Proposals for revisions to the Victorian Emergency Minimum Dataset 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 the Victorian Emergency Minimum Dataset (VEMD). This review seeks to ensure that the emergency department presentations data 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.

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

The proposed revisions for the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2008 include:

- Addition of a new code for referred by 'Nurse on Call' to the code set for existing data item *Referred by.*
- Addition of a new code for 'Mental Health Observation/Assessment Unit' to the code set for existing data item *Departure Status*.
- Introduction of a new data item to record the accuracy of the patient's reported date of birth.
- Inclusion of new terms in the Diagnosis term set and update the VEMD library file to be consistent with ICD-10-AM Sixth edition.
- Increase the frequency of VEMD data submission by hospitals.

Additionally, DHS is seeking specific feedback from the industry regarding a potential future requirement for DHS to collect or derive mesh blacks for geocoding addresses

Introduction

The VEMD proposals consultation process

This *Proposal*s 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 the VEMD 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 the Victorian Emergency Minimum Dataset for 1 July 2008* scheduled for release in December 2007.

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. Please 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 can also be obtained from the HDSS web site located at http://www.health.vic.gov.au/hdss

There will be no HDSS forum this year. The proposer or their nominated representative will present their proposal/s at the first meeting of the new VEMD Technical Reference Group (TRG) on Wednesday 21 November 2007. Minutes of this meeting will be available on the HDSS website following the meeting. There will be further opportunity to comment on these proposals following that meeting.

Queries or concerns regarding the proposals can be discussed with a member of the Health Data Standards and Systems Unit.

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 VEMD Manual are represented by a hash (#).
- Edits with proposed changes are marked with an asterisk (*) when listed as part of a Data Item or after an Edit Table.
- Proposed new 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 Emergency Minimum Dataset* Manual.
  - *Specification:* details the reporting requirements for the item.
  - *Administration:* provides additional information including the purpose for 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

CCU	Coronary Care Unit
CMI	Client Management Interface
DHS	Department of Human Services
DMAC	Data Management Advisory Committee
ED	Emergency Department
EMU	Emergency Medical Unit
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
MAPU	Medical Assessment and Planning Unit
MHSOU	Mental Health Short Stay Observation Unit
NHDD	National Health Data Dictionary
ODS	Operational Data Store
PAPU	Psychiatric Assessment and Planning Unit
SLA	Statistical Local Area
SOU	Short Stay Observation Unit
VEMD	Victorian Emergency Minimum Dataset
VINAH	Victorian Integrated Non-Admitted Health Minimum Dataset

Proposals

Proposal One: Add a new code to the code set for existing data item *Referred by*

It is proposed to	To add an additional option (code) in the code set for the *Referred By* data item.
Proposed by	Les Lambert Manager, Clinical Services Department Human Services Hume Region Department of Human Services
Implementation Date	1 July 2008
Background	NURSE-ON-CALL is a Victorian Government funded telephone health line, providing Victorians with immediate, expert health information and advice 24 hours a day, 7 days a week. At present DHS is aware of the number of callers to the Nurse-on-Call service, and we know what advice is given (for example how many callers are advised to call an ambulance or a doctor). Whilst we are currently able to measure the number of callers who are referred to the Emergency Department of a Public Hospital, we are unable to measure how many patients actually present to an Emergency Department as a result of these referrals, and to which Triage Category these patients are assigned.

Referred By

Specification

Definition	Source from which patient was referred to this Emergency Department.		
Datatype	Alpha/numeric	***Form***	Code
Field size	Two	***Layout***	N or NN
Reported for	Every Emergency Department presentation.		

Code set

Select the first appropriate category

Code	*Descriptor*
0	Staff from this campus
1	Self, family, friends
2	Local medical officer, includes local GP/Doctor
4	Private specialist
6	Staff from another campus
8	Correctional Officer / Police
9	Crisis Assessment Team
10	Community Services Staff
14	Nurse on Call
13	Other Nurse ~~(Excluding those in categories 0 to 10~~
19	Other

Reporting guide

6 Staff from another campus

Includes: Admitted and non-admitted transfers.

Also record Transfer Source.

8 Correction Officer / Police

Includes prison hospitals as these are not recognised by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities are not an inter-hospital transfer.

14 Nurse on Call

Patient has been advised by the 'Nurse on Call' operator to present to the Emergency Department of a Public Hospital.

Excludes: District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

13 Other Nurse

Includes: District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

Excludes: Personal Care Attendants (PCA), Nurse on Call, and nurses within this hospital or other acute care facility.

19 Other

Includes armed forces hospitals as these are not recognised by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities are not an inter-hospital transfer.

