Proposals for Revisions to the. Victorian Emergency Minimum Dataset. (VEMD) for 1 July 2006.

(February 2006).

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Proposals for Revisions to the VEMD for 1 July 2006

Background

The Department of Human Services (DHS) conducts an annual review of the Victorian Emergency Minimum Dataset (VEMD) data elements and format. This process is undertaken to maintain and enhance the patient level data reported to the VEMD by the participating Emergency Departments (ED).

The proposals contained within this document should not be regarded as an absolute list of changes to be made to the VEMD for the 2006—07 financial year. Items in this publication cannot be guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate that it will not change from 1 July 2006. Final changes, including new and amended edits will be released in the Specifications for Revisions to the Victorian Emergency Minimum Dataset document in March 2006.

This 'Proposals' document is being distributed to ED Directors and Submission Officers at all VEMD participating Victorian hospitals, software suppliers, and a range of industry associations.

It is expected that the release of these proposals will stimulate discussion within the health industry. Hospitals, emergency associations and software suppliers should review this document carefully and provide any queries or comments to the Health Data Standards and Systems Unit (HDSS) on the attached proforma by Friday February 2006.

A representative of the proposing organisation will present their proposal as outlined in this document at the EDIS Review Committee Meeting on Tuesday 28 February 2006. There will be further opportunity to comment in writing following this meeting.

Introduction

Since implementation of the tenth edition of the VEMD dataset, additional issues and data requirements have been noted by the Department or highlighted by data users and participating hospitals. Proposed solutions to these data needs are contained within this document and will be considered by the Emergency Department Information System (EDIS) Review Committee.

The proposals for the Eleventh Edition (1 July 2006), listed in this document comprise additions and modifications to existing Concept Definitions and Data Items. Associated business rules and edits for new and amended data items will be added or modified for inclusion in the Final Specifications for Revisions to the VEMD document.

Characteristics of this document are:

- Proposed additional text for existing data items appear in boxes;
- ~~Text proposed for deletion from existing data items is struck through;~~
- New data item additions to the VEMD are identified in the section heading rather than with individual formatting;
- Page numbers representing cross referencing to another section of the VEMD Manual are represented by a #; and
- Further information such as the background to each proposal is provided.

Complete details of existing data item formats, codes and edits are located in the Ninth Edition of the VEMD Manual, 1 July 2004 (with Tenth Edition update pages for, 1 July 2005).

Summary of proposals

For the 2006-07 financial year there are two proposals for changes to the VEMD. Both these proposals support improved information availability for policy formulation, planning, service monitoring and funding that reflect specific issues in providing emergency department care.

Proposal 1 - Change to Departure Status codeset

Modify the Departure Status data item by adding four items to the codeset.

The proposal is to add codes to the codeset to identify:

- departure to a Medical Assessment and Planning Unit;
- departure to an Intensive Care Unit;
- departure to a mental health bed at this hospital; and,
- departure to a mental health bed at a different hospital.

The existing categories of *2 - ward* and *4 - Another hospital campus* would be reduced in scope to exclude the above departure destinations. Additionally, rehabilitation in the home (RITH) is no longer considered an admitted patient activity and so departure to RITH will be removed from the scope of category 2 as well.

To support these new categories, concept definitions for Intensive Care Unit and Mental Health Bed will be added to section 2.

Proposal 2 - New data items - Time and Date seen by Mental Health Practitioner

To add new data items to record the time and date that the patient is first seen by a specialist mental health practitioner following arrival in the ED.
The proposal involves inclusion of two data items to record the date and time of this event, plus a new concept definition of a mental health practitioner.

Data Definition Structure

The below table provides descriptions of the attributes common to every data item located in Section 3, Data Definitions (VEMD User Manual).

Specification

Definition	A statement that expresses the essential nature of a data item and its differentiation from all other data items.
Datatype	The type of symbol, character or other designation used to represent a data item. For example: Alpha/Numeric - a field on which calculations are not performed Numeric - a field on which calculations are performed
Form	Name or description of the form of representation for the data item, such as: Date, Code (code set), and Quantitative value. For example, the representational form for Country of Birth is 'Code' because codes drawn from the codeset represent a different country.
Field size	The maximum number of characters used to represent this data item.
Layout	The layout of characters in the data item, expressed by a character string representation (see also Field size). For example: 'DDMMCCYY' for dates 'NNN' for a numeric value of 3 digits
Reported for	The presentation types that require this data item to be reported.
Code set	The set of valid values for the data item, according to the form, layout, datatype and field size.
Reporting guide	Additional comments or assistance on interpreting, applying and reporting the data item and code set.
Edits	Edits that relate to this data item.
Related items	Non-exhaustive reference between the data item and related subjects within this collection.

