

Section 5— Compilation and Submission

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File Structure

The file structure detailed in the following pages details the sequence, length, type and layout of data items to be transmitted to the VEMD.

File Structure Notes:

- All alpha characters must be in UPPERCASE (optional for Description of Injury Event)
- Do not zero fill items unless specified
- Padding fields with space characters (either to the left or right) is unnecessary

Note: Conditional mandatory items: See Conditional Mandatory Items Key below for the conditions under which they become mandatory. The Excel column alpha character/s in the File Structure represent each of the letters at the head of Excel worksheet columns. Each data item completed must be located in the corresponding column of the Excel worksheet (see also Page 5 – 11, File Format).

Conditional Mandatory Items Key

Key	Descriptor
M	Mandatory item
⌚	Mandatory if Medicare Suffix does not equal C-U, N-E or P-N
§	Mandatory if Referred By = 6
*	Should be reported if Arrival Transport Mode = 1, 2, 3, 4, 10
†	Mandatory if Departure Status = 4
⊕	Primary Diagnosis is a mandatory item, 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, further specified by utilising Injury Surveillance items
⊙	Mandatory if any other Injury Surveillance items are completed, or if an injury code from the Nature of Main Injury & Body Region Matrix is in the Primary Diagnosis item
▼	Mandatory if the Nurse is the definitive service provider (except where Departure Status = 6 - Left before being seen by definitive service provider)
❖	Mandatory if the Doctor is the definitive services provider (except where Departure Status = 6 - Left before being seen by definitive service provider)
⊕	Mandatory if Primary Diagnosis code = 'Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment'.
↗	Mandatory if an inpatient bed request was made, regardless of whether the patient is actually admitted as an inpatient
⌘	Mandatory if Primary Diagnosis item is completed
⊙	Mandatory if Compensable Status = 2
‡	Optional if Departure Status = 4 – Transfer from this hospital

	Field Name	Maximum Characters	Alpha / Numeric	Format / Values	Excel Position
M	Campus Code	4	A/N	NNNN	A
M	Unique Key	9	A/N	NNNNNNNNNN	B
Patient Biographic					
M	Patient Identifier	10	A/N	NNNNNNNNNN	C
∞	Medicare Number	11	N	NNNNNNNNNNNN or blank	D
M	Medicare Suffix	3	A/N	AAA	E
©	DVA Number	9	A/N	See detailed specification: VEMD Manual, 3-47	F
M	Sex	1	A/N	1, 2, 3	G
M	Date of Birth	8	N	DDMMCCYY	H
M	Country of Birth	4	A/N	NNNN	I
M	Indigenous Status	1	A/N	2, 5, 6, 7	J
M	Preferred Language	2	A/N	NN	K
M	Locality	22	A/N		L
M	Postcode	4	N	NNNN	M
Patient Management Data					
M	Arrival Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 19	N
M	Referred By	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 19	O
§	Transfer Source	4	A/N	NNNN	P
M	Type of Visit	2	A/N	1, 2, 3, 4, 5, 8, 9, 10	Q
M	Compensable Status	1	A/N	1, 2, 3, 4, 5, 6, 7	R
*	Ambulance Case Number	6	A/N	See detailed specification: VEMD Manual, 3-10	S
M	Arrival Date	8	N	DDMMCCYY	T
M	Arrival Time	4	N	HHMM	U

M	Triage Date	8	N	DDMMCCYY	V
M	Triage Time	4	N	HHMM	W
M	Triage Category	1	A/N	1, 2, 3, 4, 5, 6	X
▼	First Seen by Treating Nurse Date	8	N	DDMMCCYY or Blank	Y
▼	First Seen by Treating Nurse Time	4	N	HHMM or Blank	Z
❖	First Seen by Treating Doctor Date	8	N	DDMMCCYY or Blank	AA
❖	First Seen by Treating Doctor Time	4	N	HHMM or Blank	AB
⌘	Procedure	89	A/N	NN (x30)	AC
↗	Inpatient Bed Request Date	8	N	DDMMCCYY or Blank	AD
↗	Inpatient Bed Request Time	4	N	HHMM or Blank	AE
M	Departure Date	8	N	DDMMCCYY	AF
M	Departure Time	4	N	HHMM	AG
M	Departure Status	1	A/N	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	AH
†	Transfer Destination	2	A/N	NNNN	AI
M	Referred to on Departure	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 16, 17, 18, 19	AJ
M	Ongoing Care Communication	1	A/N	Y, N	AK
†	Reason for Transfer	1	A/N	1, 2, 3, 4, 5, 6, 7, 9	AL
‡	Escort Service	1	A/N	1, 2, 3, 4, 5, 9 or blank	AM
†	Departure Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 10, 11, 19	AN
⊛	Primary Diagnosis	5	A/N	ICD-10-AM VEMD Code	AO
☞	Additional Diagnosis 1	5	A/N	ICD-10-AM VEMD Code	AP
	Additional Diagnosis 2	5	A/N	ICD-10-AM VEMD Code	AQ

Injury Surveillance Data					
⊙	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	AR
⊙	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	AS
⊙	Description of Injury Event	250	A/N		AT
⊙	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	AU
⊙	Human Intent	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	AV
⊙	Place Where Injury Occurred	1	A/N	H, I, S, A, R, T, C, Q, F, M, P, O, U	AW
⊙	Activity When Injured	1	A/N	S, L, W, E, C, N, V, O, U	AX

Submission Overview

Every electronic file submitted to the VEMD must be:

- Named according to the File Naming Convention (See below)
- Submitted in accordance with the Schedule Requirements
(See Page 5-13)
- Sent to the VEMD email address: submit.vemd@dhs.vic.gov.au
- Resubmitted until zero REJECTIONS are achieved.

Data Definition

The definition of data elements and code sets are as published throughout this manual.

File Naming Convention

File naming conventions must be adhered to for every file submitted to the VEMD:

File Naming Convention	AAAABnna.txt
Where:	AAAA = Campus Code (for example: 1020)
	B = Version of the dataset (for example: 7)
	nn = Month of Transmission
	a = Data Submission Indicator (1 st submission 07a, 2 nd 07b)
Example:	
	1020707a.txt (<i>please ensure to zip the file before submission via e-mail 1020707a.zip</i>)

Transmission Modes

Monthly VEMD patient level data files should be sent via e-mail. Attached files must be zipped and password protected (See Page 5 – 10, File Security). Mailed DOS formatted diskettes are also acceptable, although not preferred (See Page 1 – 12, Contact Details for mail address).

File Security

To date data files transmitted by VEMD reporting hospitals and the Department via electronic mail have been password encrypted using WinZip to deter unauthorised access. Passwords are allocated by the Department 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, Version 6.0, Section 1 - 12).

At the time of printing new secure data transmission modes were being tested. The Department will advise any changes to the current security arrangements via an HDSS Bulletin.

Deletion of Episode Records

It is possible to delete a previously accepted episode record from the VEMD.

To delete the episode a deletion record must be sent, this is a copy of the accepted episode record with a Medicare number equal to '9999999999'.

Period of Extract

All records for patients who **depart** in a particular calendar month should be submitted in corresponding monthly file. That is, if a patient attends the ED on 30th of July 2002 and departs on 1 August 2002, the record should be submitted in the August file (containing discharges on and from 1 August to 31 August 2002), **NOT** in the July file.

Patients ‘Remaining In’ on 30 June 2002

The Version 7.0 VEMD format is to be implemented on 1 July 2002. Therefore, all information for patients who depart the Emergency Department on or after this date must be submitted in the new 2002—2003 format. This includes patients who remain in the Emergency Department after midnight on the 30 June 2002.

File Format

Every file must be submitted:

- In the Version 7.0 order as specified in this document, for discharges on and from 1 July 2002 to 30 June 2003 (See File Structure).
- In tab (**not** comma) delimited ASCII format
- In cases, where data in non-mandatory items is unavailable the field position should be denoted by a **tab**.
- With each record separated by a carriage return and line feed.
- Saved as a text file (.txt).
- Compressed into a '.zip' file using a utility such as WinZip.

Software suppliers are advised to have the capacity to generate earlier versions of the VEMD file formats to enable hospitals to, at any time, extract files using the version appropriate for the extraction period. (See table: Edits and the Submission process).

Also note that in relation to data format:

- Data transmitted to VEMD must only include codes specified in the File Structure (See Page 5 – 5). Local systems may collect data through the use of other codes, acronyms or text; however, these must be converted into appropriate VEMD format for submission to VEMD.
- Only VEMD ICD-10-AM diagnosis codes, from Page 4 – 69, must be utilised for submission. Do not utilise the ICD-10-AM coding books as not all codes are included and a degree of code variation exists between codes used in the VEMD and those used in the VAED.
- Procedures: Multiple procedure codes will count as one item even though the Manual allows for the transmission of up to 30 Procedure codes. Each Procedure code should be separated by a left curly bracket {.
- Description of Injury Event: The text for this item does not need to be enclosed in quotation marks (i.e. “textual information”) as each tab separates the items. Quotation marks can be used to emphasise words within the text.

Data Quality

Edits

The edit process has been further modified for financial year 2002—2003 and some new edits have been included. Wherever possible, edits should be maintained within the Emergency Department's in-house data information system to minimise rejection of records from the DHS editing program (see Section 6, Editing).

Edit messages and business rules covered in Section 6 are in alphanumeric order of the edit numbers and also detail the edit title, data items involved, the effect of the edit, the problem and the remedy. The below table outlines the problem and remedy for the three possible edit effects:

<i>Effect</i>	<i>Problem</i>	<i>Remedy</i>
Run terminated	The monthly data file is corrupt or contains data that may compromise the dataset integrity	Hospital determines and resolves the data problem and resubmits data file
Rejection	Data item/s in the attendance record did not meet the criteria specified in the business rules	Hospital determines the cause of the rejection, corrects it and resubmits the monthly data file Zero rejections must be achieved for each monthly data file to be accepted into the VEMD (See also Schedule Requirements, Page 5 – 13)
Warning	Record was acceptable but data item/s in the attendance record were questionable	Hospital checks that the data is valid. If necessary, correct the data and resubmit the data file

Standard Data Reports

Standard Data Reports are distributed to the VEMD Submission Officer and the Director of the Emergency Department.

Current data reports include information relating to waiting times, length of stay, triage categories, planned re-presentations and top 20 diagnoses. The structure and layout of the reports may change and feedback is sought (See Section 1 – 15, Contact Details).

Schedule Requirements

Electronic Patient Level Data:

<i>2002 – 2003 Data</i>	<i>Timeline</i>
Monthly electronic file	Must be received at DHS within ten days of following month (for example, July data by 10th August)
	Should be resubmitted a maximum of four times for further editing (maximum of five data submissions in total)
	Must be completed by the end of the following month (for example, July data with zero rejections by 31st August)

Note: DHS will endeavour to return reject reports within five working days of submission.

In the 2002—2003 financial year, financial bonuses apply for ‘Data Quality and Timeliness’. The aim is to maximise the number of VEMD records available for analysis as soon after the close of the transmission period as possible.

For details of the bonuses, which will apply to ‘Data Quality and Timeliness’ indicators in 2002—2003, hospitals should refer to the following documents:

- Victoria – Public Hospital’s Policy and Funding Guidelines 2002—2003, and
- Hospital Services Quality Framework Business Rules 2002—2003