Edits

*E130 Referred By Invalid

*E136 Referred By and Transfer Source Combination Invalid

Related items

Arrival Transport Mode
Transfer Source

Administration

Purpose Analysis of referral patterns.

Collection start 1 July 1995

Version

1 (Effective 01.07.95)
2 (Effective 01.07.97)
3 (Effective 01.07.01)
4 (Effective 01.07.02)
5 (Effective 01.07.03)
6 (Effective 01.07.08)

Definition source DHS

Code set source DHS

Proposal Two: Add a new code to the code set for existing data item *Departure Status*

It is proposed to	To add an additional option (code) for departure to *Mental Health Observation/Assessment Unit* in the code set for the *Departure Status* data item.
Proposed by	Michael Langley Senior Policy Officer Statewide Emergency Program Department of Human Services
Implementation Date	1 July 2008
Background	The number of mental health observation/assessment type units (for example Psychiatric Assessment and Planning Units (PAPU) and Mental Health Short Stay Observation Units (MHSOU)) is increasing. Currently, patients discharged to these facilities cannot be identified separately in the VEMD. These data will be used to help calculate co-payments for health services based on episodes of care to registered observation units.

Departure Status

Specification

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 **Select the first appropriate category**

Code	Descriptor
Departure Before Treatment Completed:	
11	Left at own risk, without treatment
10	Left after clinical advice regarding treatment options
5	Left at own risk, after treatment started
7	Died within ED
8	Dead on arrival
Ward Setting at this Hospital Campus:	
15	Intensive Care Unit – this campus
22	Coronary Care Unit – this campus
25	Mental Health Observation/Assessment Unit
3	Short Stay Observation Unit
13	Emergency Medical Unit
14	Medical Assessment and Planning Unit
16	Other Mental Health Bed - this Campus
18	Ward not elsewhere described
Transfers to another Hospital Campus:	
17	Mental Health bed at another Hospital Campus
20	Another Hospital Campus - Intensive Care Unit
21	Another Hospital Campus - Coronary Care Unit
19	Another Hospital Campus

Returning to usual residence:

23	Mental health residential facility
24	Residential care facility
12	Correctional/Custodial Facility
1	Home

Reporting guide Report 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.

Departure before treatment completed

11 Left at own risk, without treatment

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

- Without notifying staff,
- 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.

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.

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.

Ward Setting at this Hospital Campus

15 Intensive Care Unit – this campus

Patient is transferred to a registered ICU bed at this campus.

Excludes Coronary Care Unit (use 22).

Refer to: Section 2 *Intensive Care Unit*

22 Coronary Care Unit – this campus

Patient is transferred to a registered CCU bed at this campus.

Excludes Intensive Care Unit (use 15).

Refer to: Section 2 *Coronary Care Unit*

25 Mental Health Observation/Assessment Unit

Excludes:

- Short Stay Observation Unit (use 3)
- Emergency Medical Unit (use 13)
- Medical Assessment and Planning Unit (use 14)

3 Short Stay Observation Unit (SOU)

Excludes:

- Emergency Medical Unit (use 13);
- Medical Assessment and Planning Unit (use 14);
- Mental Health Observation/Assessment Unit (use 25)

Refer to: Section 2 *Short Stay Observation Unit*

13 Emergency Medical Unit (EMU)

Excludes:

- Short Stay Observation Unit (use 3);
- Medical Assessment and Planning Unit (use 14);
- Mental Health Observation/Assessment Unit (use 25)

Refer to: Section 2 Emergency Medical Unit

14 Medical Assessment and Planning Unit (MAPU)

Excludes:

- Short Stay Observation Unit (use 3);
- Emergency Medical Unit (use 13);
- Mental Health Observation/Assessment Unit

Refer to: Section 2 *Medical Assessment and Planning Unit*

16 Other Mental Health bed – this campus

The bed or ward must be part of an approved mental health program.

Refer to: Section 2 *Mental Health Bed*

18 Ward

Includes patients who:

- Go to the ward after attending the ED at the same hospital.
- Go to HITH.
- Attend the ED from an inpatient ward at the same hospital and then return to the ward

Excludes patients who:

- Attend the ED from an inpatient ward at the same hospital and then return to a Mental Health bed (use 16).
- 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).

Transfers to another Hospital Campus

17 Mental Health bed at another hospital campus

Patient has been transferred to a registered mental health bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Mental Health Bed*

20 Another Hospital Campus - Intensive Care Unit

Patient has been transferred to a registered ICU bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Intensive Care Unit*

21 Another Hospital Campus - Coronary Care Unit.

Patient has been transferred to a registered CCU bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Coronary Care Unit*.

19 Another hospital campus

Patient has been transferred to another hospital campus.