Administration

Purpose	The main reason for the collection of this data item.
Principal data users	The key/primary users of this information.
Collection start	The date the collection of this data item commenced.
Version	A version number for each data item, beginning with 1 for the initial version of the data item and 2, 3 etcetera, for each subsequent revision.
Definition source	The source from which the data item was defined.
Code set source	The source from which the data item code set was developed.

Proposals for changes to VEMD

Proposal #1

Changes to Departure Status

Proposal:

Modify the Departure Status field by adding four items to the codeset. Three of these items explicitly identify specific departure destinations for patients who leave the Emergency Department for another area within the Hospital. These are currently captured by code *2 - Ward.* The proposal is to add codes to the codeset to identify:

- departure to a Medical Assessment and Planning Unit;
- departure to an Intensive Care Unit; and,
- departure to a mental health bed at this hospital.

The existing category of *2 - ward* would be reduced in scope to exclude the above departure destinations. Additionally, rehabilitation in the home (RITH) is no longer considered an admitted patient activity and so departure to RITH will be removed from the scope of this category as well.

The fourth item identifies where a patient is transferred to a Mental Health bed at another Hospital or Hospital Campus. This event is currently captured by code *4 - Another hospital campus (also record Transfer Destination)* and this category would be reduced in scope to exclude the new departure destination.

To support these codeset categories, concept definitions for Intensive Care Unit and Mental Health Bed will be added to section 2.

Proposed by:

Statewide Emergency Program Unit, Metropolitan Health & Aged Care Services

Contact: David Gardner, Team Leader, Statewide Emergency Program

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Reason for Proposed Change:

To enable monitoring of patient flows from the Emergency Department to other areas of specific care within the hospital in order to provide improved information for service planning, monitoring and funding of healthcare initiatives. Specifically:

Departure to a Medical Assessment and Planning Unit - hospitals are funded for an observation unit co-payment for emergency patients who attend an observational

medical unit such as a MAPU. Addition of this codeset category will allow the co-payment to hospitals to be calculated in a more accurate manner.

Departure to an Intensive Care Unit - this item will provide important information regarding ICU patients in emergency departments. This information can be analysed to provide a better understanding of emergency ICU demand and the amount of time ICU type patients spend in the emergency department.

Departure to a mental health bed - information about departures to an inpatient mental health bed will assist DHS to understand the different access issues experienced in the health system for patients reuiring specialist care, such as Mental Health care. The benefits of improved access to health services assists all emergency patients.

Specification

Changes to Section 2

Add definition of Intensive Care Unit.

Intensive Care Unit

Definition

An intensive care unit (ICU) is a designated ward of a hospital that is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

Guide for use

There are five different types and levels of ICU, details of which are listed below:

- Adult intensive care – level 3, level 2, level 1
- Paediatric intensive care
- Neonatal intensive care – level 3

As defined, ICUs do not include Special Care Nurseries, Coronary Care Units, High Dependency Units, Intensive Nursing Units or Stepdown Units.

All types of ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

Adult Intensive Care Unit – Level 3:
Nature of Facility
A level 3 adult ICU must be a separate and self contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary referral centre for intensive care patients and have extensive back up laboratory and clinical service facilities to support this tertiary referral role.

Care Process
A level 3 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for an indefinite period. These types of services are illustrative of the nature of care provided in a level 3 adult ICU but are not exhaustive of the possibilities.

Adult Intensive Care Unit – Level 2:
Nature of Facility
A level 2 adult ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support.

Care Process
A level 2 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for a period of at least several days. These types of services are illustrative of the nature of care provided in a level 2 adult ICU but are not exhaustive of the possibilities.

Adult Intensive Care Unit – Level 1:
Nature of Facility
A level 1 adult ICU must be a separate and self-contained facility in the hospital capable of providing basic multi-system life support usually for less than a 24-hour period.

Care Process
A level 1 adult ICU must be capable of providing mechanical ventilation and simple invasive cardio-vascular monitoring for a period of at least several hours. These types of services are illustrative of the nature of care provided in a level 1 adult ICU but are not exhaustive of the possibilities.

Paediatric Intensive Care Unit:
Nature of Facility
A paediatric ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary referral centre for children needing intensive care and have extensive backup laboratory and clinical service facilities to support this tertiary role.

Care Process
A paediatric ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for an indefinite period to infants and children less than 16 years of age. These types of services are illustrative of the nature of care provided in a paediatric ICU but are not exhaustive of the possibilities.

Neonatal Intensive Care Unit – Level 3:
Nature of facility
A level 3 neonatal ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period.

Care Process
A neonatal ICU must be capable of providing mechanical ventilation and invasive cardio-vascular monitoring. These types of services are illustrative of the nature of care provided in a neonatal ICU but are not exhaustive of the possibilities.

Add definition of Mental Health Bed.

Mental Health Bed

Definition A DHS Mental Health Branch approved and funded bed in an Area Mental Health service.

Guide for use None.

Changes to Section 3

Modify departure status:

Departure Status

Definition

Patient destination or status on departure from the Emergency Department.

Datatype Alpha/numeric ***Form*** Code

Field size Two ***Layout*** N or NN

Reported for

Every Emergency Department presentation.

Code set

Code	Descriptor
0	Residential care facility (includes nursing home, hostel, psychogeriatric nursing home, residential care respite bed)
1	Home
2	Ward ~~(includes HITH, RITH and Medical Assessment and Planning Unit~~; ~~Excludes Emergency Medical Unit, and Short Stay Observation Unit)~~
3	Short Stay Observation Unit ~~(excludes Emergency Medical Unit and Medical Assessment and Planning Unit)~~
4	Another hospital campus (excludes for Mental Health; also record Transfer Destination)
5	Left at own risk, after treatment started
7	Died within ED
8	Dead on arrival
9	Mental health residential facility ~~(excludes psychogeriatric nursing home, use 0)~~
10	Left after clinical advice regarding treatment options
11	Left at own risk, without treatment
12	Correctional/Custodial Facility
13	Emergency Medical Unit ~~(excludes Medical Assessment and Planning Unit and Short Stay Observation Unit)~~
14	Medical Assessment and Planning Unit ~~(excludes Emergency Medical Unit and Short Stay Observation Unit)~~
15	Intensive Care Unit
16	Mental Health bed in this hospital
17	Mental Health bed at a different hospital

Reporting guide

Used to identify the **immediate** destination or departure status of the patient upon departure from the ED. This may not necessarily be to the patient's usual place of residence.

0 - Residential care facility (includes nursing home, hostel, psychogeriatric nursing home, residential care respite bed)

Includes: nursing home, hostel, psychogeriatric nursing home, residential care respite bed and nursing home beds which are located within an acute or sub-acute hospital campus

1 - Home

Includes:

- house;
- unit;
- boarding/rooming house;
- hotel;
- caravan;
- youth hostel accommodation;
- homeless person's shelters;
- shelter/refuges;
- armed forces hospitals;
- no fixed abode; and
- patients going to a Rehabilitation In The Home programme.

Excludes:

- accommodation described in remainder of codeset.

2 – Ward ~~(includes HITH, RITH and Medical Assessment and Planning Unit; Excludes Emergency Medical Unit, and Short Stay Observation Unit)~~

Includes patients who:

- are admitted to the ward after attending the ED at the same hospital;
- are admitted to HITH;
- attend the ED from an inpatient ward at the same hospital and then return to the ward (except as noted below.)

Excludes patients who:

- attend the ED from an inpatient ward at the same hospital and then return to a Mental Health bed (use 16);
- return home to RITH (RITH is no longer considered an admitted patient service - use 1.)
- depart to a Short Stay Observation Unit (use 3);
- depart to an Emergency Medical Unit (use 13);
- depart to a Medical Assessment and Planning Unit (use 14);
- depart to an Intensive Care Unit (use 15).

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

See also Section 2 – Concept and Derived Item Definitions.

Any change in 'Campus code' in multi-campus transfers is considered a transfer and requires a 'Transfer Destination' code.

3 – Short Stay Observation Unit ~~(Excludes Emergency Medical Unit and Medical Assessment and Planning Unit)~~

Excludes:

- Emergency Medical Unit (use 13);
- Medical Assessment and Planning Unit (use 14);

See also Section 2 – Concept and Derived Item Definitions.

4 - Another hospital campus

Excludes:

- armed forces hospitals (use 1);
- correction facility hospital (use 12);
- Patients being transferred to a Mental Health bed at another hospital campus (use 17).

Transfer Destination must also be reported.

