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| Victorian Admitted Episodes Dataset (VAED) manual 2022-23 Section 1 Introduction |
| 32nd edition |
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| To receive this document in another format, email HDSS help desk <HDSS.Helpdesk@health.vic.gov.au>.Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Australia, Department of Health, June 2022.**ISBN** 978-1-76096-796-3 **(pdf/online/MS word)**Available at [HDSS VAED](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset> |
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# Introduction

The Victorian Admitted Episodes Dataset (VAED) comprises demographic, clinical and administrative details for admitted episode of care occurring in Victorian hospitals, rehabilitation centres, extended care facilities and day procedure centres.

VAED data is used to provide equitable funding to public hospitals under the casemix system, support health service planning, policy formulation and epidemiological research, and meet national data reporting requirements.

## VAED scope

The VAED data collection includes admitted episodes of care in Victorian public and private hospitals, rehabilitation centres, extended care facilities and day procedure centres.

Patient episodes of care must meet one of the Criteria for Admission as detailed in the Victorian Admitted Episodes Dataset: Criteria for Reporting document.

All organisations that receive funding for admitted patient services must submit data to the VAED.

It is a condition of registration that private hospitals and day procedure centres submit data to the VAED monthly, as set out in the *Health Services (Health Service Establishments) Regulations 2013*.

## Purpose

The VAED manual provides VAED contributors and users with a complete dataset resource including:

* definitions of data items
* how to compile and submit data
* information for contributors and data users
* valid code lists and links to reference files
* contact details for support services

This manual together with subsequent HDSS Bulletins forms the data submission specifications for each financial year.

## Contact details

For advice and assistance with data submission, reported data elements, the ICD-10-AM/ACHI library file or the content of this manual, contact

Email HDSS help desk <hdss.helpdesk@health.vic.gov.au>

# Data quality statement

This is a summary of what the department does to ensure consistent capturing and reporting of data quality across data sets and over time.

## Accuracy

The department publishes the VAED manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users. There are lists of valid codes in the manual and reference files on the HDSS website.

Data submitted by health services is subject to a validation process, checking for valid values and compliance with VAED business rules.

The department performs monthly data quality checks:

* birthing mothers (more than one delivery episode reported)
* duplicate births
* Admission Type / diagnosis code mismatch for birth episodes
* overlapping ED presentation times and admission times
* unseparated patients

Where anomalies are detected, health services are required to correct the data.

The VAED is subject to audits. The audit program is managed by Health Data Integrity Unit in the Victorian Agency for Health Information (VAHI).

## Validity

The VAED validation process provides reports for the health service to verify the accuracy of data submitted, reconcile the data accepted with internal systems, and make appropriate corrections.

## Completeness

The department distributes a monthly compliance report to monitor completeness of submissions.

The department monitors completeness through regular analyses of the VAED, sending out compliance emails to health services when a reporting deadline is missed, or clinical records are outstanding.

Monthly reconciliation reports are sent to public health services for review.

## Coherence

Each year the department reviews the VAED to ensure the data collection:

* supports the department's state and national reporting obligations
* assists planning and policy development
* reflects changes in hospital funding and service provision arrangements for the coming financial year
* incorporates appropriate feedback from data providers on improvements.

Definitions for common data items are consistent across data collections.

## Interpretability

The VAED manual provides definitions of concepts, data items, reporting guides and business rules relating to more than one data item.

Changes to the data collection during the year are published in the HDSS Bulletin.

The department provides data reporting advice and support to health services via the HDSS help desk.

## Timeliness

The VAED is updated after the 10th day of each month from data held in the VAED processing database.

Health services must submit data to the VAED at least monthly.

Data reporting for the financial year must be completed by the annual consolidation date published in the Department of Health and Human Services policy and funding guidelines.

## Accessibility

The department provides a suite of reports that allows health services to verify that all relevant data has been submitted.

The VAHI Data Request Hub provides information regarding data available, data release and confidentiality, and the application process.

The Victorian Health Services Performance website provides statistical information on Victoria’s public hospitals and health services. Activity and performance data are updated quarterly, with an aim to provide greater transparency and a better understanding of Victoria's public health and ambulance services.

# Reference Files

Reference files of code sets including postcodes and localities and campus codes are available at [HDSS reference files](https://www.health.vic.gov.au/data-reporting/reference-files) <https://www.health.vic.gov.au/data-reporting/reference-files> Updates to these reference files are notified in the HDSS Bulletin.

## Victorian Admitted Episode Dataset: Criteria for Reporting

The Victorian Admitted Episodes Dataset: Criteria for Reporting document provides guidelines to enable hospitals to distinguish between admitted and non-admitted patient episodes for data reporting. To be reported to the Victorian Admitted Episodes Dataset (VAED), patient episodes of care must meet one of the Criteria for Admission outlined in this document.

[HDSS VAED](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>

## ICD-10-AM/ACHI Library File

This file contains diagnosis, morphology, and procedure codes, including Victorian validations applied to those codes. It is available as a zip file to Victorian hospitals and their software suppliers, for submitting data to the VAED, on application to the HDSS Help Desk.