Excludes patients transferred to the following registered bed types at another campus:

- Mental Health bed (use 17)
- ICU bed (use 20)
- CCU bed (use 21)

A *Transfer Destination* must also be reported.

Returning to usual residence

23 Mental health residential facility

Includes psychogeriatric nursing home.

Excludes transfer to hospital Mental health bed:

- At this campus (use 16)
- At another hospital campus (use 17).

24 Residential care facility

Includes:

- Nursing home
- Hostel
- Residential care respite bed
- Nursing home beds located within an acute or sub-acute hospital campus.

Excludes psychogeriatric nursing home (use 23)

12 Correctional / Custodial Facility

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.

Does not require a *Transfer Destination* code.

1 - Home

Includes:

- House,
- Unit,
- Boarding/rooming house,
- Hotel,
- Caravan,
- Youth hostel accommodation,
- Homeless person's shelters
- Shelter/refuges
- Armed forces hospitals and
- No fixed abode.
- Patients going to a Rehabilitation In The Home program

Armed Forces 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'.

Transit Lounges

Transit lounges/holding areas are not generally considered to be inpatient wards. Thus, emergency patients located in these areas, prior to being admitted to a ward, should be considered to be in the care of the emergency department.

Edits	E142	Dead on Arrival Combination Invalid
	E182	First Seen By Treating Clinician 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
	E376	Unregistered Medical Assessment and Planning Unit
	E377	Unregistered Intensive Care Unit
	E378	Unregistered Coronary Care Unit
	###	Unregistered Mental Health Observation/Assessment Unit

Related items Section 3: *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.
- Define patients for performance measures calculation.

Principal data users Monash University Accident Research Centre; Statewide Emergency Program, 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)
7 (Effective 01.07.08)

Definition source NHDD

Code set source DHS

Proposal Three: Add a new data item to record the accuracy of the date of birth

It is proposed to

Introduce a new field to record the accuracy of the patient's reported 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 VEMD 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 VEMD 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, that is 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 (for example 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

Reported for Every emergency department presentation.

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.

Edits *###* Invalid Date of Birth Accuracy code

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

Administration

Purpose Required to derive age for demographic analyses and for analysis by age at a point of time.

Principal data users Multiple internal and external research users.

Collection Start 2008-09

Definition source	NHDD (DHS modified)	***Value Domain source***	NHDD 294429

Proposal Four: VEMD Library file review

It is proposed to Conduct a review of the VEMD Library file with a view to including additional terms for use in data items *Primary Diagnosis* and *Additional Diagnoses 1 and 2.*

Proposed by Sara Harrison
Senior Health Information Management Advisor
Health Data Standards and Systems Unit
Department of Human Services

Implementation Date 1 July 2008

Background Primary Diagnosis and Additional Diagnoses are reported to the VEMD using a specific modified subset of ICD-10-AM.
Periodically this modified subset has been updated with additional terms/codes upon request of both data providers and data users. HDSS has received the following list of terms/codes to include in the VEMD ICD-10-AM subset.
Submissions are welcome from other data providers and users proposing additional terms/codes to include in the Library file.

Requested Diagnosis	ICD-10 AM Code
Acute Behavioural Disturbance	F69
Acute coronary syndrome non ST elevation (non STEACS)	I20.0
Acute Delirium	F05.9
Alprazolam (Xanax) overdose	T42.4
Amphetamine overdose	T43.6
Angina	120.9
Attendance for Administration of Antibiotics	Z29.2
Borderline Personality Disorder	F60.31
Bronchiectasis	J47
Cellulitis Leg	L03.11
Cholangitis	K83.0
Chronic Pain Syndrome	R52.2
Chronic Pancreatitis	K86.1
Diverticulitis	K57.92
Empyema	J86.9
Extradural Haematoma – Non Traumatic	I62.1
Extradural Haematoma – Traumatic	S06.4
Fractured Clavicle	S42.00
GHB overdose	T41.2
Hypertension	I10
Hyponatremia	E87.1
Injuries of Eye	S05.9
Intracranial Aneurysm – non-ruptured	I67.1
Intracranial Aneurysm - ruptured	I60.9
Issue of Medical Certificate	Z02.7
Issue of Prescription	Z76.0
IVF injection / procedure	Z31.2
Mallet finger	M20.0
Methamphetamine (ICE) overdose	T43.6
Methylenedioxymethamphetamine (Ecstasy) overdose	T43.6
Non stemi (non ST elevation AMI)	I21.4
Obstetric labour without delivery gestation greater than 37 weeks	Z34.9
Obstetric labour without delivery gestation greater than 37 weeks	060.0
Open would lower leg	S81.9