5 – Left at own risk, after treatment started

Patient departs the Emergency Department after being seen by a definitive service provider despite being advised by clinical staff NOT to leave. The appropriate hospital forms must be completed and signed by the patient.

7 – Died Within ED

Patient died after commencement of ED presentation. Includes where there is an intention to resuscitate but the patient is later pronounced dead.

8 – Dead on Arrival

Patient is pronounced dead by a medical practitioner before (or without) being brought into the ED or where the patient is bought into the ED but there is no intention to resuscitate.

9 – Mental health residential facility ~~(Excludes psychogeriatric nursing home, use 0)~~

Does not require a Transfer Destination code.

Excludes:

- psychogeriatric nursing home (use 0);
- transfer to inpatient Mental health bed (use 16 or 17).

10 – Left after clinical advice regarding treatment options

At or subsequent to triage, the patient has received advice about Emergency Department and alternative treatment options. On consideration of this advice, the patient chooses to leave without being seen by a definitive service provider.

11 – Left at own risk, without treatment

Patient departs the Emergency Department before being seen by a definitive service provider:

- Without notifying staff; OR
- Despite being advised by clinical staff NOT to leave; OR
- Without receiving advice about alternatives to treatment in the Emergency Department

Common descriptions include: Did Not Wait, DNW, Failed To Answer, FTA.

12 – Correctional / Custodial Facility

Does not require a Transfer Destination code. Refer to comments below.

13 – Emergency Medical Unit ~~(Excludes Medical Assessment and Planning Unit and Short Stay Observation Unit)~~

Excludes:

- Short Stay Observation Unit (use 3);
- Medical Assessment and Planning Unit (use 14);

See also Section 2 – Concept and Derived Item Definitions.

14 – Medical Assessment and Planning Unit

Excludes:·

- Short Stay Observation Unit (use 3);
- Emergency Medical Unit (use 13).

See also Section 2 – Concept and Derived Item Definitions.

15 – Intensive Care Unit

See also Section 2 – Concept and Derived Item Definitions.

16 – Mental Health bed at this hospital

The bed or ward must be part of an approved mental health programme. See also Section 2 – Concept and Derived Item Definitions.

17 – Mental Health bed at a different hospital

Excludes:

- armed forces hospitals (use 1);
- correction facility hospital (use 12).

The bed must be an approved bed. Transfer destination must also be reported.

See also Section 2 – Concept and Derived Item Definitions.

Armed Forces and Prison Hospitals:

These are not generally recognised as hospitals by the Commonwealth 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 hospital, Departure Status equals '1 - Home'.

If a patient is transferred from the ED to a Prison hospital, Departure Status equals '12 - Correctional/Custodial Facility'.

Edits

E142	Dead on Arrival Combination Invalid
E181	First Seen By Treating Nurse Date/Time Before Triage Date/Time
E182	First Seen By Treating Nurse / Doctor Date/Time and Departure Status Combination Invalid
E230	Departure Status Invalid
E232	Transfer Departure Status Code Combination Invalid
E233	Unregistered Short Stay Observation Unit
E242	Referred to on Departure and Departure Status Combination Invalid
E260	Primary Diagnosis Blank
E339	Inpatient Bed Request Date/Time and Departure Status Combination Invalid
E342	Primary Diagnosis Recorded When Departure Status Is '10', '11' OR '8'.
E356	Type of Usual Accommodation and Departure Status Combination Invalid
E366	Departure Status and Triage Category Combination Invalid
E367	Unregistered Emergency Medical Unit
E???	Unregistered Medical Assessment and Planning Unit
E???	Unregistered Intensive Care Unit
E???	Unregistered Mental Health programme

Related items

Escort Source, Transfer Destination, Referred to on Departure, Reason for Transfer, Departure Transport Mode, Departure Date/Time.

Administration

Purpose

To identify and monitor the status and location of patients on departure from the ED. It is also used to define patients for whom performance measures, including admission block, are calculated.

Principal data users

Monash University Accident Research Centre; Hospital Demand Management, DHS.

Collection start

1 July 1995

Version

1 (Effective 01.07.95)
2 (Effective 01.07.00)
3 (Effective 01.07.01)
4 (Effective 01.07.02)
5 (Effective 01.07.03)
6 (Effective 01.07.06)

Definition source

NHDD

Code set source

DHS

Proposal #2

(New data items) First Seen By Mental Health Practitioner

Proposal:

To add new data items to record the time and date that the patient is first seen by a specialist mental health practitioner following arrival in the ED.
The proposal involves inclusion of two data items to record the date and time of this event, plus a new concept definition of a mental health practitioner.

Proposed by:

Statewide Emergency Program Unit, Metropolitan Health & Aged Care Services

Contact: David Gardner, Team Leader, Statewide Emergency Program

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Reason for Proposed Change:

Ther is strong anecdotal evidence that there are increasing numbers of patients attending emergency departments across the state who are in need of treatment or assessment by a mental health practitioner. Management of this group of patients was identified by the Auditor General in the report "Managing emergency demand in public hospitals" as an area requiring further work.
Current information systems do not accurately record the numbers of these patients presenting to EDs. The VEMD currently can provide only indicative data based on diagnosis codes. Including this item will provide more accurate data on the number of patients in EDs who require mental health services.
This proposal is supported by a policy initiative that prompt access to and assessment by a mental health clinician become a required element of emergency department services. Time to assessment by that clinician will become part of the performance monitoring process for emergency departments.
For many patients with mental health conditions who attend emergency departments, assessment by a mental health clinician is clearly definitive treatment. Where a mental health clinician sees the patient before either the treating nurse or doctor, then the time of that assessment should be recorded as the treatment time.

Changes to Section 2

Add new concept definition:

Mental Health Practitioner

Classification	Concept
Definition	A Mental health practitioner is a registered nurse (Division 1 or Division 3), psychologist, social worker, occupational therapist, Medical Officer/Psychiatrist or other suitably qualified staff member who is employed by an approved mental health service or working as part of a mental health program.
Guide for Use	None.

Changes to Section 3

Add two new data items:

First Seen By Mental Health Practitioner Date

Definition	The date the patient was first attended to by a Mental Health Practitioner.		
Datatype	Date	***Form***	Date
Field size	Eight	***Layout***	DDMMCCYY or blank

Reported for

All presentations where the patient is seen by a mental health practitioner. (Conditional mandatory.)

Reporting guide

Where the Mental Health practitioner is the definitive service provider First Seen By Doctor Date/Time and First Seen By Treating Nurse Date/Time may be left blank.

Where Departure Status is '10 – Left after clinical advice, regarding treatment options', or '11 – Left at own risk, without treatment' first Seen By Mental Health Practitioner Date/Time, First Seen By Doctor Date/Time and First Seen By Treating Nurse Date/Time should be left blank.

Where a valid date has been entered in First Seen By Mental Health Practitioner Date, a valid time must be entered in First Seen By Mental Health Practitioner Time.

The date/time must be between arrival date/time and departure date/time.

Administration:

Purpose

To facilitate service planning for and monitoring of access and service provision to emergency department patients in need of mental health treatment or assessment.

Principal data users

Statewide Emergency Services Program; Mental health Branch, DHS.

Collection start	1 July 2006	***Version***	1 (Effective 01.07.06)
Definition source	DHS	***Code set source***	DHS

First Seen By Mental Health Practitioner Time

Specification

Definition	The time the patient was first attended to by a Mental Health Practitioner.		
Datatype	Time	***Form***	Quantitative Value
Field size	Four	***Layout***	HHMM or blank

Reported for

All presentations where the patient is seen by a mental health practitioner. (Conditional mandatory.)

Reporting guide

Where a valid date has been entered in First Seen By Mental Health Practitioner Date, a valid time must be entered in First Seen By Mental Health Practitioner Time.

The date/time must be between arrival date/time and departure date/time.

Valid Format:

HHMM (Must be in 24-hour format) between 0001 and 2359

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

See Section 2 – Concept and Derived Item Definitions.

Edits

E???	First Seen By Mental Health Practitioner Date/Time Before Arrival Date/Time
E???	First Seen By Mental Health Practitioner Date/Time After Departue Date/Time
E???	First Seen By Mental Health Practitioner Date/Time Invalid
E182	First Seen By Treating Nurse / Doctor / Mental Health Practitioner Date/Time and Departure Status Combination Invalid

Related items

First Seen By Mental Health Practitioner Date.
First Seen By Doctor Date.
First Seen By Doctor Time.
First Seen By Nurse Date.
First Seen By Nurse Time.

Administration

Purpose	To facilitate service planning for and monitoring of access and service provision to emergency department patients in need of mental health treatment or assessment.		
Principal data users	Statewide Emergency Services Program; Mental health Branch, DHS.		
Collection start	1 July 2006	***Version***	1 (Effective 01.07.06)
Definition source	DHS	***Code set source***	DHS