

Proposals for revisions to PRS/2  
and the Victorian Admitted  
Episodes Dataset (VAED) for  
1 July 2009

October 2008

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# Executive Summary

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

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

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

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

The proposed revisions for the Victorian Admitted Episodes Dataset (VAED) for 1 July 2009 are summarised below. They include:

1. Change to deadlines for submission of Diagnosis records, and final consolidation date.
2. Addition of *Impairment* codes for sub-acute episodes.
3. Addition of Admission and Separation FIM Scores.
4. Allow statistical admission/separation to/from Palliative Care (Care Type 8) and remove the need to collect *Palliative Care Patient Days*.
5. Inclusion of *Mental Health Statewide Patient Identifier* (MHSWPI) on same-day ECT Care Type 4 episodes
6. Addition of *Employment Status* and *Usual Accommodation Type* for Mental Health episodes to streamline Commonwealth reporting, and with a view to reducing duplicated data entry (to the mental health CMI/ODS and the VAED) in the future.
7. Addition of *Program Identifier* to identify episodes admitted under specified programs
8. Addition of data elements relating to ICU/NICU accommodation. Data elements to be added are: *Arrival Datetime to Intensive Care Unit*, *Departure Datetime from Intensive Care Unit*, *Source of Referral to Intensive Care Unit*, and *Ready to Depart Intensive Care Unit Datetime*.
9. Addition of Start and End Date/Time of Procedure.
10. Change of definition for *Admission Type* values to clarify meanings.
11. Addition of data elements related to birth episodes. Data elements to be added are: *Mother's UR*, first APGAR Score (*APGAR1*), second APGAR score (*APGAR2*), and *First Birth Indicator*.
12. Addition of *Ready for Separation Datetime* data element, relating to patients awaiting referral to other services
13. Introduction of *Country of Birth* (SACC) codeset 2nd Edition 2008

# Introduction

## The VAED proposals consultation process

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

The Proposal document is being distributed to all Victorian hospitals, to patient management system suppliers known to have Victorian clients, and to a range of industry bodies. It outlines *proposals* for changes to PRS/2 and the VAED as at the time of its release in October 2008. This should not be regarded as a complete list of changes to be made for 2009-10. 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 2009. Confirmed changes will be published in the document '*Specification for Revisions to PRS/2 and the VAED for 1 July 2009*', expected to be published in December 2008.

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

**Prompt feedback is sought on these proposals.** Hospitals and software suppliers should review this document and assess the feasibility of the proposals. All are invited to provide written feedback to DHS by completing the proforma provided as an Appendix to this document, and forwarding it to HDSS as indicated **by 14 November 2008**. Copies of the proforma may also be obtained from the HDSS web site located at <http://www.health.vic.gov.au/hdss>.

## Orientation to this document

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

- New values are marked as (New)
- Changes to existing items are highlighted in green.
- Redundant values and definitions relating to existing items are struck through.
- Comments relating only to the proposal document [*appear in square brackets and italics.*]
- Page numbers representing cross referencing to another section of the VAED Manual are represented by a #.
- Edits that are proposed to change are marked when listed as part of a Data Item or after an Edit Table with a \* after the edit number. New proposed edits will be shown with an edit number of ###.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Admitted Episodes Dataset (VAED 18<sup>th</sup> Edition, 1 July 2008)*.
  - Specification*: details the reporting requirements for the item.
  - Administration*: provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each proposal is provided.

## Abbreviations

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
ACHI	Australian Classification of Health Interventions
AHCA	Australian Health Care Agreement
AIHW	Australian Institute of Health and Welfare
AIMS	Agency Information Management System
APGAR	Activity, Pulse, Grimace, Appearance and Respiration – test to evaluate the health of a newborn
AR-DRG	Australian Refined Diagnosis Related Group
DHS	Department of Human Services
ERC	Expenditure Review Committee
FIM	Functional Independence Measure
HDSS	Health Data Standards and Systems
HITH	Hospital In The Home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive Care Unit
KHSU	Koori Human Services Unit
NHDD	National Health Data Dictionary
NICU	Neonatal Intensive Care Unit
NIV	Non-invasive Ventilation
NMDS	National Minimum Data Set
PRS/2	Patient Reporting System, Version 2
SCN	Special Care Nursery
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VICC	Victorian ICD Coding Committee
WIES	Weighted inlier Equivalent Separations

## Symbols

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

# Proposed revisions/additions to data items

## Proposal 1 – Change to deadlines for submission of Diagnosis records, and final consolidation date

<b>It is proposed to</b>	<p>Change the deadlines for submission of VAED data as follows:</p> <ul style="list-style-type: none"><li>• Diagnosis records to be submitted one month after the month of separation (current deadline stipulates that the diagnosis record must be submitted one month and seventeen days after the month of separation)</li><li>• Final consolidation on 31 July (current final consolidation date is 17 September)</li></ul>
<b>Proposed by</b>	<p>Mark Gill Assistant Director, Health Information Funding, Health &amp; Information Policy Metropolitan Health and Aged Care Services Department of Human Services</p>
<b>Implementation Date</b>	<p>1 July 2009</p>
<b>Background</b>	<p>This change would allow for earlier access to WIES activity information for reporting and statistical purposes. The change to the final consolidation date would allow for completed data to be incorporated into reports produced by the Department, such as the <i>Your Hospitals</i> report.</p> <p>The deadline for the submission of Episode Records (E4) would be removed. The deadline for the submission of Diagnosis Records would be changed to the end of the month following separation. For example, where the Separation Date is 5 July, the submission deadline for the Diagnosis Record would be 31 August.</p>

## Proposal 2 – Addition of Australian Impairment Codeset

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

**Proposed by** Austin Health (Royal Talbot Hospital)

**Implementation Date** 1 July 2009

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

It is proposed to introduce the Australian Impairment codeset into the VAED. The Impairment codeset is an expansion of the Clinical Sub-Program codeset, providing a greater level of detail than currently available. Note that Clinical Sub-Program will continue to be used for funding purposes.

The addition of this data element would align the VAED with other data collections such as AROC and Hospital Casemix Protocol (HCP), and allow services already using this codeset to report it to the VAED.

A mapping table will be provided to allow mapping from Impairment to Clinical Sub-Program, for services who may wish to introduce this codeset.

There are two possible methods of implementation for this proposal:

1. Collect one of Clinical Sub-Program or Impairment codes:  
Hospitals using the Impairment codeset - report only Impairment codes and DHS will programmatically map to Clinical Sub-Program.  
Hospitals using Clinical Sub-Program- continue to report Clinical Sub-Program only.

OR

2. Collect only Impairment codes and remove the Clinical Sub-Program data element. The implementation of this option would rely on all hospitals choosing to adopt the Impairment codeset.

Hospitals providing feedback are asked to nominate the method most appropriate for their service.

## Data Definitions:

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# Impairment (*New*)

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## Specification

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

### Code set

#### **Code Descriptor**

##### **Stroke**

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

##### **Brain Dysfunction**

###### **Non-traumatic brain dysfunction:**

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

###### **Traumatic brain dysfunction:**

0221	Open injury
0222	Closed injury

##### **Neurological Conditions**

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

039 Other neurological disorders

### **Spinal Cord Dysfunction**

#### ***Non-traumatic spinal cord dysfunction:***

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

#### ***Traumatic spinal cord dysfunction:***

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

### **Amputation of Limb**

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

### **Arthritis**

061 Rheumatoid  
062 Osteoarthritis  
069 Other Arthritis

### **Pain Syndromes**

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

### **Orthopaedic Conditions**

#### ***Fracture: (includes dislocation, excludes neurological involvement)***

08111 Fracture of hip, unilateral (includes #NOF)  
08112 Fracture of hip, bilateral (includes #NOF)  
0812 Fracture of shaft of femur (excludes femur involving knee joint)  
0813 Fracture of pelvis  
08141 Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)  
08142 Fracture of lower leg, ankle, foot  
0815 Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)  
0816 Fracture of spine (excludes where the major disorder is pain)  
0817 Fracture of multiple sites (multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum Excludes with brain injury or with spinal cord injury)

0819 Other orthopaedic fracture (includes jaw, face, rib, orbit or sites not elsewhere classified)

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

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

**Cardiac**

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

**Pulmonary**

101 Chronic Obstructive Pulmonary Disease  
102 Lung Transplant  
109 Other pulmonary

**Burns**

110 Burns

**Congenital Deformities**

121 Spina Bifida  
129 Other Congenital

**Other Disabling Impairments**

131 Lymphoedema  
132 Other disabling impairments

**Major Multiple Trauma**

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

**Developmental Disabilities**

151 Developmental Disabilities

**Re-Conditioning/Restorative**

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

**Reporting guide**

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

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

[http://chsd.uow.edu.au/aroc/documents/aroc\\_aicv1\\_coding\\_guidelines.pdf](http://chsd.uow.edu.au/aroc/documents/aroc_aicv1_coding_guidelines.pdf)

<b>Edits</b>	253	Rehab Invalid Clin Sub-Prog
	258	Sub-Acute: No Sub-Acute Record
	293	Clin Sub-Prog Present
	405	Inapplic Clin Prog For Care Type 2
	454	Incompat Fields for Interim Care

**Related items** Section 2: *Rehabilitation Care*.

Section 4:

- *Yet to be determined.*

## Administration

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

**Principal data users** Ambulatory and Continuing Care (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 2009-10

<b>Definition source</b>	DHS	<b>Code set source</b>	DHS
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### Edits:

- Business rules and cross-edits as for Clinical Sub-Program

## Proposal 3 – Addition of Admission and Separation Functional Independence Measure (FIM Scores)

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

**Proposed by** Austin Health (Royal Talbot Hospital)

**Implementation Date** 1 July 2009

**Background** The Australasian Rehabilitation Outcomes Centre (AROC) collects rehabilitation data from a number of Victorian hospitals. AROC currently collects FIM scores rather than Barthel Index Scores. The FIM is considered to have greater clinical relevance than the Barthel Index.

It is proposed to continue to collect Barthel Index Scores but also to enable the reporting of FIM Scores. Services that currently use the FIM measure will report both FIM and Barthel, but those who only use the Barthel measure are not required to report FIM. Note that Barthel Index Scores will continue to be used for funding purposes.

The addition of this data element would align the VAED with other data collections such as AROC and HCP, and allow services already using this measure to report it to the VAED, thereby enabling them to obtain more relevant data from the VAED.

## FIM Score on Admission (a) (New)

## FIM Score on Separation (b) (New)

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### Specification

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

## FIM Scores

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

### **Reporting guide**

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

Statistical separations:

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

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

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

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

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

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

## Administration

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

**Principal data users** Ambulatory and Continuing Care (Metropolitan Health and Aged Care Services, DHS).

**Collection start** 2009-10

**Definition source** DHS

**Code set source** FIM

### Edits:

- Business rules and cross-edits as for Barthel Scores
- Reporting of FIM scores required only for services using the FI measurement. Other services continue to report Barthel only and leave these fields blank.

## Proposal 4 – Allow statistical admission/separation to/from Palliative Care (Care Type 8)

**It is proposed to** Allow patients to be statistically separated to and from Care Type 8 *Palliative Care Program* to other Care Types.

**Proposed by** Northern Health

**Implementation Date** 1 July 2009

**Background** Changes of Care Type are generally reported to the VAED as statistical admissions/separations, where a new episode is created when the type of care changes. However, an existing business rule does not allow a statistical change between Palliative Care and other Care Types (except for NHT Care Type).

It is proposed to allow statistical changes between palliative care and other care types. This would improve data quality in palliative care reporting, removing the requirement to report Palliative Care Patient Days. It would also enable appropriate funding to be allocated to the type of care provided.

Statistical analysis of palliative and acute care would better reflect activity.

## Care Type (*Amended*)

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### Specification

<b>Definition</b>	The nature of the clinical service provided to an admitted patient during an episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	2	<b>Layout</b>	AA or NN or NA Left justified, trailing spaces.
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Select the first appropriate category:		

<b>Code</b>	<b>Descriptor</b>
F	Interim Care Program – Nursing Home Type
E	Interim Care Program
1	NHT/Non-Acute
P	Designated Paediatric Rehabilitation Program/Unit
2	Designated Rehabilitation Program/Unit: Level 1
6	Designated Rehabilitation Program/Unit: Level 2
7	Designated Rehabilitation Program/Unit: Level 3
K	Non-Designated Rehabilitation Program/Unit
8	Palliative Care Program
5x	Approved Mental Health Service or Psychogeriatric Program: <ul style="list-style-type: none"> <li>• 5T – Mental Health Nursing Home Type</li> <li>• 5E – Mental Health Secure Extended Care Unit (SECU)</li> <li>• 5K – Child and Adolescent Mental Health Service (CAMHS)</li> <li>• 5G – Acute, Aged Persons Mental Health Service (APMH)</li> <li>• 5S – Acute, Specialist Mental Health Service</li> <li>• 5A – Acute, Adult Mental Health Service</li> </ul>
9	Geriatric Evaluation and Management Program
0	Alcohol and Drug Program
4	Other care (Acute) including Qualified newborn
U	Unqualified newborn

## **Reporting guide**

Care Type reported should reflect the treatment the patient receives, not the location of the bed in the facility.

### **F Interim Care Program –Nursing Home Type**

Use this Care Type only for a patient admitted to a unit designated to provide Interim Care and who has been classified as NHT.

#### **NHT**

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care.

Such a patient will have been assessed by an Aged Care Assessment Service and will hold a 2624 certificate (formerly NH5 Form).

Private hospitals: Do not use code F.

#### *Excludes:*

- NHT/Non-Acute (1)
- Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T).

### **E Interim Care Program**

Use this Care Type only for a patient admitted to a unit designated to provide Interim Care and who has not been classified as NHT.

Such a patient will have been assessed by an Aged Care Assessment Service and will hold a 2624 certificate (formerly NH5 Form) before 35 days of continuous hospitalisation.

Private hospitals: Do not use code E.

### **1 NHT/Non-Acute**

This Care Type occurs after an admitted patient has been designated NHT or Non-Acute:

#### **NHT**

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner provides certification documented in the medical record that the patient is in need of acute care.

#### **Non-Acute**

The patient has been in one or more hospitals (public and private) for a continuous period of more than 35 days (with a maximum break of seven consecutive days). If this patient had not been a compensable/ineligible patient, they would be deemed to be a Nursing Home Type patient.

Such a patient may or may not have been assessed by an Aged Care Assessment Team and may or may not have an approved 2624 certificate (formerly NH5 Form).

#### *Excludes:*

- Interim Care Program – Nursing Home Type (F)
- Approved Mental Health Service or Psychogeriatric Program Mental Health Nursing Home Type (5T).

**P *Designated Paediatric Rehabilitation Program/Unit***

A patient who is admitted to, or transferred to, a designated Paediatric Rehabilitation Program/Unit. Use code P only if the public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has such a designated unit.

Private hospitals: Do not use code P.

**2 *Designated Rehabilitation Program/Unit: Level 1***

A patient who is admitted to, or transferred to, a designated Rehabilitation Program/Unit Level 1. Use code 2 only if:

- The public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has such a designated unit.
- The rehabilitation episode directly follows the acute care episode in which the principal diagnosis is a spinal cord injury or head injury, or an amputation has been performed.

Private hospitals: Do not use code 2.

**6 *Designated Rehabilitation Program/Unit: Level 2***

A patient who is admitted to, or transferred to, a designated Rehabilitation Program/Unit Level 2. Use code 6 only if the public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has such a designated unit.

Private hospitals: Use code 6 only if registered under the Health Services Act 1988 to provide this category of care.

**7 *Designated Rehabilitation Program/Unit: Level 3***

A patient who is admitted to, or transferred to, a designated Rehabilitation Program/Unit Level 3. Use code 7 only if the public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has such a designated unit.

Private hospitals: Do not use code 7.

**K *Non-Designated Rehabilitation Program/Unit***

A patient who is admitted to, or transferred to, a non-designated Rehabilitation Program/Unit. Use code K only if the public hospital has approval from the Sub-Acute Program to run this program.

The program involves the provision of admitted patient services; where:

- The patient will be monitored by an identified medical leader responsible for admission assessment and care plan development; and
- The patient will have an appointed case manager; and
- The agency will provide a medium to high intensity program with allied health interventions.

Private hospitals: Do not use code K.

## **8 Palliative Care Program**

A patient who is admitted to a Palliative Care Program, or a palliative care patient receiving treatment to alleviate pain or symptoms.

Public hospitals: Code 8 must only be used on formal admission, if the patient receives palliative care under the supervision of a palliative care specialist or physician. A statistical change is permitted when a patient changes between Nursing Home Type (Care Types 1, 5T or F) and Palliative Care.

Private hospitals: If the hospital operates a similar program and wishes to identify episodes of care using code 8, they may.

## **5x Approved Mental Health Service or Psychogeriatric Program**

A patient who is admitted to, or transferred to, an approved Mental Health Service or Psychogeriatric Program. Use code 5x only if the public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has such an approved Mental Health Service or Psychogeriatric Program.

Private hospitals: Use code 5x only if registered under the Health Services Act 1988 to provide this category of care.

## **5T Mental Health Nursing Home Type**

This Care Type occurs after an admitted patient has been designated NHT or Non-Acute:

### ***NHT***

Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care.

Such a patient may or may not have been assessed by an Aged Psychiatric Assessment and Treatment Team (APATT) or an Aged Care Assessment Service (ACAS) and may or may not have an approved 2624 certificate (formerly NH5 Form).

### ***Excludes:***

- Interim Care Program – Nursing Home Type (F)
- NHT/Non-Acute (1).

## **5E Mental Health Secure Extended Care Unit (SECU)**

This Care Type occurs when a patient is admitted to an approved unit designed to accommodate persons who require active clinical care in the secure/safe environment of a locked ward, often with the intention of longer term (extended) care.

### ***Excludes:***

- Mental Health Nursing Home Type (5T)
- Community Care Units (CCU) including Vahland CCU
- Aged Person's Mental Health Nursing Homes (APMHNH)
- Psychogeriatric Nursing Homes (PGNH)

## **5K Child and Adolescent Mental Health Service (CAMHS)**

A patient who is admitted to an approved CAMHS unit.

**5G Acute, Aged Persons Mental Health Service (APMH)**

A patient who is admitted to an approved APMH (Psychogeriatric) unit.

*Excludes:*

- Aged Person's Mental Health Nursing Home (APMHNH)
- Psychogeriatric Nursing Home (PGNH)

**5S Acute, Specialist Mental Health Service**

A patient who is admitted to an approved Specialist Mental Health Service.

*Includes:*

- Brain Disorder Unit
- Eating Disorders Unit
- Forensic Unit
- Mother and Baby Unit
- Neurological Unit

*Excludes:* Child and Adolescent Mental Health Service (5K)

**5A Acute, Adult Mental Health Service**

A patient who is admitted to an approved Adult Mental Health Service.

*Excludes:*

- Community Care Units (Residential)
- Mental Health Nursing Home Type (5T)

**9 Geriatric Evaluation and Management Program**

A patient who is admitted to, or transferred, to a Geriatric Evaluation and Management Program. Use code 9 only if the public hospital's Health Service Agreement and/or Statement of Priorities specifies that the hospital has a Geriatric Evaluation and Management Program. This program excludes Nursing Home Type/Non-Acute patients.

Private hospitals: If the hospital operates a similar program and wishes to identify episodes of care using code 9, they may.

**0 Alcohol and Drug Program**

A patient who is admitted to an Alcohol and Drug Program. Use code 0 only if the patient receives treatment by a specialist physician for an alcohol or drug related condition that is the principal diagnosis. Report this Care Type on admission but not for a change of Care Type following another episode of care.

Private hospitals: Use if the hospital operates a similar program and wishes to identify episodes of care as such.

#### **4 Other (Acute) Care including Qualified newborn**

Other types of patient:

*Includes:*

- Same day and acute ~~(except mental health)~~
- Sameday ECT episodes (mental health)
- Geriatric respite care.
- Newborn who has been a Qualified newborn for some or all of the duration of this episode.

*Excludes:*

- Patients admitted to designated units and programs covered by other Care Types.
- Newborn who has been an Unqualified newborn for the entire duration of this stay (U).
- Mental Health patients (except sameday ECT episode – see 'Includes' above)

#### **U Unqualified newborn**

A newborn who has been an Unqualified newborn for the entire duration of this episode.

*Excludes:* A newborn who has had any period as a Qualified newborn during this episode (4).

#### **Additional Notes:**

##### **Newborns**

In a single episode, a newborn may change between being Qualified and Unqualified with such changes being recorded in the (Status Segment) Qualification Status field. Care Type may need updating if a newborn changes from being Unqualified to Qualified.

Refer to Sections 2 and 4: *Newborn*.

### All other episodes

For all other episodes, if the Care Type changes during the episode, the date of that change must be reported in the Separation Date field and other Separation Status details completed; then a new Episode Record must be started (that is, a statistical separation and a statistical admission).

For example:

- If the patient is admitted to Acute care (Care Type 4) but later is transferred to an Approved Mental Health Service, the Care Type changes to Care Type 5x, therefore the earlier Episode Record should be completed and a new Episode Record should be started.
- If the patient is admitted to one of the acute Care Types and after 35 days is deemed to require only NHT care (Care Type F, 1 or 5T), the earlier Episode Record should be completed and a new Episode Record should be started.

There are some circumstances when a patient cannot change between Care Types, for example, a patient cannot move between ~~Care Type 4 and Care Type 8~~, they must remain under the original Care Type levels of rehabilitation. Further information on changes of Care Type is provided in Sections 2 and 4: *Episode of Care*.

A new Episode Record requires Diagnosis and Procedure Codes specific to that episode and therefore a separate DRG identified. The Separation Mode in the earlier Episode Record indicates the episode is being completed not because the patient has gone home, died or been transferred but because the Care Type has changed. The Admission Source of the new Episode Record indicates the new episode is starting not because the patient has been formally admitted but because the Care Type has changed.

### Edits

094	Combination A/C Accom Care Med Suff
107	Invalid Care Type
122	Sameday Adm Source/Sep Mode Mismatch
222	Unqual Newborn; Adm Date Not Birth
235	Adm Criterion is N But Care Not 4
250	Deleted – Episode is Sub-Acute
251	Invalid Adm Barthel
252	Invalid Sep Barthel
253	Rehab: Invalid Clin Sub-Prog
254	Rehab: Invalid Adm/Re-Adm to Rehab
255	Rehab: Invalid Onset Date
258	Sub- Acute: No Sub – Acute Record
260	Invalid Care For Qual
261	Newborn Care But Age > 9 Days
262	Invalid Care Type For Newborn
268	Inv Comb Legal, Care & PFS
285	Sub-Acute Record not required
288	Sep Barthel & Sep Mode Incompatible
289	Adm Sce T'fer & Onset = Adm Date
290	Stat Adm Sc & Onset = Adm Date
291	Adm Barthel > Sep Barthel
292	Sep Barthel Present
293	Clin Sub-Prog Present
294	Onset Date Present
295	Adm/Readmit To Rehab Present
297	Sep Rug ADL & Sep Mode Incompatible
298	Adm Barthel Present
303	Pall Care But Invalid Adm Rug ADL
304	Pall Care But Invalid Sep Rug ADL
305	Adm Rug ADL Present

306 Sep Rug ADL Present  
 329 Geri Respite – Invalid Comb  
 340 Invalid Source Refer to Pal Care  
 341 Source Refer to Pal Care Present  
 390 Incompat Care Type, Carer Avail, Age and Sep Mode  
 405 Inapplic Clin Prog For Care Type 2  
 406 Rehab Care Type W/Out Rehab PDX  
 407 Rehab Level 2 or 3 W Low Adm Barthel  
 421 Not Separated; Carer Avail Present  
 437 NIV Duration for Unqual Newborn  
 447 Unqual Newborn; Age at Sep  
 448 ICU Stay but Care Type not Acute  
 453 Wrong PDx for Interim Care  
 454 Incompat Fields for Interim Care  
 455 Inconsist Newborn Transferred/Unqual Data  
 461 ACAS Status not Required  
 463 Accom Type 4, Care Type invalid  
 464 Accom Type 7, not Care Type 4  
 468 Care Type ≠ 1 or F of 5T, LOS >365 Days  
 471 Care Type 5x, not usual Sep Referral  
 472 Pall Care, not approved for Palliative Care Program (*Amended*)  
 473 Care Type 9, not approved for GEM  
 474 Care Type E, LOS > 35 Days  
 475 Care Type F or E, not approved for Interim Care  
 488 Incompat Care Type/Adm Source Statistical (*Amended*)  
 489 Incompat Care Type/Sep Mode Statistical (*Amended*)  
 491 Incompat Fields for ESAS  
 492 Incompat Fields for RPI  
 498 Pall Care without Pall care Diag  
 502 Stat Episode: Care Type same as Next Episode  
 503 Stat Episode: Care Type same as Prior Episode  
 506 Stat Episode: Rehab also in Next Episode  
 507 Stat Episode: Rehab also in Prior Episode  
 528 ~~Stat Episode Pall: Not NHT in Prior Episode~~  
 529 ~~Stat Episode Pall: Not NHT in Next Episode~~  
 532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U  
 533 ACAS Status Code Required  
 535 Care Type 5E, not approved for SECU  
 536 Care Type 5T, not approved for NHT  
 537 Care Type 5K, not approved for CAMHS  
 538 Care Type 5G, not approved for Aged Acute  
 539 Care Type 5S, not approved for Specialist Acute  
 540 Care Type 5A, not approved for Adult Acute  
 541 Care Type K, not approved for Non-Desig Rehab  
 542 MH Acute Adult Care Type But Age < 14 Years  
 543 MH Acute Adult Care Type But Age > 65 Years  
 544 MH APMHS Care Type But Age < 55 Years  
 545 MH CAMHS Care Type But Age < 5 Years  
 546 MH CAMHS Care Type But Age > 19 Years  
 547 MH SECU Care Type But Age < 14 Years  
 548 MH Specialist Acute Care Type But Age < 14 Years  
 575 Care Type 5x, MHSWPI Blank  
 578 MHSWPI Present, not Care Type 5x  
 586 Care Type 2, not approved for Rehab Lvl 1  
 587 Care Type 6, not approved for Rehab Lvl 2  
 588 Care Type 7, not approved for Rehab Lvl 3  
 596 Same Day ECT: Not in Care Type 4  
 597 Mental Health Episode: Sep Mode = S  
 598 Same Day Rehabilitation: Not in Scope  
 599 Carer Availability Not Required

607	Care Type Pall Care: Pall Care Pt Days not = Pt Days Total
608	Invalid Palliative Care Pt Days
620	Adm Barthel/Functional Assessment Date/Care Type mismatch
621	Sep Barthel/Functional Assessment Date/Care Type mismatch
626	Invalid Combination for Funding Arrangement PHESI
631	Care Type P, not approved for Paediatric Rehabilitation
634	Palliative Care Patient Days = Total LOS, Care Type <=> 8
XXX	Care Type 4, Procedure code 93341-xx, MHSWPI Blank

**Related items**

Section 2: *Acute Care, Admission, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management Program, Interim Care Program, Newborns, Nursing Home Type/Non-Acute Care, Palliative Care, Rehabilitation Care and Sub-Acute Care.*

Section 4:

- Business Rules (non-tabular) *Episode of Care, Newborn Reporting and Palliative Care Reporting.*
- Business Rules (tabular) *Account Class, Acc Type, Care Type and Medicare Suffix, and Admission Source and Care Type, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type P: Designated Paediatric Rehabilitation, and Care Type: Interim Care Program (F and E), and Care Type and Separation Mode, and Age, Care Type, Carer Availability and Separation Mode, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Funding Arrangement: Private Hospitals Elective Surgery Initiative, and Newborns: Criteria for Admission, Qualification Status, Care Type, and Reporting History of Code Changes.*

Section 5: *Status Segments.*

Section 9:

- Supplementary Code Lists: *Care Type Care Type 2: Rehabilitation Program: Level 1, and Care Type 5A: Mental Health Service and Psychogeriatric Program – Acute, Adult Mental Health Service, and Care Type 5E: Mental Health Service and Psychogeriatric Program – Mental Health Secure Extended Care Unit (SECU), and Care Type 5G: Mental Health Service and Psychogeriatric Program – Acute, Aged Persons Mental Health Service (APMH), and Care Type 5K: Mental Health Service and Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS), and Care Type 5S: Mental Health Service and Psychogeriatric Program – Acute, Specialist Mental Health Service, and Care Type 5T: Mental Health Service and Psychogeriatric Program – Mental Health Nursing Home Type, and Care Type 6: Rehabilitation Program: Level 2, and Care Type 7: Rehabilitation Program: Level 3, and **Care Type 8 and Palliative Care Patient Days: Palliative Care Program**, and Care Type 9: *Geriatric Evaluation and Management (GEM) Program, and Care Type F and E: Interim Care Program, and Care Type K: Non-Designated Rehabilitation Program/Unit, and Care Type P: Designated Paediatric Rehabilitation.**

## Administration

<b>Purpose</b>	To distinguish various types of care in order to: <ul style="list-style-type: none"><li>• Apply the appropriate funding formula to the episode.</li><li>• Group episodes to facilitate analysis.</li></ul>		
<b>Principal data users</b>	Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS). Continuing Care and Clinical Service Development (Metropolitan Health and Aged Care Services, DHS).		
<b>Collection start</b>	1995-96		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

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## Palliative Care Patient Days (*Deleted*)

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### Specification

<b>Definition</b>	The total number of patient days for which the patient received palliative care under an approved palliative care program during the whole episode of care, excluding leave days.		
<b>Datatype</b>	Numeric	<b>Form</b>	Quantitative value
<b>Field size</b>	3	<b>Layout</b>	NNN or spaces
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public Hospitals		
<b>Reported for</b>	Episodes with Care Type P, 2, 4, 6, 7, K, 8, 9 and E, where the hospital campus is approved for Palliative Care.  [For Care Types 0, 1, 5x, F and U, report spaces in this field.]  Otherwise, report spaces.		
<b>Reported when</b>	A Separation Date is reported in the Episode Record.		
<b>Code set</b>	A number in the range of 001 to 999.		

## ***Reporting guide***

~~Palliative Care Patient Days is reported for patients treated under approved programs, as defined by the Cancer and Palliative Care unit. An approved program is one funded specifically for the delivery of palliative care to patients by suitably qualified staff. The list of public hospitals authorised to report this data item is the same as those eligible to report a Care Type of 8.~~

~~A day should be reported as a Palliative Care Patient Day when the Palliative care program was primarily responsible for the patients care.~~

~~Palliative Care Patient Days must be equal to or less than Patient Days Total. Where the Care Type is not 8, the Palliative Care Patient Days should not equal the total length of stay.~~

~~Where Palliative Care Patient Days is greater than zero, the Diagnosis Code Z51.5 *Palliative Care* must be present in the Diagnosis Code string.~~

## ***Edits***

~~472 — Pall Care, not approved for Palliative Care Program  
498 — Pall Care without Pall Care Diag  
609 — Pall Care Pt Days > Patient Days Total  
612 — Palliative Care mismatch  
613 — Pall Care Diag no Pall Care (at approved campus)  
634 — Palliative Care Patient Days = Total LOS, Care Type <> 8~~

## ***Related items***

~~Section 2: *Episode of Admitted Patient Care, Leave With Permission, Palliative Care and Patient Day.*~~

~~Section 3: *Care Type, page 3-19, Diagnosis Code, page 3-Error! Bookmark not defined., and Patient Days Total, page 3-Error! Bookmark not defined.*~~

~~Section 4:~~

- ~~• Business Rules (non-tabular) *Palliative Care Reporting*~~
- ~~• Business Rules (tabular) *Care Type and Palliative Care Patient Days*~~

~~Section 9:~~

- ~~• *Care Type 8 and Palliative Care Patient Days: Palliative Care Program.*~~

## **Administration**

### ***Purpose***

~~To measure the demand for palliative care services for:~~

- ~~• Planning of palliative care services~~
- ~~• Managing funding arrangements for palliative care services~~

### ***Principal data users***

~~Continuing Care and Clinical Service Development, (Metropolitan Health and Aged Care Services, DHS).~~

### ***Collection start***

~~2005-06~~

### ***Definition source***

~~DHS~~

~~**Code set  
source**~~

~~DHS~~

## Palliative Care Reporting (*Amended*)

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**Guide for use** The Palliative Care Type ~~and Palliative Care Patient Days are~~ is only reported to the VAED for patients admitted to approved programs. Palliative Care patients receiving 'acute' services for the alleviation of pain or symptomatic relief may be reported as Care Type 8 Palliative Care ~~and Palliative Care Patient Days~~.

### ~~Care Type 8~~

For public hospitals, activity reported under Care Type 8 is delivered by approved palliative care programs. This activity counts towards palliative care targets.

An approved program is one funded specifically for the delivery of palliative care to patients in approved beds or units by suitably qualified staff.

In some circumstances it may be appropriate for Care Type 8 to be reported where the patient is not in a designated palliative care bed but the palliative care program was primarily responsible for the patient's care. This may occur if a designated palliative care bed is not available or it is inappropriate to move the patient to a designated palliative care bed.

### ~~Palliative Care Patient Days~~

~~Patients treated under an approved palliative care program should be reported under Palliative Care Patient Days whether they are coded as Care Type 8 or another Care Type.~~

~~The list of campuses authorised to report this data item is the same as those eligible to report Care Type of 8.~~

~~Funding for episodes where the Care Type is not 8 is based on the Care Type reported and does not count towards palliative care targets.~~

The Cancer and Palliative Care Unit, DHS, determines which campuses can report Care Type 8 ~~and palliative care patient days~~.

When a patient is deemed to require palliative care during a non-Palliative Care Type episode ~~(with or without Palliative Care Patient Days)~~, a Diagnosis Code of Z51.5 Palliative Care must be included in the Diagnosis Code string to denote the component of palliation.

~~Change from or to Palliative Care (Care Type 8) as a statistical separation or a statistical admission is prohibited, unless the change is from or to Nursing Home Type (Care Types F, 1 or 5T).~~

### Refer to:

- Section 2: *Episode of Admitted Patient Care*.
- Section 3: *Care Type and Palliative Care Patient Days*.
- Section 5: *Sub-Acute Record*.
- Section 9: Supplementary Code Lists: *Care Type 8 and Palliative Care Days*:  
~~Palliative Care Units~~:  
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

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# Reporting history of code changes (*Amended*)

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## **Guide for use**      **Account Class, Accommodation Type and Qualification Status**

The Account Class, Accommodation Type and Qualification Status of a patient are reported 'as of midnight' to PRS/2. A history of changes is reported in the Status Segments of the Episode (E4) record. If more than one change occurs within the same day, do not report the first change, only report the patient's status as of midnight each day. This is because bed days are reported for each status segment, therefore if there is more than one status segment reported for activity within the same day, bed day calculations will be incorrect.

Examples:

A patient is admitted to a private ward for three days and is then moved to a shared ward for two days. Report three days Accommodation Type 2 in the first Status Segment, and two days for Accommodation Type 1 in the second Status Segment.

A patient is admitted as Account Class PE *Medical 1* but is changed to Account Class PC *Surgery* on the same day where the patient remains until separation. Report only one Status Segment with Account Class PC.

A patient is admitted to Emergency Department Accommodation at 9.00am, is moved to a Private Ward at 10.30am and moved again to a Shared Ward at 10.45pm. Report only Accommodation Type 1 *Overnight Accommodation: Shared room*.

### **Refer to:**

- Section 2: *Length of Stay*.
- Section 4: *Length of Stay*.

### **How to Count Patient Days**

It is not possible for a Status Segment to have zero Patient Days, therefore:

- If, on the one day, a patient's details change, then change again, the first change should not be reported to PRS/2.
- If, on the one day, a patient's details are changed then found to be incorrect, the incorrect change should not be reported to PRS/2.
- If, on the one day, a patient's details change then the patient is separated (formally or statistically), the change should not be reported to PRS/2; the separation should be reported.
- If, on the one day, a patient is admitted then their details change, the original details should not be reported to PRS/2.

### **Refer to:**

- Section 2: *Length of Stay*.
- Section 4: *Length of Stay*.

### ***When to create a Status Segment***

The first Status Segment must be created, recording the details at admission (formal or statistical).

If later there is a change to Account Class, Accommodation Type or Qualification Status, a new Status Segment is created. A move to or from Accommodation Type 4 *In the Home (Hospital – HITH)* is reported as a new Status Segment, not a new Episode Record.

A Status Segment should only be created if it is needed; surplus Status Segments should be left blank, not zero-filled.

### **Care Type**

Changes to Care Type must result in a new episode record being created, rather than a new Status Segment. The only exception to this rule is when newborns change between Qualified and Unqualified; this should be reported as a new status segment rather than a new episode.

Only one care type change per day can be reported. For example, if a patient is admitted as Care Type 4 and then changes to Care Type 5x the same day, do not report the Care Type 4 portion of the episode to the VAED.

The Separation Mode of the first episode must be S *Statistical Separation (change in Care Type within this hospital)* and the Admission Source of the next episode must be S *Statistical Admission (change in Care Type within this hospital)*, thereby linking the two episodes statistically. The Admission Time of the subsequent episode must be one minute after the Separation Time of the previous episode.

**Statistical readmissions to or from Care Type 8 are not permitted, unless a patient changes between Nursing Home Type (Care Types 1, 5T or F) and Palliative Care.**

### **Refer to:**

Section 4: *Episode of Care*

Section 5: *Episode Record*

### **New Business Rules and Edits:**

- Remove edit blocking statistical changes between Care Type 8 and other Care Types
- Statistical changes between Care Type 8 and other Care Types to comply with the existing business rules and edits for statistical changes.

## Care Type and Palliative Care Patient Days (Deleted)

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Care Type	Palliative Care Patient Days
8	001-999
P, 2, 4, 6, 7, K, 9, E	Space or 001-999
0, 1, 5x, F, U	Space

Edits 612 — Palliative Care Mismatch

### Amended Edits:

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## 472 Pall Care, not approved for Palliative Care Program (Amended)

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**Effect** REJECTION

**Problem** The E4 Episode Record's Care Type is 8 Palliative Care. This is a Palliative Care episode (represented by Care Type 8 and/or the presence of Palliative Care Patient Days in the E4 Episode Record) yet this Hospital Campus is not approved to provide Palliative Care.

**Remedy** Check Care Type and Palliative Care Patient Days, amend as appropriate and re-transmit the E4. If you believe that this Hospital Campus is approved to report palliative care episodes under approved palliative care programs, contact the HDSS Help Desk.

Refer to Supplementary Code Lists Care Type 8 and Palliative Care Days: Palliative Care Program:

<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

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## 488 Incompat Care Type/Adm Source Statistical (Amended)

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**Effect**

REJECTION

**Problem**

The E4 Episode Record has an invalid Care Type with Admission Source S  
*Statistical Admission (change in care type within this hospital).*

**Remedy**

Check Admission Source and Care Type, amend as appropriate and re-transmit the E4.

In a public hospital, Care Type 0 *Alcohol & Drug Program* can only be used on formal admission, not for statistical admission (private hospitals can have Care Type 0 with a statistical Admission Source).

~~Care Type 8 *Palliative Care Program* must only be used on formal admission, unless the episode is changing from Nursing Home Type (Care Type F, 1, 5T) to Palliative Care (Care Type 8). A statistical admission is permitted only in this instance.~~

Statistical changes between qualified and unqualified status of newborns are not permitted. These changes are recorded in the Qualification Status field of the Status Segments. Refer to Section 2: *Newborns*. Therefore statistical separation from Care Type U with a subsequent statistical admission to a Care Type 4 is not permissible.

Refer to:

Section 4: Business Rules (tabular) *Admission Source and Care Type*.

---

## 489 Incompat Care Type/Sep Mode Statistical (Amended)

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**Effect**

REJECTION

**Problem**

The E4 Episode Record has an invalid Care Type with Separation Mode S  
*Statistical Separation (change in care type within this hospital).*

**Remedy**

Check Care Type and Separation Mode, amend as appropriate and re-transmit the E4.

~~Patients admitted with a Care Type of 8 Palliative Care Program must remain so until they are formally separated, unless the episode is changing from Palliative Care (Care Type 8) to Nursing Home Type (Care Type F, 1, 5T). A statistical separation is permitted only in this instance.~~

Statistical changes between qualified and unqualified status of newborns is not permitted. These changes are recorded in the Qualification Status field of the Status Segments. Refer to Section 2: *Newborns*. Therefore statistical separation from Care Type U with a subsequent statistical admission to a Care Type 4 is not permissible.

Refer to:

Section 4: Business Rules (tabular) *Care Type and Separation Mode*.

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## 613 Pall Care diag, no Pall Care (at approved campus) (*Amended*)

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Effect	Warning
Problem	<p>This hospital campus is approved to provide Palliative Care.</p> <p>The E4 Episode Record is neither Care Type 8 Palliative Care <del>nor has Palliative Care Patient Days reported</del>, yet the X4/Y4 Diagnosis Record for this episode has a Diagnosis Code indicating that palliative care was provided during the episode (Z51.5 Palliative Care).</p>
Remedy	Check Care Type, <del>Palliative Care Patient Days</del> and the Diagnosis Code, amend as appropriate and retransmit as required.

### Deleted Edits:

- 609 Pall Care Pt Days > Patient Days Total
- 612 Palliative Care mismatch
- 634 Palliative Care Patient Days = Total LOS, Care Type <> 8

## Proposal 5 – Inclusion of Mental Health Statewide Patient Identifier (MHSWPI) on same-day ECT Care Type 4 episodes

<b>It is proposed to</b>	Require the Mental Health Statewide Patient Identifier (MHSWPI) on same-day ECT episodes which are reported as Care Type 4.
<b>Proposed by</b>	Tracey Burgess Manager, Information Analysis and Reporting Mental Health & Drugs Division Department of Human Services
<b>Implementation Date</b>	1 July 2009
<b>Background</b>	<p>Admitted episodes for Mental Health patients are required to be reported to both the CMI/ODS and the VAED. Including the MHSWPI will improve the linkage of data between the datasets with a view to reducing duplicated data entry in the future.</p> <p>Episodes reported with an ACHI code 93341-* will require a MHSWPI to be reported.</p> <p>Due to the complexity of editing the contents of episode records against diagnosis records, some edits may be relaxed. For example, edit 578 <i>MHSWPI Present, not Care Type 5x</i> may be amended to allow MHSWPI to be accepted for any Care Type 4 record, and output editing undertaken as a data quality exercise on a regular basis to identify any records with unusual or incorrect data combinations.</p>

## Mental Health Statewide Patient Identifier (Amended)

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### Specification

<b>Definition</b>	The client identifier, unique to the client for approved Mental Health Service and Psychogeriatric Programs.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	10	<b>Layout</b>	NNNNNNNNNN or spaces Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian public hospitals with an approved Mental Health Service.  Private hospitals: Report spaces in this field.		
<b>Reported for</b>	All mental health admitted episodes of care and same-day ECT episodes reported with Care Type 4.		
<b>Reported when</b>	The episode record is reported.		
<b>Code set</b>	ODS generated.		
<b>Reporting guide</b>	Report the primary Mental Health Statewide Patient Identifier for all mental health episodes of care (Care Types 5x) and same-day ECT episodes reported with Care Type 4 and an ACHI code in the range 93341-00 to 93341-99.		
<b>Edits</b>	575 Care Type 5x, MHSWPI Blank 576 Invalid MHSWPI 577 MHSWPI not on ODS 578 MHSWPI Present, not Care Type 5x (Amended) 579 MHSWPI Valid, no Matching DOB 580 MHSWPI Valid, no Matching Sex 581 MHSWPI Valid, Secondary on ODS XXX Care Type 4, Procedure code 93341-xx, MHSWPI Blank		
<b>Related items</b>	Section 9: <ul style="list-style-type: none"> <li>• Supplementary Code Lists: Care Type Care Type 5A: Mental Health Service and Psychogeriatric Program – Acute, Adult Mental Health Service, and Care Type 5E: Mental Health Service and Psychogeriatric Program – Mental Health Secure Extended Care Unit (SECU), and Care Type 5G: Mental Health Service and Psychogeriatric Program – Acute, Aged Persons Mental Health Service (APMH), and Care Type 5K: Mental Health Service and Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS), and Care Type 5S: Mental Health Service and Psychogeriatric Program – Acute, Specialist Mental Health Service, and Care Type 5T: Mental Health Service and Psychogeriatric Program – Mental Health Nursing Home Type.</li> </ul>		

### Administration

<b>Purpose</b>	To enable management of clients and their associated data.		
<b>Principal data users</b>	Mental Health Branch, DHS		
<b>Collection start</b>	2004-05		
<b>Definition source</b>	DHS	<b>Code set source</b>	ODS generated

**New Edits:**

- Care Type 4, Procedure Code 93341-xx but MHSWPI blank (Rejection, X4)

**Amended Edits:**

## 578 MHSWPI Present, Not Care Type 5x (Amended)

**Effect** REJECTION

**Problem** The E4 Episode Record contains a Mental Health Statewide Patient Identifier, but the Care Type is not 5x *Approved Mental Health Service or Psychogeriatric Program* or Care Type 4 (in the case of sameday ECT episodes).

**Remedy** Check Care Type and Mental Health Statewide Patient Identifier, amend as appropriate and re-transmit the E4.

## Proposal 6 – Addition of ‘Employment Status’ and ‘Usual Accommodation Type’ for Mental Health episodes

**It is proposed to** Add two new data elements (‘Employment Status’ and ‘Accommodation’) for all Mental Health episodes (Care Type 5x and same-day ECT episodes).

**Proposed by** Tracey Burgess  
Manager, Information Analysis and Reporting  
Mental Health & Drugs Division  
Department of Human Services

**Implementation Date** 1 July 2009

**Background** Admitted episodes for Mental Health patients are required to be reported to both the CMI/ODS and the VAED. The data elements are required for reporting to the Admitted Patient Mental Health Care National Minimum Dataset.

The new data elements will be required for all episodes with Care Type 5x, and same-day ECT episodes with Care Type 4.

Due to the complexity of editing the contents of episode records against diagnosis records, some edits may not be stringently applied. For example, Employment Status and Usual Accommodation Type may be accepted for any Care Type 4 record, with output editing undertaken as a data quality exercise on a regular basis to identify any records with unusual or incorrect data combinations.

## Employment Status (*New*)

### Specification

<b>Definition</b>	The patient's Employment Status on admission.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	1	<b>Layout</b>	N or space
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian public hospitals with an approved Mental Health Service.  Private hospitals: Report spaces in this field.		
<b>Reported for</b>	All mental health admitted episodes of care (Care Type 5x and same-day ECT episodes with Care Type 4).		
<b>Reported when</b>	The episode record is reported.		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	1	Child not at school	
	2	Student	
	3	Employed	
	4	Unemployed	
	5	Home duties	
	6	Other	
	9	Not stated / inadequately described	
<b>Reporting guide</b>	<p><b>Private hospitals</b> Report spaces in this field.</p> <p><b>Public hospitals</b> Patients in Care Type 5x <i>Approved Mental Health Service or Psychogeriatric Program</i> in public hospitals whose care is funded by Mental Health Services, and patients admitted for same-day ECT with Care Type 4:</p> <ul style="list-style-type: none"> <li>Report the employment status of the patient which was current at the time of admission.</li> </ul>		
<b>Edits</b>	XXX	Invalid Employment Status	
<b>Related items</b>	<p>Section 9: Supplementary Code Lists: Care Type <i>Care Type 5A: Mental Health Service and Psychogeriatric Program – Acute, Adult Mental Health Service</i>, and <i>Care Type 5E: Mental Health Service and Psychogeriatric Program – Mental Health Secure Extended Care Unit (SECU)</i>, and <i>Care Type 5G: Mental Health Service and Psychogeriatric Program – Acute, Aged Persons Mental Health Service (APMH)</i>, and <i>Care Type 5K: Mental Health Service and Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS)</i>, and <i>Care Type 5S: Mental Health Service and Psychogeriatric Program – Acute, Specialist Mental Health Service</i>, and <i>Care Type 5T: Mental Health Service and Psychogeriatric Program – Mental Health Nursing Home Type</i>.</p>		



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# Usual Accommodation Type (New)

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## Specification

**Definition** The type of accommodation setting in which a person usually lives/lived.

**Datatype** Numeric **Form** Code

**Field size** 2 **Layout** NN or spaces

**Location** Episode Record

**Reported by** All Victorian public hospitals with an approved Mental Health Service.  
Private hospitals: Report spaces in this field.

**Reported for** All mental health admitted episodes of care (Care Type 5x and same-day ECT episodes with Care Type 4).

**Reported when** The episode record is reported.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	10	House or flat
	20	Independent unit as part of retirement village
	30	Hostel or hostel-type accommodation
	31	Residential care service
	32	Supported residential service
	36	Community residential service
	40	Psychiatric hospital
	50	Acute hospital
	60	Other accommodation
	61	Caravan
	62	Homeless persons shelter
	63	Boarding/rooming house
	64	Group home
	70	No usual residence
	90	Not specified

**Reporting guide** **Private hospitals**  
Report spaces in this field.

### **Public hospitals**

Patients in Care Type 5x *Approved Mental Health Service or Psychogeriatric Program* in public hospitals whose care is funded by Mental Health Services, and patients admitted for same-day ECT with Care Type 4:

- Report the type of usual accommodation of the patient on admission.

'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's usual accommodation. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

**10 House or Flat**

Patient resides in a house or flat that is owned or rented. This includes public housing.

*Excludes:*

- House or flat within a retirement village
- Group Home

**20 Independent unit as part of retirement village**

Patient lives independently within an established retirement village.

**30 Hostel or hostel type accommodation**

Hostel accommodation provides help with daily tasks for people who cannot live by themselves but do not require full time nursing care. Hostels may or may not provide 24-hour residential support. Staff help with personal care. Hostels are registered under the Health Services Act 1988.

**31 Residential Care Service**

Supervised residence, clinically staffed 24 hours per day. Government funded or subsidised care for resident assessed as requiring low or high level care

*Includes:*

- Aged persons mental health residential service

*Excludes:*

- Community care units (adult)

**32 Supported Residential Service**

Residential accommodation provided by private agencies providing special and personal care and support (including meals) as defined by the Health Services Act 1988. Residents pay fees for accommodation and personal support. The Department of Human Services manages registration, regulation and monitoring of Supported Residential Services.

**36 Community Residential Service**

Residential services provide medium to long term accommodation, clinical care and rehabilitation for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide the residents with 'home like' accommodation where they can learn or re-learn everyday living skills necessary for their successful living in the community.

*Includes:*

- Community Care Units
- Residential Rehabilitation (Non Government sector)

**40 Psychiatric Hospital**

Includes psychiatric hospitals and psychiatric wards and facilities co-located with general hospitals.

**50 Acute Hospital**

Patient usually resides in an Acute Hospital.

*Excludes:*

- Patients usually resident in psychiatric wards within an Acute hospital (report 40—Psychiatric Hospital)

**61 Caravan**

Patient normally resides in a caravan. This may be on privately owned land, or within a caravan park or similar.

**62 Homeless Persons Shelter**

Patient currently receiving temporary accommodation/housing in a homeless persons shelter.

**63 Boarding/Rooming House**

Patient resides in a public or private boarding house. Residents pay an accommodation fee to proprietor. Proprietor has no responsibility to provide special and personal care services to residents. Regulated by the Rooming House Act 1990.

**64 Group Home**

Accommodation in a group home providing combined accommodation and community based residential support to people in a residential setting. Usually no more than six people are located in any one house, although this can vary. Group homes are generally staffed 24 hours per day.

**70 No usual residence**

Patient has no usual residence and is not currently residing in a temporary shelter. Patient is considered to be itinerant or homeless.

**60 Other accommodation**

Patient resides in accommodation type not listed here.

**90 Not Specified**

Client housing not specified.

**Edits**

XXX Invalid Usual Accommodation Type

**Related items**

Section 9:

Supplementary Code Lists: Care Type *Care Type 5A: Mental Health Service and Psychogeriatric Program – Acute, Adult Mental Health Service*, and *Care Type 5E: Mental Health Service and Psychogeriatric Program – Mental Health Secure Extended Care Unit (SECU)*, and *Care Type 5G: Mental Health Service and Psychogeriatric Program – Acute, Aged Persons Mental Health Service (APMH)*, and *Care Type 5K: Mental Health Service and Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS)*, and *Care Type 5S: Mental Health Service and Psychogeriatric Program – Acute, Specialist Mental Health Service*, and *Care Type 5T: Mental Health Service and Psychogeriatric Program – Mental Health Nursing Home Type*.

## Administration

**Purpose**

To enable management of clients and their associated data.

**Principal data users**

Mental Health & Drugs Division, DHS

**Collection start**

2009-10

**Definition source**

NHDD

**Code set source**

NHDD (Mental Health modified)

**Edits:**

- Invalid *Employment Status* code (Rejection, E4)
- Invalid *Usual Accommodation Type* code (Rejection, E4)
- *Employment Status* code reported but Care Type not 5x or 4 (with Procedure Code 93341-xx) (Rejection, E4 and output editing for Care Type 4 E4 vs X4)
- *Usual Accommodation Type* code reported but Care Type not 5x or 4 (with Procedure Code 93341-xx) (Rejection, E4 and output editing for Care Type 4 E4 vs X4)

## Proposal 7 – Addition of Program Identifier to identify episodes admitted under specified programs

**It is proposed to** Add a new data element, 'Program Identifier', to enable patients admitted under various programs to be identified in the data.

**Proposed by** Access & Metropolitan Performance Branch  
Metropolitan Health & Aged Care Services  
Department of Human Services

**Implementation Date** 1 July 2009

**Background** The addition of this new data element will enable patients admitted under a specified program to be identified in the data, without affecting other data elements or funding streams. Codes for various programs may be added and de-activated as required.

For example, this element would be used to identify Winter Demand Strategy episodes, and patients admitted to designated 23 Hr Surgery Units.

## Program Identifier (*New*)

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### Specification

<b>Definition</b>	Identifies the specified program, if any, which applies to this episode of care.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	2	<b>Layout</b>	NN or space
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public and Private Hospitals.		
<b>Reported for</b>	Episodes for patients admitted under a specified DHS program.  Otherwise, report a space in this field.		
<b>Reported when</b>	An Episode Record is transmitted.		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	01	Winter Demand Strategy	
	02	23 Hour Surgery Unit	
<b>Reporting guide</b>	Report the corresponding code for the program when advised to do so by the Department of Human Services' unit responsible for administration of the program, or by HDSS.		
<b>Edits</b>	XXX	Invalid Program Identifier	

### Related items

### Administration

<b>Purpose</b>	To: <ul style="list-style-type: none"><li>• Identify whether a specified program applies to this episode.</li><li>• Facilitate health services planning and monitoring.</li></ul>		
<b>Principal data users</b>	Multiple internal and external data users.		
<b>Collection start</b>	2009-10		
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

### Edits:

- Invalid *Program Identifier* (Rejection, E4)

## Proposal 8 – Addition of data elements relating to ICU/NICU accommodation

**It is proposed to** Add four new data elements to collect information on patient movements in and out of intensive care units, including neonatal and paediatric intensive care units.

The new elements are:

- Arrival Date/Time to Intensive Care Unit
- Departure Date/Time from Intensive Care Unit
- Source of Referral to Intensive Care Unit
- Date/Time Patient Ready to Depart Intensive Care Unit

**Proposed by** Access & Metropolitan Performance Branch  
Metropolitan Health & Aged Care Services  
Department of Human Services

**Implementation Date** 1 July 2009

**Background** Currently the VAED collects only the total hours a patient was accommodated in an intensive care unit. The introduction of these data elements would enhance the data available on patient movement in and out of intensive care units, and will provide information on the true volume of ICU services, impact of new beds opened, and trends and seasonal demands.

Where a patient experiences more than one stay in an ICU/NICU, only information on the first visit will be collected.

## Arrival Datetime to Intensive Care Unit (*New*)

---

### Specification

<b>Definition</b>	Date and Time at which an admitted patient commences arrives in an Intensive Care Unit.		
<b>Datatype</b>	Numeric	<b>Form</b>	Datetime
<b>Field size</b>	12	<b>Layout</b>	DDMMYYYYHHMM or spaces
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	All Victorian public hospitals, and private hospitals treating public patients under contract.		
<b>Reported for</b>	All admitted episodes of care during which a patient stayed in an intensive care unit: <ul style="list-style-type: none"><li>• In a public hospital; and</li><li>• In a private hospital as a public patient under contract.</li></ul>		
<b>Reported when</b>	The Diagnosis Record is reported.		
<b>Code set</b>	Valid datetime.		
<b>Reporting guide</b>	Report the date and time the patient arrived in an Intensive Care Unit.  If this data element is inapplicable to the episode, report spaces in this field.  Intensive Care Units include designated Intensive Care Units (ICU), and designated Neonatal Intensive Care Units (NICU).		
<b>Edits</b>	XXX Invalid Arrival Datetime to Intensive Care Unit XXX ICU Hours < calculated LOS in Intensive Care Unit		
<b>Related items</b>	Section 2: <i>Intensive Care Unit</i>  Section 3: <i>Duration of Stay in ICU</i> on page 3-xx.  Section 9: <ul style="list-style-type: none"><li>• Supplementary Code Lists: <i>Intensive Care Units</i></li></ul>		

## Administration

<b>Purpose</b>	To enable analysis of patient movement in and out of ICUs/NICUs, and to monitor usage of resources.
<b>Principal data users</b>	Access & Metropolitan Performance, DHS
<b>Collection start</b>	2009-10
<b>Definition source</b>	DHS

---

## Departure Datetime from Intensive Care Unit (New)

---

### Specification

<b>Definition</b>	Date and Time at which an admitted patient departed from an intensive care unit.		
<b>Datatype</b>	Numeric	<b>Form</b>	Datetime
<b>Field size</b>	12	<b>Layout</b>	DDMMYYYYHHMM or spaces
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	All Victorian public hospitals, and private hospitals treating public patients under contract.		
<b>Reported for</b>	All admitted episodes of care during which a patient stayed in an intensive care unit: <ul style="list-style-type: none"><li>• In a public hospital; and</li><li>• In a private hospital as a public patient under contract.</li></ul>		
<b>Reported when</b>	The Diagnosis Record is reported.		
<b>Code set</b>	Valid datetime.		
<b>Reporting guide</b>	Report the date and time the patient departed from an intensive care unit.  If this data element is inapplicable to the episode, report spaces in this field.  Intensive Care Units include designated Intensive Care Units (ICU), and designated Neonatal Intensive Care Units (NICU).		
<b>Edits</b>	XXX Invalid Departure Datetime from Intensive Care Unit XXX ICU Hours < calculated LOS in Intensive Care Unit		

- Related items**
- Section 2: *Intensive Care Unit*
  - Section 3: *Duration of Stay in ICU* on page 3-xx.
  - Section 9:
    - Supplementary Code Lists: *Intensive Care Units*

## Administration

- Purpose** To enable analysis of patient movement in and out of ICUs/NICUs, and to monitor usage of resources.
- Principal data users** Access & Metropolitan Performance, DHS
- Collection start** 2009-10
- Definition source** DHS

## Source of Referral to Intensive Care Unit (*New*)

### Specification

- Definition** The location of the patient prior to their arrival in an intensive care unit.
- Datatype** Numeric                      **Form**                      Code
- Field size** 1                              **Layout**                      N
- Location** Diagnosis Record
- Reported by** All Victorian public hospitals, and private hospitals treating public patients under contract.
- Reported for** All admitted episodes of care during which a patient stayed in an intensive care unit:
  - In a public hospital; and
  - In a private hospital as a public patient under contract.
- Reported when** The Diagnosis Record is reported.
- Code set**
- | <b>Code</b> | <b>Descriptor</b>                             |
|-------------|---|
| 1           | Emergency Department this hospital            |
| 2           | Emergency Department another hospital/campus  |
| 3           | Post-surgery this hospital                    |
| 4           | Post-surgery another hospital/campus          |
| 5           | Ward of this hospital                         |
| 6           | Transfer from ward of another hospital/campus |
| 7           | Transfer from ICU of another hospital/campus  |
- Reporting guide** Report the location of the patient prior to their arrival in an intensive care unit.

**1      *Emergency Department this hospital***

Patient moved from the Emergency Department of this hospital to the ICU/NICU.

**2      *Emergency Department another hospital/campus***

Patient moved from the Emergency Department of another hospital or campus directly to the ICU/NICU of this hospital.

*Excludes:*

- Patients transferred to the Emergency Department of this hospital (Use Code 1)

**3      *Post Surgery this hospital***

Planned or unplanned move directly to the ICU/NICU of this hospital following a surgical or diagnostic procedure.

**4      *Post Surgery another hospital/campus***

Transfer following a surgical or diagnostic procedure from another hospital/campus directly to the ICU/NICU of this hospital.

**5      *Ward of this hospital***

Patient moved from a ward of this hospital directly to the ICU/NICU of this hospital.

*Excludes:*

- Emergency Department (Use Code 1)

**6      *Transfer from ward of another hospital/campus***

Patient moved from a ward of another hospital or campus directly to the ICU/NICU of this hospital.

*Excludes:*

- Emergency Department of another hospital (Use Code 2)

**7      *Transfer from ICU of another hospital/campus***

Patient moved from an ICU/NICU of another hospital or campus directly to the ICU/NICU of this hospital.

*Excludes:*

- Planned or unplanned transfer from another hospital/campus following a surgical or diagnostic procedure (Use Code 4)

***Edits***

XXX    Invalid Source of Referral to ICU

***Related items***

Section 2: *Intensive Care Unit*

Section 3: *Duration of Stay in ICU* on page 3-xx.

Section 9:

- Supplementary Code Lists: *Intensive Care Units*

## Administration

<b>Purpose</b>	To enable analysis of patient movement in and out of ICUs/NICUs, and to monitor usage of resources.
<b>Principal data users</b>	Access & Metropolitan Performance, DHS
<b>Collection start</b>	2009-10
<b>Definition source</b>	DHS

---

## Ready to Depart Intensive Care Unit Datetime (New)

---

### Specification

<b>Definition</b>	Date and Time at which an admitted patient was ready to depart an intensive care unit.		
<b>Datatype</b>	Numeric	<b>Form</b>	Datetime
<b>Field size</b>	12	<b>Layout</b>	DDMMYYYYHHMM or spaces
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care during which a patient stayed in an intensive care unit.		
<b>Reported when</b>	The Diagnosis Record is reported.		
<b>Code set</b>	Valid datetime.		
<b>Reporting guide</b>	Report the date and time it was determined by a clinician that the patient was ready to depart an intensive care unit.		

If this data element is inapplicable to the episode, report spaces in this field.

Intensive Care Units include designated Intensive Care Units (ICU), and designated Neonatal Intensive Care Units (NICU).

A patient may be considered ready to depart an intensive care unit but may be required to stay in the unit due to a lack of resources at the intended destination. Therefore the *Ready to Depart an Intensive Care Unit Datetime* may be before the *Departure Datetime from an Intensive Care Unit*.

The decision that the patient is ready to depart the intensive care unit must be made by a clinician. The date and time reported as 'ready to depart' should be the date and time when:

- The patient is medically stable

- All required assessments and paperwork have been completed
- Transfer preparations have been completed.

**Edits**

XXX Invalid Datetime Ready to Depart Intensive Care Unit  
 XXX Datetime Ready to Depart Intensive Care Unit > Departure Datetime

**Related items**

Section 2: *Intensive Care Unit*

Section 3: *Arrival Datetime to Intensive Care Unit* on page 3-xx and *Departure Datetime from Intensive Care Unit* on page 3-xx

Section 9:

- Supplementary Code Lists: *Intensive Care Units*

## Administration

**Purpose** To enable analysis of patient movement in and out of ICUs/NICUs, and to monitor usage of resources.

**Principal data users** Access & Metropolitan Performance, DHS

**Collection start** 2009-10

**Definition source** DHS

### Edits:

- Invalid format for all data elements (Rejection, X4)
- ICU Hours reported but one or all of the new data elements not reported (Rejection, X4)
- ICU Hours less than the calculated time spent in an ICU/NICU (Rejection, X4)
- Datetime ranges outside Admission/Separation dates (Rejection, X4)
- Data element reported but site does not have an approved ICU/NICU (Rejection, X4)

## Proposal 9 – Addition of Start and End Datetime of a Procedure

**It is proposed to** Add two new data elements to collect information on patient movements in and out of surgery.

The new elements are:

- Start Date/Time of Procedure
- End Date/Time of Procedure

**Proposed by** Access & Metropolitan Performance Branch  
Metropolitan Health & Aged Care Services  
Department of Human Services

**Implementation Date** 1 July 2009

**Background** In April 2008 a sector wide forum 'Victorian Surgical Services Strategy' attended by approximately 70 participants from health services (rural, regional and metropolitan), professional associations and the Department identified timely access to emergency surgery as a potential area warranting further investigation and policy development by the department. The workshop articulated the need for the Department to 'develop data systems to support hospital monitoring of emergency and elective surgery demand and service provision'.

The introduction of these data elements would enable the Department to collect patient level information relating to surgery and procedures, which will inform service and resource planning.

Where a patient experiences more than one visit to theatre during the episode of care, only information on the first visit will be collected.

## Start Datetime of Procedure (*New*)

---

### Specification

<b>Definition</b>	Date and Time at which a procedure commenced for an admitted patient.		
<b>Datatype</b>	Numeric	<b>Form</b>	Datetime
<b>Field size</b>	12	<b>Layout</b>	DDMMYYYYHHMM or spaces
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care during which a patient underwent a procedure.		
<b>Reported when</b>	The Diagnosis Record is reported.		
<b>Code set</b>	Valid datetime.		
<b>Reporting guide</b>	<p>Report the date and time the procedure commenced in an operating or procedure room.. The procedure is deemed to have commenced when:</p> <ul style="list-style-type: none"><li>• The first incision is made for a surgical procedure; or</li><li>• The scope is inserted for a diagnostic procedure; or</li><li>• An exam begins for an Examination Under Anaesthetic.</li></ul> <p>As a guide, Start Datetime of Procedure should be reported for procedures with an 'OR Flag' of 'S' or 'O' in the ICD-10-AM Library File for the current year. The Library file is available from: <a href="http://www.health.vic.gov.au/hdss/icdcoding/libfilesindex.htm">http://www.health.vic.gov.au/hdss/icdcoding/libfilesindex.htm</a></p> <p>Report the first visit to an operating or procedure room only, do not report any subsequent visit in this episode.</p> <p>If this data element is inapplicable to the episode, report spaces in this field.</p>		
<b>Edits</b>	XXX Invalid Start DateTime of Procedure		
<b>Related items</b>	Section 3: <i>End Datetime of Procedure</i> on page 3-xx.		

### Administration

<b>Purpose</b>	To enable analysis of wait times for, and duration of, procedures.
<b>Principal data users</b>	Access & Metropolitan Performance, DHS
<b>Collection start</b>	2009-10
<b>Definition source</b>	DHS

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## End Datetime of Procedure (*New*)

---

### Specification

<b>Definition</b>	Date and Time at which a procedure ended for an admitted patient.		
<b>Datatype</b>	Numeric	<b>Form</b>	Datetime
<b>Field size</b>	12	<b>Layout</b>	DDMMYYYYHHMM or spaces
<b>Location</b>	Diagnosis Record		
<b>Reported by</b>	All Victorian hospitals (public and private).		
<b>Reported for</b>	All admitted episodes of care during which a patient a patient underwent surgery.		
<b>Reported when</b>	The Diagnosis Record is reported.		
<b>Code set</b>	Valid datetime.		
<b>Reporting guide</b>	<p>Report the date and time the procedure ended. The procedure is deemed to have ended when:</p> <ul style="list-style-type: none"><li>• The time when all instruments and sponge counts are completed and verified as correct; and</li><li>• All postoperative radiological studies done in the operating/procedure room are completed; and</li><li>• All dressings and drains are secured and the surgeons/physicians have completed all procedure-related activities on the patient.</li></ul> <p>As a guide, End Datetime of Procedure should be reported for procedures with an 'OR Flag' of 'S' or 'O' in the ICD-10-AM Library File for the current year. The Library file is available from: <a href="http://www.health.vic.gov.au/hdss/icdencoding/libfilesindex.htm">http://www.health.vic.gov.au/hdss/icdencoding/libfilesindex.htm</a></p> <p>Report the first visit to an operating or procedure room only, do not report any subsequent visit in this episode.</p> <p>If this data element is inapplicable to the episode, report spaces in this field.</p>		
<b>Edits</b>	XXX Invalid End Datetime of Procedure		
<b>Related items</b>	Section 3: <i>Start Datetime of Procedure</i> on page 3-xx.		

## Administration

**Purpose** To enable analysis of duration of procedures.

**Principal data users** Access & Metropolitan Performance, DHS

**Collection start** 2009-10

**Definition source** DHS

### Edits:

- Datetime invalid (Rejection, X4)
- Start/End Datetime of Procedure is before Admission Date or after Separation Date (Rejection, X4)
- Start Datetime of Procedure is after End Datetime of Procedure (Rejection, X4)
- Start/End Datetime of Procedure reported but no procedure codes are reported. (Rejection, X4)
- Start/End Datetime of Procedure reported but no procedure codes with an OR flag of 'S' or 'O' is reported. (Rejection, X4)

## Proposal 10 – Change of definition for Admission Type values

**It is proposed to** Clarify the definitions of Admission Types L (*Admission – From the Waiting List*) and X (*Other Admission*), and C (*Emergency admission through Emergency Department at this hospital*) and O (*Other emergency admission*) to enable consistent reporting across services.

**Proposed by** Health Data Standards and Systems Unit  
Metropolitan Health & Aged Care Services  
Department of Human Services

**Implementation Date** 1 July 2009

**Background** The definitions for these four codes do not provide clear guidelines for reporting and therefore the effective use of these codes in data analysis is compromised.

Providing unambiguous definitions for these codes will improve data quality and consistency of use.

## Admission Type (*Amended*)

### Specification

**Definition** The category of admission (patient characteristic) relating to this episode of care.

**Datatype** Alpha **Form** Code

**Field size** 1 **Layout** A

**Location** Episode Record

**Reported by** All Victorian hospitals (public and private).

**Reported for** All admitted episodes of care.

**Reported when** The Episode Record is reported.

**Code set** Select the first appropriate category:

<b>Code</b>	<b>Descriptor</b>
S	Statistical admission (change in Care Type within this hospital)
Y	Birth episode
M	Maternity
C	Emergency admission through Emergency Department at this hospital (VEMD Only)
L	Admission – from the Waiting List (ESIS Episodes Only)
O	Other emergency admission
X	Other admission

**Reporting guide** **S Statistical admission (change in Care Type within this hospital)**  
Used for statistical admissions.

**Y Birth episode**  
Admission of newborn at or directly after birth.

*Excludes* second or subsequent admissions in the newborn period:

- Newborns admitted after the birth episode, while still nine (9) days old or less (use code C, L, O or X).

**M Maternity**  
Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy.

**C Emergency admission through Emergency Department at this hospital (VEMD only)**

Admission of an emergency patient, arising from presentation at the Emergency Department of this hospital.

Use of this code is **not** limited to those facilities that report to the Victorian Emergency Minimum Dataset (VEMD).

*Includes:*

- Threatened miscarriage before 20 weeks.

*Excludes:*

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

**L Admission – from the Waiting List (ESIS Episodes only)**

Admission of a patient currently on the waiting list for elective medical or surgical treatment as an admitted patient. Waiting list patients include only those elective admissions for whom names, addresses and other necessary details are held by the hospital on a specific list prepared from a written request for admission from the patient's doctor.

Use of this code is **not** limited to those episodes that required to be reported to the Elective Surgery Information System (ESIS).

~~Includes:~~

~~Non-elective admissions managed through the use of a 'waiting list', for example rehabilitation episodes.~~

*Excludes:*

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

**O Other emergency admission**

Admission of an emergency patient, not arising from presentation at the Emergency Department at this hospital, **or arising from presentation at the Emergency Department of a hospital which does not report data to the Victorian Emergency Minimum Dataset (VEMD).**

*Includes:*

- GP-referred admission or self-referral for acute illness (such as unstable diabetes, CCF, pneumonia, asthma attack) directly for emergency admission.
- Threatened miscarriage before 20 weeks.
- Emergency admission to a hospital without a formal Emergency Department.
- **Emergency admission to a hospital which does not report data to the Victorian Emergency Minimum Dataset (VEMD).**
- Admission from Outpatient Department where patient is an emergency patient.

*Excludes:*

- Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).

## **X Other admission**

Routine or elective admission regardless of expected length of stay, where the patient is not recorded on the waiting list or the patient is recorded on a waiting list of a hospital which does not report to the Elective Surgery Information System (ESIS).

*Includes:*

- Admission from the waiting list of a hospital which does not report to the Elective Surgery Information System (ESIS).
- Planned admission for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.
- Admission from Outpatient Department where patient is an elective patient.
- Follow-up admission following a previous emergency admission or presentation where the patient has not been added to an elective surgery waiting list.

## **Edits**

052	Invalid Adm Type
056	Incompatible Adm Type/Source
057	Incompat Adm Type/Age
059	Maternity - Not Female
328	Early Parenting Centre – Invalid Comb
329	Geri Respite - Invalid Comb
336	Invalid Comb For Crit Care Transfer
454	Incompat Fields for Interim Care
455	Inconsist Newborn Transferred/Unqual Data
466	Adm Type L & Newborn Qual Status
484	Incompat Adm Type/Crit for Adm
485	Incompat Adm Type/Qual Stat
491	Incompat Fields for ESAS
492	Incompat Fields for RPI
626	Invalid Combination for Funding Arrangement PHESI
633	Delivery Episode, Adm Type not M

## **Related items**

Section 2: *Admission, Geriatric Respite, Newborn, and Urgency of Admission.*

Section 4:

- Business Rules (non-tabular) *Newborn Reporting.*
- Business Rules (tabular) *Account Class: Geriatric Respite, and Admission Source and Admission Type, and Admission Type and Age, and Admission Type and Criterion For Admission, and Admission Type and Qualification Status, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type P: Designated Paediatric Rehabilitation Program, and Care Type: Interim Care Program (F and E), and Criterion for Admission, Age, Admission Type, Admission Source, Qualification Status, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative and Funding Arrangement: Private Hospital Elective Surgery Initiative.*

## **Administration**

**Purpose**

To:

- Distinguish between emergency and non-emergency admissions.
- Monitor admissions from the Waiting List.
- Identify data for maternity and birth episodes.

**Principal data users**

Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

**Collection start**

1979-80

**Definition source**

DHS

**Code set  
source**

DHS

**Edits:**

No change to edits.

## Proposal 11 – Addition of data elements related to birth episodes

**It is proposed to** Add four new data elements to increase the information collected about birth episodes.

The new data elements are:

- Mother's UR number (to be recorded on the baby's episode)
- APGAR score (first and second)
- First birth indicator

**Proposed by** Access & Metropolitan Performance  
Metropolitan Health & Aged Care Services  
Department of Human Services

**Implementation Date** 1 July 2009

**Background** The inclusion of these data elements would increase the information available about the birth episode as follows:

- Adding a link between the mother and baby episode will allow for enhanced data analysis of the factors affecting the care of both the mother and baby.
- Adding APGAR scores will improve the data available for analysis of the factors affecting the care of newborns.
- The First Birth Indicator will inform analysis of the rates of, and reasons for, caesarean deliveries.

## Mother's UR (*New*)

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### Specification

<b>Definition</b>	The UR Number (Patient Identifier) of the mother of the baby.		
<b>Datatype</b>	Alphanumeric	<b>Form</b>	Code
<b>Field size</b>	10	<b>Layout</b>	XXXXXXXXXX or spaces Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Victorian hospitals (public and private).		
<b>Reported for</b>	Public Hospitals: Newborn episodes where both mother and baby is admitted. Private hospitals: Newborn episodes where both mother and baby is admitted, and the newborn episode is reported.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Valid Patient Identifier.		
<b>Reporting guide</b>	When the baby is born in hospital during this episode of care, report the Patient Identifier of the mother's episode of care.  If the baby was not born during this episode of care, but both mother and baby are admitted to the hospital, report the Patient Identifier of the mother's episode of care.		
<b>Edits</b>			
<b>Related items</b>	-		

### Administration

<b>Purpose</b>	To enable analysis of the factors affecting the care of both the mother and baby.		
<b>Principal data users</b>	Internal and External data users.		
<b>Collection start</b>	2009-10		
<b>Definition source</b>	DHS	<b>Code set source</b>	Hospitals

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# APGAR1 (*New*)

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## Specification

<b>Definition</b>	The APGAR score calculated after the first test of a baby born in the hospital.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	2	<b>Layout</b>	NN or spaces Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public Hospitals: Newborn episodes where both mother and baby is admitted. Private hospitals: Newborn episodes where both mother and baby is admitted, and the newborn episode is reported.		
<b>Reported for</b>	Newborn episodes where the baby is born in the hospital.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Score between 0 and 10.		
<b>Reporting guide</b>	When the baby is born in hospital during this episode of care, report the APGAR Score calculated from the first test, usually performed one minute after birth.		
<b>Edits</b>			
<b>Related items</b>	-		

## Administration

<b>Purpose</b>	To enable analysis of the factors affecting the care of the baby.		
<b>Principal data users</b>	Internal and External data users.		
<b>Collection start</b>	2009-10		
<b>Definition source</b>	DHS	<b>Code set source</b>	Hospitals

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## APGAR2 (New)

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### Specification

<b>Definition</b>	The APGAR score calculated after the second test of a baby born in the hospital.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	2	<b>Layout</b>	NN or spaces Right justified, zero filled.
<b>Location</b>	Episode Record		
<b>Reported by</b>	Public Hospitals: Newborn episodes where both mother and baby is admitted. Private hospitals: Newborn episodes where both mother and baby is admitted, and the newborn episode is reported.		
<b>Reported for</b>	Newborn episodes where the baby is born in the hospital.		
<b>Reported when</b>	The Episode Record is reported.		
<b>Code set</b>	Score between 0 and 10.		
<b>Reporting guide</b>	When the baby is born in hospital during this episode of care, report the APGAR Score calculated from the second test, usually performed five minutes after birth.		
<b>Edits</b>			
<b>Related items</b>	-		

### Administration

<b>Purpose</b>	To enable analysis of the factors affecting the care of the baby.		
<b>Principal data users</b>	Internal and External data users.		
<b>Collection start</b>	2009-10		
<b>Definition source</b>	DHS	<b>Code set source</b>	Hospitals

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# First Birth Indicator (*New*)

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## Specification

**Definition** Whether or not the patient delivered her first baby during this episode of care.

**Datatype** Alphanumeric **Form** Code

**Field size** 1 **Layout** X or space

**Location** Episode Record

**Reported by** Victorian hospitals (public and private).

**Reported for** Mother's Episode in which a baby was delivered.

**Reported when** The Episode Record is reported.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	Y	Episode included mother's first delivery
	N	Delivery but not mother's first delivery

**Reporting guide** Where the episode includes the delivery of a baby, indicate whether it was the mother's first delivery. Both this delivery and any previous deliveries include both live- and still-births.

Report a space when no delivery occurred in this episode.

### **Edits**

**Related items** -

## Administration

**Purpose** To enable analysis of the factors affecting the mode of delivery and care of mother and baby.

**Principal data users** Internal and External data users.

**Collection start** 2009-10

**Definition source** DHS **Code set source** Hospitals

**Edits:***Mother's UR:*

- Invalid format Mother's UR (Rejection, E4)
- Mother's UR does not exist (Rejection, E4)
- Admission Source Y but Mother's UR not reported (Rejection, E4)

*APGAR1/APGAR2:*

- Invalid APGAR1/2, outside range 0 - 10 (Rejection, E4)
- Admission Source Y but APGAR1/2 not reported (Rejection, E4)
- APGAR1/2 reported but not newborn episode (Admission Source is not Y) (Rejection, E4)

*First Birth Indicator:*

- First Birth Indicator reported but Admission Source not 'M' (Warning, E4)
- First Birth Indicator reported but X4 does not contain Z38.- code (Rejection, X4)

## Proposal 12 – Addition of *Ready for Separation Datetime* data element, relating to patients awaiting referral to other services

<b>It is proposed to</b>	Add a new data element, <i>Ready for Separation Datetime</i> , to collect information about how long a patient remains in hospital due to the unavailability of other services.
<b>Proposed by</b>	Access & Metropolitan Performance Metropolitan Health & Aged Care Services Department of Human Services
<b>Implementation Date</b>	1 July 2009
<b>Background</b>	The introduction of this data element would allow the Department to monitor the number of patient days that occur due to the unavailability of other services or resources.

## Ready for Separation Datetime (*New*)

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### Specification

<b>Definition</b>	Date and Time at which an admitted patient was ready for separation.		
<b>Datatype</b>	Numeric	<b>Form</b>	Datetime
<b>Field size</b>	12	<b>Layout</b>	DDMMYYYYHHMM or spaces
<b>Location</b>	Episode Record		
<b>Reported by</b>	All Victorian public hospitals (Private hospitals report spaces)		
<b>Reported for</b>	All admitted episodes of care.		
<b>Reported when</b>	The Separation Date is reported.		
<b>Code set</b>	Valid datetime.		
<b>Reporting guide</b>	<p>Report the date and time it was determined by a clinician that the patient was ready to be separated. Where the Separation Date is not reported (i.e. the patient is not separated), report spaces in this field.</p> <p>A patient may be considered ready to be separated but may be required to remain admitted due to a lack of resources at the intended destination or post-separation services.</p> <p>Private hospitals report spaces in this field.</p> <p>The decision that the patient is ready to be separated must be made by a clinician. The date and time reported as 'ready to be separated' should be the date and time when:</p> <ul style="list-style-type: none"><li>• The patient is medically stable</li><li>• All required assessments and paperwork have been completed</li><li>• Transfer/separation preparations have been completed.</li></ul>		

#### **Edits**

#### **Related items**

Section 2: *Separation*

Section 3: *Separation Date* on page 3-xx and *Separation Time* on page 3-xx

### Administration

#### **Purpose**

To enable analysis of patient movement, to monitor usage of resources, and to monitor access to resources and services.

#### **Principal data users**

Access & Metropolitan Performance, DHS

**Collection start** 2009-10

**Definition source** DHS

**Edits:**

- Invalid *Ready for Separation Datetime* (Rejection, E4)
- *Ready for Separation Datetime* > *Separation Date* and *Separation Time* (Rejection, E4)

## Proposal 13 – Introduction of Country of Birth (SACC) codeset 2<sup>nd</sup> Edition 2008

It is proposed to	Revise the <i>Country of Birth and Country of Residence</i> codeset to be consistent with the Standard Australian Classification of Countries (SACC) Second Edition 2008.
Proposed by	Health Data Standards and System Unit Funding, Health and Information Policy Metropolitan Health and Aged Care Services Division Department of Human Services
Implementation Date	1 July 2009
Background	<p>The Australian Bureau of Statistics released the SACC Second edition in May 2008. This edition of the SACC has been incorporated into the National Health Data Dictionary (NHDD) as the classification scheme for the <i>Country of Birth</i> data element.</p> <p>DHS currently uses the SACC for the <i>Country of Birth</i> data element, as well as for reporting country of residence for overseas patients in the <i>Locality</i> data element.</p> <p>The following changes are required to align the <i>Country of Birth</i> codeset to the SACC Second Edition 2008.</p>

### Changed in name

Code	SACC Second Edition for 1 July 2009	Formerly
2100	United Kingdom, Channel Islands and Isle of Man	United Kingdom
2402	Faroe Islands	Faeroe Islands
5105	Vietnam	Viet Nam
6101	China (Excludes SARS and Taiwan)	China (Excludes SARS and Taiwan Province)
7206	Kyrgyzstan	Kyrgyz Republic

### Added to the classification

Code	SACC Second Edition for 1 July 2009	Formerly in or part of
1513	Pitcairn Islands	1599 Polynesia (excludes Hawaii), nec
2107	Guernsey	2101 Channel Islands
2108	Jersey	2101 Channel Islands
2408	Aland Islands	2403 Finland
3216	Kosovo	3215 Serbia
4108	Spanish North Africa	4199 North Africa, nec

8431	St Barthelemy	8413 Guadeloupe
8432	St Martin (French part)	8413 Guadeloupe

### Removed from the classification

<b>Code</b>	<b>Name</b>	<b>SACC Second Edition for 1 July 2009</b>
2101	Channel Islands	Separately identified as 2107 Guernsey and 2108 Jersey
4199	North Africa, nec	All parts now in 4108 Spanish North Africa

## Appendix: Feedback Proforma

A Microsoft Word format Feedback Proforma is available from the HDSS Website:

[www.health.vic.gov.au/hdss](http://www.health.vic.gov.au/hdss)