Open Wound of thigh	S71.1
Other Post Operative Complications	T81.9
Paracetamol overdose	T39.1
Post Operative Wound Infection	T81.41
Postural Hypotension	I95.1
PR Bleed	K92.2
Pulmonary Abscess	J85.2
Rib Fracture	S22.32
Sedative overdose	T42.7
Sleep deprivation	G47.9
ST elevation AMI (STEMI)	I21.3
Stimulant overdose	T50.9
Subdural Haematoma- traumatic	S06.5
Subdural Haematoma–Non Traumatic	I62.0
Suicide Attempt/ideation	R45.81
Testicular Haematoma – Non-traumatic	N50.1
Testicular Haematoma – Traumatic	S30.2
Tetanus Prophylaxis	Z23.5
Tetracyclic antidepressant overdose	T43.0
Tricyclic antidepressant overdose	T43.0
Vasculitis	I77.6

Proposal Five: VEMD Library file update

It is proposed to	Update the VEMD ICD-10-AM Library file to be consistent with ICD-10-AM Sixth edition
Proposed by	Sara Harrison Senior Health Information Manager Health Data Standards and Systems Department of Human Services
Implementation Date	1 July 2008
Background	ICD-10-AM Sixth Edition is scheduled for implementation in Australia from 1 July 2008. To ensure consistency nationally and between DHS datasets, the VEMD ICD-10-AM Library file will be updated to include ICD-10-AM sixth edition codes.

Proposal Six: Increase data submission frequency

It is proposed to	Increase the submission rate of VEMD data by hospitals. Hospitals would be required to submit weekly files to DHS for processing based on the timeline below.
Proposed by	Michael Langley Senior Policy Officer Statewide Emergency Program Department Human Services
Implementation Date	1 July 2008
Background	Currently, DHS receives a minimum of two VEMD submissions per month from each participating hospital. In an environment of increasing pressures on acute health services via emergency departments this period of delay between event and report does not provide a satisfactory service. By increasing the frequency of data submissions to a weekly rate, it would provide a service closer to meeting real-time demands. This would enable DHS to provide a more rapid policy response to issues such as demand surges from seasonal peaks due to influenza, gastroenteritis, or workforce issues that require up to date data on ED activity. Benefits to health services would include more accurate assessment by DHS of prevailing demands and resource requirements. This information would be shared with health services and related service providers such MAS.

Hospitals receiving the non-admitted emergency services grant or otherwise designated by the department will transmit data to the Victorian Emergency Minimum Dataset (VEMD) according to the following timelines:

VEMD, 2008-09	**Timeline**
First 7 days of the month	Submission (at least one) must be received by the 14th of the reporting month. (For example 1-7 July data by 14 July).
First 14 days of the month	Submission must be received by the 21st of the reporting month. (For example new data for 8-14 July and corrections for 1-7 July by 21 July)
First 21 days of the month	Submission must be received by the 28th of the reporting month. (For example new data for 15-21 July and outstanding corrections for 1-14 July by 28 July).
Full month	Remainder of the month must be supplied by the 7th of the following month. (For example new data for 22-31 July and outstanding corrections for 1-21 July by 7 August).
Full month (zero rejections and notifiable edits).	Must be complete by the 21st of the following month. For example July data by 21 August.

Potential Changes and Developments – Feedback sought

This section identifies a future development and possible change that will not be introduced for 2008-09 but is being considered for the future. Your feedback is sought so that we can evaluate the implications of introducing this change.

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 VEMD as part of Victoria's National reporting obligations. At this time, SLA is derived in VEMD 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 VEMD either collect or derive mesh blocks. There are two options:

1. The patient's street name and number is reported to the VEMD 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

Appendix: Feedback Proforma

Feedback: Proposals for Revisions - VAED, VEMD, ESIS, AIMS or VINAH 1 July 2008

<table>
<tr><td>To:</td><td colspan="3">HDSS Help Desk, Department of Human Services</td></tr>
<tr><td>Send to:</td><td>Email: HDSS.HelpDesk@dhs.vic.gov.au
Fax: (03) 9096 7743</td><td>Date sent:</td><td></td></tr>
<tr><td>Sender name:</td><td colspan="3"></td></tr>
<tr><td>Telephone number:</td><td colspan="3"></td></tr>
<tr><td>Email address:</td><td colspan="3"></td></tr>
<tr><td>Organisation name:</td><td colspan="3"></td></tr>
<tr><td colspan="4">My comment/question relates to (please indicate [X]): [ ] VAED [ ] VEMD [ ] ESIS
[ ] AIMS [ ] VINAH
Please use one email/form per item. Thank you for your input.</td></tr>
<tr><td>Proposal Reference (number & title)</td><td colspan="3"></td></tr>
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Comments/Questions: