

Victorian Emergency Minimum Dataset Technical Reference Group

Minutes of the first meeting of the Victorian Emergency Minimum Dataset (VEMD) Technical Reference Group (TRG) held at 10:30am on Wednesday 21 November 2007, 18th floor, Department of Human Services, 50 Lonsdale Street.

1.0 Welcome

Andrew Brown welcomed members to the first meeting of the VEMD TRG. Andrew advised that the new TRG is intended to fill the role of the previous EDIS Review Committee, being the reference group for the VEMD. In addition, the TRG is intended as the venue for discussion and action on strategic issues relating to data and information systems for emergency departments. The meeting opened at 10.40am

2.0 Present

Andrew Brown	Department of Human Services (Chair)
Anna Cooper	Department of Human Services
Elizabeth May	Bendigo Health
Helen Rizzoli	St Vincent's Health
Karen Smith	Metropolitan Ambulance Service
Les Lambert	Department of Human Services
Peter Barnett	Royal Children's Hospital
Ruth Paterson	Department of Human Services
Simon Judkins	Austin Health
Sara Harrison	Department of Human Services (Secretary)
Sue Colby	West Gippsland Healthcare Group
Sue O'Sullivan	Department of Human Services
Tracy Burgess	Sandringham Hospital

Apologies

Don Liew	Melbourne Health
Fergus Kerr	Austin Health
Jacqui Allen	Eastern Health
Jeff Wassertheil	Peninsula Health
Michael Langley	Department of Human Services
Tony Kambourakis	Southern Health

3.0 Housekeeping

3.1 Confirmation of Terms of Reference

The draft Terms of Reference had been distributed with the meeting invitations. Andrew Brown provided a brief summary of the terms of reference. Meeting attendees endorsed the terms of reference.

A copy of the final terms of reference for the VEMD TRG is attached to these minutes.

3.2 Meeting schedule

Andrew Brown advised that it is anticipated that VEMD TRG meetings will be held three to four times per year. A November/December meeting will provide the avenue for presentation and discussion of the *Proposals for Revisions to the VEMD* document.

It was agreed that future meetings be held on a Tuesday whenever possible.

The next meeting will be held in approximately three months time (date to be advised).

3.3 Membership

Andrew Brown advised that the membership of the group had been selected taking into account the different roles of members within their different hospitals.

Andrew proposed that the minutes of these meetings be circulated to VEMD submission officers and other interested parties for information. It was agreed that this would be appropriate.

4.0 Specification for Revisions to the VEMD for 1 July 2008

4.1 Proposal 1: Add a new code to the code set for existing data item *Referred By*.

Les Lambert provided the following information regarding the requirement for this proposal.

DHS produces statistics from the Nurse on Call program regarding patterns of referral by the Nurse on Call operators, however is unable to determine how many people actually take the advice of these operators. Some hospitals have also made complaints to the Nurse on Call program regarding unnecessary referrals of people to hospital emergency departments. Collection of these data would give DHS a measure of the appropriateness of referrals to public hospitals. That is, if the majority of patients referred by Nurse on Call are triage categories 1 and 2, then it would appear that the advice being given is appropriate. However if the majority of these referrals are provided to patients who are triage categories 4 and 5, then this may indicate a problem with Nurse on Call referrals.

Pater Barnett advised that at the Royal Children's Hospital, the point of data collection is the clerical staff, and that these staff will not know where the patient has come from. Generally, patients will advise the triage nurse if someone has referred them to the hospital and 70% of the RCH ED attendances are 'Referred By' self, family or friends.

Sue Colby advised that Trak software collects these data at the point of triage, rather than at clerical registration.

In general there was support for the introduction of this new *Referred by* code, although there was some concern regarding how this would actually work in practice. Depending on other feedback received during the comments period, it is likely that this will continue through to the specification stage as a revision for 1 July 2008.

4.2 Proposal 2: Add a new code to the code set for existing data item *Departure Status*.

Sue O'Sullivan provided the following information regarding the requirement for this proposal.

There are 3-4 mental health observation units across Victorian health services. This model is specifically targeted for short stay mental health patients who will

be either discharged within 24 hours or moved to an admitted bed within that time. The aim is to move mental health patients out of the emergency department environment so that they can begin treatment in an appropriate environment. At this stage it is expected that the model will continue to be rolled out across the system.

Sue Colby queried whether this would include recommended beds for secure patients. Sue O'Sullivan advised that secure patients are not admitted to these units.

Andrew Brown advised that HDSS would also be investigating whether this data need can be met through data linkage with the VAED rather than introducing this proposal.

In general there was support for the introduction of this new *Departure Status* code if this is determined necessary, but monitoring of this information will occur over a 12 month period.

4.3 Proposal 3: Add a new data item to record the accuracy of the Date of Birth.

Andrew Brown provided the following information regarding the requirement for this proposal.

This proposal is based on a national standard definition for date accuracy flag. The aim of this proposal is to collect consistency of dates of birth across DHS data collections. Currently estimated date of birth is collected differently for DHS collections and in hospitals.

This proposal was raised last year, however it was not favourably received at the time due to the complexity of the item. This year, the item has been simplified and DHS has indicated a willingness to accept either 'accurate' or 'estimate' as a mapping from an IT system checkbox. Hospitals are at liberty to implement the complete code set if desired.

Inclusion of this data item will assist record linkage between the different DHS datasets. Date of birth is often one of the fields used for linkage, therefore knowledge that a date is an estimate rather than accurate will assist the linkage process.

Anna Cooper and Sara Harrison advised that hospitals will need to advise their data input/clerical staff of this change to ensure that clerical staff attempt to estimate date of birth rather than use a sentinel value (for example 01/01/1900).

Helen Rizzoli advised that St Vincent's Hospital has recently done some linkage of the PMIs from three separate facilities and discovered that the 'accurate' dates of birth for a significant number of records differed. These dates of birth would be reported as being 'accurate' by the hospital, when in fact they may not be (due to data input or other error). Sue Colby advised that Gippsland had encountered similar issues when implementing a regional PMI.

In general there was cautious support for the implementation of this item. Helen Rizzoli advised that the implementation of this item might not give DHS everything that it wants to know.

4.4 Proposals 4: VEMD Library File Review and 5: VEMD Library File Update

Sara Harrison provided the following information regarding these proposals.

DHS has received a request from hospitals to include this list of diagnoses in the VEMD. Hospitals are invited to suggest any further diagnoses that would be useful inclusions in the VEMD.

Peter Barnett advised that:

- Bites and stings are hard to code because injury surveillance data must be reported for these. Some patients present to the emergency department with a swollen mosquito bite which must be reported as a non-venomous bite, however this is not an injury.
- Pulled elbow should be included in the termset. Other members advised that pulled elbow is listed under subluxed elbow and pulled elbow.
Action: Peter B to check reference data at Royal Children's Hospital.

Simon Judkins advised that the differences between stimulant and amphetamine drug overdoses are not always notable, and that some of these overdose categories may be too detailed for an emergency department setting. Ruth Paterson recommended that HDSS consult with the DHS drugs policy area.

Peter Barnett asked how the national emergency department termset fits in with the VEMD.

Andrew Brown advised that the national termset would be likely to replace the VEMD termset. This would be dependent on the national termset being implemented and Victoria being comfortable with the termset. At this stage Victoria is waiting on the outcome of the termset pilot.

The Royal Children's Hospital is keen to participate in the pilot.

Peter Barnett explained that the national termset is based on decision paths; where the user drills down to get to the diagnostic term required. This is a user-friendly, as well as word friendly system with easy to follow paths. It has been initially built for the HASS ED system that has approximately 85% of the market nationally. Victorian hospitals do not follow this national trend.

Sue Colby asked whether DHS would review the existing diagnoses with a view to removing those that were redundant or duplicates. Anna Cooper advised that some codes have been removed, and that hospitals should notify HDSS of redundant codes for removal.

ICD-10-AM Sixth edition will be implemented in Australia on 1 July 2008. In order to keep VEMD in line with other datasets, the VEMD Library file will be updated to include Sixth edition ICD-10-AM codes.

4.5 Proposal 6: Increase data submission frequency

Sue O'Sullivan reported that the Department would like to increase VEMD data submission to weekly to enable closer monitoring of activity in emergency departments.

Simon Judkins advised that this would require more resources to manage this, and that it would be virtually impossible to manage on current resources. Generally members agreed with this statement.

Andrew Brown noted that this is potentially a significant change, and requested that members provide DHS with an estimate of the cost burden that would be imposed by this change.

Action: All members to provide HDSS with an estimate of the cost burden associated with this change. Feedback to be provided on standard feedback proforma by 30 November.

Andrew Brown advised that the reason for very tight deadlines this year is partly due to the increased lead-time required for HealthSmart specifications.

4.6 Potential Changes and Developments: Replacement of SLA with mesh blocks

Andrew Brown reported that the ABS is changing its statistical geography structure and is replacing SLA with something else. This means that the SLA conversion tables previously supported by the ABS are no longer being supported.

At this stage it is likely that the ABS will implement mesh blocks. This will cause issues for hospitals and the Department with regard to reporting burden and privacy issues. DHS is seeking comments from hospitals in this regard, as well as an indication of preference if any.

Generally members agreed that the option placing the least burden on hospitals would be the best.

5.0 Departure Status *Left after clinical advice regarding treatment options* – Co-located GP Clinics

Andrew Brown reported that when a patient presents to triage and is advised to either stay and wait in the emergency department or go to the co-located or well-located GP clinic, the presentation is currently reported to the VEMD because the patient has been triaged. Presentations are required to be reported to the VEMD if the patient is triaged. Andrew queried whether members felt it was appropriate for referrals to co-located or well located GP clinics to be included in the VEMD.

Helen Rizzoli advised that triaging of these patients takes considerable resources, and that data should reflect this resource demand. Members agreed with this position.

Patients referred co-located and well-located GP clinics are reported in the VEMD with a Departure Status 10 - *Left after clinical advice regarding treatment options*. Members advised that these are not the only patients reported in this Departure Status category.

Andrew Brown advised that DHS would consider options for reporting these referrals so that the group can be separately identified.

6.0 Definition of Treatment in ED

Deferred to next meeting.

7.0 Emergency Department Systems

Andrew Brown advised that there was nothing particular to discuss about this agenda item at this meeting, however this should be an ongoing item. When HealthSmart releases the next strategy document, ED systems are expected to form a part of this strategy.

Andrew Brown queried whether members had specific systems issues they wanted to discuss.

Tracey Burgess discussed the shortfalls of the Cerner System in place at Sandringham Hospital.

8.0 VEMD Audit

Andrew Brown reported on the pilot audit of VEMD data that was undertaken about a year ago on six months of data belonging to Maroondah Hospital, Monash Medical Centre Clayton and Ballarat Base Hospital.

The findings of this audit showed problems with the methodology, mainly due to the assumption that the patient's medical record would be the system of record for emergency departments, when in fact the audit found the computer system to be the system of record. For this and other reasons, the reports have not been publicly released. Sue O'Sullivan queried whether all hospitals had the same situation whereby the computer system is the system of record. Members agreed that this is the case in the majority of hospitals.

DHS will prepare an options paper to explore future auditing options for the VEMD.

9.0 Other Business

9.1 Procedures codeset

Sue Colby queried whether DHS had any intention to review the list of procedures in the VEMD. Some of these procedures are out of date and no longer performed, while others are missing and always classified to 'other'. Andrew Brown advised that DHS would review this list and encouraged hospitals to submit any feedback.

10.0 Next Meeting

The next meeting will be held on a Tuesday in three months time, agenda content permitting.