more intensive initial period of assessment and re-evaluation over a shorter period.

In order to understand the potential value of SOUs within the Victorian health context, and capitalise on the opportunities that these units may offer for improving patient care practices, it will be necessary to measure and analyse a variety of performance measures. In addition, the data is required to enable the exclusion of these patients from calculations of emergency patients who wait > 12 hour for an inpatient bed.

Description of Injury Event

Revision Summary	Data entry prompts are to be added in order to ensure that the relevant details are recorded correctly.
-------------------------	---

Specification

Definition Patient's description of injury event, provided at triage.

Datatype Alpha/numeric **Form**

Field size One hundred **Layout**

Reported for Mandatory if any other Injury Surveillance items are completed, indicating that the attendance was due to an injury, or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field.

This may be the only injury surveillance item completed if the attendance was **not** due to an injury.

Reporting guide Data entry prompts must be installed to ensure the collection of the required components (see following list).

Data entry prompts

Briefly and concisely describe the injury event using the prompts. and Information should be incorporated into a single description of the injury event covering the following elements for data transmission:

- **Location**
Specific location of where was the person at the time the injury occurred.
For example: own home in the bathroom, workshop, local shops.
- **Activity**
Specific activity what was the person was undertaking at the time the injury occurred.
For example: playing, working on forklift pallet, playing competition Australian rules football.

- *Product*
~~Was there a~~ Specific product involved in the injury (where applicable).
For example: 50mls brand name X medicine, wooden pallet, football.
- *Safety Equipment*
~~Were any~~ Safety devices in use or absent at the time the injury occurred
(where applicable).
For example: wearing steel capped work boots, not wearing seatbelt,
child resistant close was on bottle, mouthguard worn.
- *Additional*
 What the injuries were.
 Which (thing or person) caused the injuries (subject).
Any other relevant information.

Attendances NOT due to injury

Description of Injury Event may be the only injury surveillance item completed in these cases. This is permitted because the item can potentially record valuable data as to the reason for attendance in both injury and non-injury cases.

Valid characters

This field can contain any valid ASCII character for the VEMD as listed in the reference file (see Section 3-111)

Examples:

1. Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing in the bathroom at home.
2. Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, was wearing steel capped boots.
3. Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre.

The above examples outline the sequence of events and information needed to complete the following data items:

Primary Diagnosis

1. Poisoning, paracetamol (code = T391)
2. Crush injury of foot (code = S978)
3. Contusion of cheek (code = S0080)

Nature of Main Injury

1. Poisoning, toxic effect (code = 20)
2. Crushing injury (code = 9)
3. Superficial (code = 1)

Body Region

1. Body Region code not required (code = 22)
2. Foot (code = 19)
3. Face (code = 2)

Description of Injury Event

See above examples 1, 2, and 3

Injury Cause

1. Poisoning - other or unspecified substance (code = 17)
2. Struck by or collision with object (code = 24)
3. Struck by or collision with person (code = 23)

Human Intent

1. Accident (code = 1)
2. Accident (code = 1)
3. Assault not otherwise specified (code =7)

Place Where Injury Occurred

1. Own home, bathroom (code = H)
2. Construction site (code = C)
3. Shopping centre (code = T)

Activity When Injured

1. Leisure (code = L)
2. Working for income (code = W)
3. Working for income (code = W)

Edits

- E290 : Description of Injury Event Invalid
- E291 : Description of Injury Event Blank

Related items

Diagnosis codes, Nature of Main Injury, Body Region, Injury Cause, Human Intent, Place Where Injury Occurred, Activity When Injured

Administration

Purpose To clarify the injury event (vital for identifying the interventions) and provide additional information relevant to the injury (product type, brand name, safety precautions, etc). The narrative is very important to identify injury event features not captured by the coded data.

Principal data users Monash University Accident Research Centre; Access Unit, Quality Branch, DHS

Collection start 1 July 1995 **Version** 1 (Effective 01.07.95)

Definition source DHS **Code set source** DHS

Revision Background

Prompts are to be added to encourage the reporting of the relevant details.

Escort Source

Revision Summary	Discontinue the mandatory collection of Escort Source if Departure Status = 4 - Transfer out of this hospital to another hospital. This field is retained in the VEMD, but the collection of it is optional.
-------------------------	--

Specification

Definition The work location or source of the medical or nursing assistant(s) accompanying a patient being transferred to another hospital.

Datatype Alpha/numeric **Form** Code

Field size One **Layout** N

Reported for Optional ~~Mandatory~~ if Departure Status = 4 - Transfer out of this hospital to another hospital.

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>
	1	Emergency Department
	2	ICU/CCU
	3	Ward
	4	Retrieval Service
	5	Nil (no medical or nursing escort)
	9	Other medical or nursing escort

Reporting guide Item should be left blank if transfer does not apply or if transfer is to a Nursing Home.

Report the first appropriate code which best explains the escort resource.

Edits * E232 : Transfer Departure Status Code Combination Invalid
E250 : Escort Source Code Invalid

Related items Departure Status, Transfer Destination, Reason for Transfer, Departure Transport Mode

Administration

Purpose To monitor ED medical or nursing staff resource consumption for patient transfers.

Principal data users Monash University Accident Research Centre; Access Unit, Quality Branch, DHS

Collection start	1 July 1995	Version	1 (Effective 01.07.95)
			2 (Effective 01.07.97)
			3 (Effective 01.07.01)

Definition source	DHS	Code set source	DHS
--------------------------	-----	------------------------	-----

Revision Background

This item was originally proposed for deletion, however the November 2000 VEMD forum revealed that some sites use it to monitor Reason for Transfer and staff resource utilisation. Therefore, the EDIS Review Committee decided to make the item optional for collection and reporting.

Procedure

Revision Summary	Discontinue the mandatory collection of Procedure if Primary Diagnosis is recorded. This field is retained in the VEMD, but the collection of it is now optional for all VEMD attendances.
-------------------------	--

Specification

Definition Specific interventions/treatments performed in the Emergency Department.

Datatype Alpha/numeric **Form** Code

Field size Eighty nine **Layout** NN (x 30)

Reported for ~~Conditional mandatory~~ **Optional** Mandatory if the Primary Diagnosis item is completed (~~Conditional mandatory item~~).

Reporting guide **Multiple procedure codes:**
Up to 30 procedure codes will be accepted.
Each procedure code must be separated by a left { curly bracket:
For example 01{21{71{91
Procedures will count as one item, even though up to thirty codes can be entered.
It is not necessary to have multiples of 'Other' and 'unspecified' procedure codes. For example: 42{91{91{91{43 → 43{42{91

See: Section 3—53, Procedure Codes.

Edits ~~E205 : Procedure Blank~~
E206 : Procedure Code Invalid
* E207 : Procedure Code Format Invalid

Administration

<i>Purpose</i>	Provides a measure of Emergency Department activity.		
<i>Principal data users</i>	Monash University Accident Research Centre; Access Unit, Quality Branch, DHS		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) <u>2</u> (Effective 01.07.01)
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

Revision Background

This item was originally proposed for deletion in the ‘*Proposals for Revisions to the VEMD for 1.7.2001*’ document. The November 2000 VEMD forum showed that although this item is not currently essential, it is being developed for inclusion in automatically generated electronic discharge letters. Therefore, the EDIS Review Committee decided to make the item optional for collection.

Referred By

Revision Summary	A working definition of Nursing Home and some clarification on allocating code 7-Nursing Home, has been provided.
-------------------------	---

Specification

<i>Definition</i>	Source from which patient was referred to this Emergency Department.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Code
<i>Field size</i>	Two	<i>Layout</i>	NN
<i>Reported for</i>	Every emergency department attendance (Mandatory item).		

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>
	1	Self, family, friends
	2	Local medical officer, includes local GP/Doctor
	3	Outpatients, from this or another hospital
	4	Private specialist
	5	Emergency Department Review from this hospital
	6	Transfer from another hospital campus (also record Transfer Source). Includes both admitted and non-admitted transfers
	7	Nursing Home
	8	Prison / Custodial care
	9	Crisis Assessment Team
	10	Other Community Services
	11	Hospital In The Home Service
	12	Inpatient ward in this hospital campus
	19	Other

Reporting guide Select the first appropriate category.

5-Emergency Department Review from this hospital:

The Emergency Department at this hospital campus has organised a review attendance for the patient. NB: Type of Visit should also reflect this appropriately.

7-Nursing Home

- If patient has come from a nursing home with a referral from a GP (eg accompanying letter or phone call), Referred by = 2-Local medical officer, includes GP/Doctor
- If patient has come from a nursing home without GP referral, that is patient, nursing home staff or relatives have initiated the referral, Referred by = 7- Nursing Home

It is recommended that the following working definition of Nursing Home/Aged Residential Care Facility be used to assist the coding process:

Nursing Homes (also called High Level Care facilities) accommodate elderly people who:

- Require 24 hour nursing care
- Have been assessed by an Aged Care Assessment Service as requiring nursing home care.

Exclude people from Low Level care facilities such as hostels (use Code 19-Other).

Armed Forces and Prison Hospitals:

Armed Forces and Prison Hospitals are not recognised by Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

- If a patient is transferred to the ED from an Armed Forces hospital, Referred By = 19-Other.
- If a patient is transferred to the ED from a Prison hospital, Referred By = 8 - Prison/Custodial care.
- If a patient is transferred from the ED to an Armed Forces or Prison hospital, Departure Status = 1- Discharge to home (includes return to nursing home, mental health residential facility)

Edits

E130 : Referred By Blank

E131 : Referred By Code Invalid

E132 : Referred By and Type of Visit Combination Invalid

E136 : Referred By and Transfer Source Combination Invalid

Related items

Arrival Transport Mode

Administration

<i>Purpose</i>	Required for analyses and monitoring sources of referral to the ED.		
<i>Principal data users</i>	Monash University Accident Research Centre; Access Unit, Quality Branch, DHS		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) 2 (Effective 01.07.97)
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

Revision Background

There is increasing interest in the contribution of patients from nursing homes attending Emergency Departments and the impact this has on emergency workload. The intent of “Referred by” field is to allow for analysis and monitoring of referral sources. Analysis suggests that the allocation and reporting of Referred By code 7-Nursing Home varies across different sites.

Concept Definitions

Medical Assessment and Planning Unit

- Definition*** A Medical Assessment and Planning Unit (MAPU) is a designated ward of a hospital, registered with DHS, that concentrates admissions for general medical conditions in one geographical area to streamline the care planning processes. Patients' planned length of stay in the Medical Assessment and Planning Unit may be up to 48 hours prior to transfer to another ward or discharge home if appropriate.
- Context*** Institutional health care: MAPU patients are admitted patients. Therefore, these patients are included in Departure Status code 2- Admission/return to ward (includes HITH & MAPU; Excludes SOU)
- Guide for use*** For further details and registration information contact the Access Unit, DHS (see Contact Details). The guidelines for registration are currently being defined
- Comments:*** The concept of medical assessment and planning units has gathered momentum within the Victorian health system of recent times and MAPUs have been developed under the auspice of the Division of Medicine, in some hospitals. The primary function of a MAPU is to receive medical admissions and provide an area of focus for effective planning of investigations and care, and engagement between the patient and all health care disciplines, prior to transfer to the appropriate medical ward or home if appropriate.

Short Stay Observation Unit

Definition: A Short Stay Observation Unit (SOU) is a designated unit within a hospital, registered with DHS, that is specifically staffed and equipped to provide observation, care and treatment for emergency patients who have an expected length of stay of between 4 and 24 hours.

Context: Institutional health care: SOU patients are admitted patients.

Guide for use For further details and registration information contact the Access Unit, DHS (see Contact Details). The guidelines for registration are currently being defined. Hospitals must register with DHS in order to be report Departure Status code 3-Admission to short stay observation unit. Edits will identify any non-designated reporting of this code.

Comments: The concept of short stay observation units has gathered momentum within the Victorian health system of recent times and SOUs have been developed in conjunction with Emergency Departments. An SOU may be in, adjacent to or remote from the emergency department. The primary function of an SOU is an extension of emergency care and enables observation, care and treatment of non-elective patients for less than 48 hours. The concept of an SOU excludes elective surgical and radiological procedures.

In order to understand the potential value of SOUs within the Victorian health context, and capitalise on the opportunities that these units may offer for improving patient care practices, it will be necessary to measure and analyse a variety of performance measures. The data required to derive the vast majority of these performance measures are captured through the VAED and the VEMD. However, at this point in time there is no opportunity to differentiate between patients who are managed within an SOU and those that are not.

In addition, the data is required to enable the exclusion of these patients from calculations of emergency patients who wait > 12 hour for an inpatient bed.

Reference File Updates

Postcode File

An updated postcode file will be loaded for July 2001 data onwards. This reference file is used for reporting in the Postcode and Locality fields.

It is anticipated that the updated reference file will be available on the Department's web site from June 2001 at:

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

Select 'Postcode / Locality / SLA File June 2001' located under the 'Selected Reference Files' section.

Hospital Code Table

The Hospital Code Table is currently being updated and VEMD contacts will be notified when it is complete.

File Format

Every file must be submitted:

- in tab (**not** comma) delimited ASCII format (See VEMD Manual, V5.0, Section 3-111, Valid ASCII Characters reference table)
- with each record separated by a carriage return and line feed
- with the data items in the order as specified in the File Structure (See File Structure)
- saved as a text file (.txt)
- compressed into a '.zip' file using a utility such as Winzip

Data items, for discharges on and from 1 July 2001 to 30 June 2002, should be in the Version 6.0 order as specified in this document (See File structure).

Software suppliers are advised to have the capacity to provide multiple versions of the VEMD program to enable hospitals to, at any time, extract files using the appropriate version for the month of data (See table: Edits and the submission process).

All fields should be provided for every record including those instances where the data provision is not mandatory. In cases where data in non-mandatory fields is not available, the field position should still be denoted by **tab**.

Data Submission

Every electronic file submitted to the VEMD must be:

- Named according to the File Naming Convention (See following page)
- Submitted in accordance with the Schedule Requirements (See V5.0 User Manual, Section 4-14)
- Sent to the VEMD email address:
submit.vemd@dhs.vic.gov.au
- Resubmitted until zero rejections are achieved

Period of Extract

All records for patients who **depart** in a particular calendar month should be submitted in the corresponding monthly file. That is, if a patient attends the ED on 30th of September 2001 and departs on the 1st of October 2001, the record should be submitted in the October file (containing discharges on and from 1 October 2001 to 30 October 2001), **NOT** the September file.

File naming conventions

File Name Convention:	AAAABnna.txt		
Where:	AAAA	=	Campus Code (for example: 1020)
	B	=	Version of the dataset (for example: 6)
	nn	=	Month of transmission
	a	=	Data submission indicator (1st submission:11a; 2nd submission:11b)
Example:	1020611a.txt		<i>(Please ensure to zip the file before submission via e-mail)</i>
	1020611a.zip		

File Security

Data file transmission via electronic mail is password encrypted using Winzip by VEMD reporting hospitals and DHS to prevent unauthorised access. Passwords are allocated by DHS and are required to open VEMD data files attached to e-mail messages. Please contact the HDSS Help desk if you have not received a password (See VEMD Manual, V5.0, Section 1-12, Contact Details).

Method for Reporting 'Remaining Ins' on 30 June 2001

The Version 6.0 VEMD format is to be implemented on 1 July 2001. Therefore, **all** information for patients who depart the emergency department on or after this date must be submitted in the new 2001/02 format. This includes patients who remain in the emergency department after midnight on the 30th of June 2001.

Software suppliers are advised to ensure they have the capacity to provide multiple versions of the VEMD program to enable hospitals to, at any time, extract files using the appropriate version for the month of data (See table: Edits and the submission process).

File Structure

Appendix A

The following pages provide details of the revisions to the VEMD, to be implemented from 1 July 2001.

The file structure shows the VEMD data items to be transmitted, and in what sequence. It also summarises the length, type and layout of each data item.

All alpha characters are uppercase (optional for Description of Injury Event).

All numeric fields are right justified

All alpha/numeric fields are left justified, unless otherwise specified

Do not zero fill unless specified.

Conventions Used in this Document

Additions to the 2000-01 VEMD File Structure, effective 1 July 2001 are underlined.

Deletions from the 2000-01 VEMD File Structure, effective 1 July 2001 are ~~struckthrough~~.

Items where changes have been made (including reference file updates), effective 1 July 2001 are in **bold**.

Conditions under which some fields become mandatory

- M = Mandatory
- Ⓔ = Mandatory if Medicare Suffix does not equal C-U, N-E or P-N
- § = Mandatory if *Referred By* = 6
- * = Mandatory if *Arrival Transport Mode* = 1,2,3,4,10
- † = Mandatory if *Departure Status* = 4
- + = Primary Diagnosis is a mandatory field, except where *Departure Status* = 6 - *Left before being seen by doctor (or definitive service provider)* or 8 - *Dead on arrival*. If Diagnosis is an injury, it should be further specified by utilising Injury Surveillance fields
- Ⓢ = Mandatory if any other Injury Surveillance fields are completed, or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis
- ▼ = Mandatory if the Nurse is the definitive service provider (except if *Departure Status* = 6 - *Left before being seen by definitive service provider*)
- ❖ = Mandatory if the Doctor is the definitive services provider (except if *Departure Status* = 6 - *Left before being seen by definitive service provider*)
- Υ = Mandatory if *Inpatient Bed Request* = Y
- ~~⌘ = Mandatory if Primary Diagnosis field is completed~~
- © = Mandatory if *Compensable Status* = 2

	Field name	Maximum characters	Alpha/ numeric	Format/Values
M	Campus Code	4	A/N	NNNN
M	Unique Key	9	A/N	NNNNNNNNN
Patient Biographic				
M	Patient Identifier	10	A/N	NNNNNNNNNN
⌚	Medicare Number	11	N	NNNNNNNNNNN or blank
M	Medicare Suffix	3	A/N	AAA
©	DVA Number	9	A/N	See detailed specification, page 20
M	Sex	1	A/N	1, 2, 3
M	Date of Birth	8	N	DDMMCCYY
M	Country of Birth	4	A/N	NNNN
M	Indigenous Status	1	A/N	2, 5, 6, 7
M	Preferred Language	2	A/N	NN
M	Locality	22	A/N	
M	Postcode	4	N	NNNN

	Field name	Maximum characters	Alpha/ numeric	Format/Values
Patient Management				
M	Arrival Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 19
M	Referred By	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 19
§	Transfer Source	4	A/N	NNNN
M	Type of Visit	2	A/N	1, 2, 3, 4, 5, 8, 9, 10
M	Compensable Status	1	A/N	1, 2, 3, 4, 5, 6, 7
*	Ambulance Case Number	6	A/N	See detailed specification, page 10
M	Arrival Date	8	N	DDMMCCYY
M	Arrival Time	4	N	NNNN
M	Triage Date	8	N	DDMMCCYY
M	Triage Time	4	N	NNNN
M	Triage category	1	A/N	1, 2, 3, 4, 5, 6
▼	First Seen by Treating Nurse Date	8	N	DDMMCCYY or blank
▼	First Seen by Treating Nurse Time	4	N	HHMM or blank
❖	First Seen by Doctor Date	8	N	DDMMCCYY or blank
❖	First Seen by Doctor Time	4	N	HHMM or blank

	Field name	Maximum characters	Alpha/ numeric	Format/Values
⌘	Procedures	89	A/N	NN x 30 or blank
M	Inpatient Bed Request	1	A/N	Y, N
γ	Inpatient Bed Request Date	8	N	DDMMCCYY or blank
γ	Inpatient Bed Request Time	4	N	HHMM or blank
M	Departure Date	8	N	DDMMCCYY
M	Departure Time	4	N	HHMM
M	Departure Status	1	A/N	0, 1, 2, 3, 4, 5, 6, 7, 8, 9
†	Transfer Destination	4	A/N	NNNN
M	Referred to on Departure	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 16, 17, 18, 19
M	Ongoing Care Communication	1	A/N	Y, N
†	Reason for Transfer	1	A/N	1, 2, 3, 4, 5, 6, 7, 9
‡	Escort Source	1	A/N	1, 2, 3, 4, 5, 9 or blank
†	Departure Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 19
+	Primary Diagnosis	6	A/N	ICD-10-AM code
	Additional Diagnoses 1	6	A/N	ICD-10-AM code
	Additional Diagnoses 2	6	A/N	ICD-10-AM code

	Field name	Maximum characters	Alpha/ numeric	Format/Values
Injury Surveillance				
⊙	Nature of Main Injury	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26
⊙	Body Region	2	A/N	F1, F2, F3, F4, F5, F6, F7 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22
⊙	Description of Injury Event	100	A/N	
⊙	Injury Cause	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30
⊙	Human Intent	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
⊙	Place Where Injury Occurred	1	A/N	H, I, S, A, R, T, C, Q, F, M, P, O, U
⊙	Activity When Injured	1	A/N	S, L, W, E, C, N, V, O, U

Amended, deleted and new edits

Appendix B

Deleted edit

E205 Procedure Blank

Effect REJECTION

Problem

~~Procedure code has not been recorded.~~

~~The recording of a procedure is mandatory in all cases where the Primary Diagnosis item has been completed.~~

~~See: Section 2-89, Procedure.~~

Remedy

~~Allocate an appropriate Procedure code and resubmit the transaction.~~

Amended Edit

E207 Procedure Code Format Invalid

Effect REJECTION

Problem

- Procedure code format is not valid, eg) Procedure codes have been separated by more than one curly bracket `}}`, or include a space; **OR**
- Procedure code sequence is not valid, eg) There is a blank first Procedure followed by a valid Procedure code.

~~Procedure codes must be completed, unless the Primary Diagnosis is blank.~~

Remedy

Remove incorrect formatting or blank the Procedure, and resubmit transaction.

~~Contact your software supplier to ensure blank procedure codes are not transmitted.~~

Amended edit

E232 Transfer Departure Status Code Combination Invalid

Effect REJECTION

Problem

- Departure Status = 4-Transfer out of this hospital to another hospital, but Transfer Destination, Reason for Transfer, ~~Escort Source~~ and/or Departure Transport Mode are null.
If the Departure Status = 4, Transfer Destination, Reason for Transfer, ~~Escort Source~~ and Departure Transport Mode items must be completed;
OR
- Departure Status = 0, 1, 2, 5, 6, 7, or 9, but Transfer Destination, Reason for Transfer, ~~Escort Source~~ and/or Departure Transport Mode not null.
If Departure Status = 0, 1, 2, 5, 6, 7, or 9, then Transfer Destination, Reason for Transfer, ~~Escort Source~~ and Departure transport Mode must be null.

Remedy

Check the Departure Status, correct as appropriate and resubmit transaction.

New Edit

E233 Unregistered Short Stay Observation Unit

Effect REJECTION

Problem

Departure Status = 3 – Admission to short stay observation unit (Excludes MAPU), but the Campus Code is not registered with DHS.

Remedy

Check the Departure Status, correct as appropriate and resubmit the transaction.

Contact DHS, Access Unit (see Contact Details, Section 1-12) for registration of the short stay observation unit.