## Calendar of ICD coding and DRG grouping systems

Information regarding the release dates and implementation dates for the admitted heath classifications (ICD-10-AM/ACHI/ACS and DRG) used in Victoria from 1986 is available at: [Admitted Care Classifications](https://www.bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/admitted-care-classifications) < https://www.bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/admitted-care-classifications>

## Victorian Additions to Australian Coding Standards

Victoria's additions to the Australian Coding Standards (ACS) supplement the advice in the ACS. Available: [Victorian additions to ACS](https://www.bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/additions) < https://www.bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/additions>

# Communications

## HDSS Bulletin

The HDSS Bulletin, published by the department, provides advice on several data collections including the VAED.

It is available at [HDSS Communications](https://www.health.vic.gov.au/data-reporting/communications) <https://www.health.vic.gov.au/data-reporting/communications>

To subscribe, use the online form on the HDSS website or Email HDSS help desk <hdss.helpdesk@health.vic.gov.au>

## Useful links

### Victorian ICD Coding Committee (VICC)

The VICC, comprising expert Victorian coders and department and industry representatives, is responsible for responding to coding queries and providing advice on coding related matters. It liaises with health services, health information managers and clinical coders to provide advice on specific coding issues. The committee works with The National Centre for Classification in Health (NCCH) and contributes to the NCCH’s ongoing development of the Australian Coding Standards and classification systems. A database of queries submitted to the VICC from 2004, and the VICC’s responses, is available for search or download at: [Victorian ICD Coding Committee](https://bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/ICD-coding-committee) <https://bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/ICD-coding-committee>

### Clinical coding and classifications

Health classifications group aspects of patient information and characteristics into categories based on established criteria, logic, and conventions. These categories can be used to undertake a range of activities that underpin the analysis of health service delivery. Further information is available at [Clinical coding and classification](https://www.bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications/additions) < https://www.bettersafercare.vic.gov.au/our-work/information-management-and-standards/clinical-coding-and-classifications>

### Privacy and confidentiality of health records

Privacy and confidentiality, access and regulations on disposal and retention of health records [Health Records Act](https://www2.health.vic.gov.au/about/legislation/health-records-act) <https://www2.health.vic.gov.au/about/legislation/health-records-act>

### Private Hospitals and Day Procedure Centres

For general enquiries relating to registration of private hospitals and day procedure centres in Victoria, please contact: Private Health Services Regulations Unit (03) 9096 2164 [Private hospitals](https://www2.health.vic.gov.au/hospitals-and-health-services/private-hospitals)

<https://www2.health.vic.gov.au/hospitals-and-health-services/private-hospitals>

### Victorian health policy and funding guidelines

The Department of Health and Human Services (the department) is responsible for and publishes the Policy and funding guidelines for funded agencies annually. The Policy and Funding Guidelines (the guidelines) contains the relevant business-critical conditions of funding, pricing arrangements, funding amounts, and activity levels for relevant funded agencies. Funding and financial policy outline. Data quality and timeliness penalties [Policy and funding guidelines](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>

### Patient fees and charges for public health services

The Commonwealth Department of Health and Victorian Department of Health and Human Services provide policies about the fees and charges that can be levied on patients of public hospitals and health services for some services they receive. Details available at [Fees and charges](https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services) <https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services>

### Victorian health services performance data

The Victorian Health Services Performance website provides statistical information on Victoria's public hospitals and health services. [Performance data](https://vahi.vic.gov.au/reports/victorian-health-services-performance) <https://vahi.vic.gov.au/reports/victorian-health-services-performance>

# Requests for VAED data

## VAED annual file consolidation

The department creates an annual consolidated file of the VAED for each financial year.

* Prior to final consolidation data is subject to change
* After the consolidated file has been locked, no further changes are made.

The department maintains separate notes on any significant data anomalies identified in the locked file.

## Data release

The department’s policy on releasing data aims to protect the privacy of individuals, small community groups and private hospitals. Requests for VAED data can be submitted via the [VAHI Data Request Hub](https://vahi.freshdesk.com/support/home) <https://vahi.freshdesk.com/support/home>

# History and development of the VAED

Patient level statistical information from public hospitals has been collected since 1979. This collection, previously known as the Victorian Inpatient Minimum Database (VIMD), has developed into the Victorian Admitted Episodes Dataset (VAED).

Changes have been made to the dataset since 1979 to:

* meet national reporting requirements
* reflect the gradual introduction of the concept of episodes of care
* meet the requirements of changes to the funding formula (casemix funding)
* meet the increased need for information by providers and users of health services and other bodies.

**2022-23**

New data elements

* Medically Ready for Discharge Date
* Unplanned return to theatre

Changes to existing data elements

* Amend definition of Duration of Non-invasive Ventilation (NIV) in ICU to be consistent with ACS 1006 Ventilatory Support
* Add Funding Arrangement code for NHRA-funded highly specialised therapy
* Continue optional reporting of Proceduralist ID in 2022-23, mandatory in 2023-24
* Amend reporting guide for Sex

Reference file update

VAED ICD-10-AM/ACHI 2022-23 library file updated to 12th edition

**2021-22**

**New data elements**

* **NDIS Participant Flag**
* **Triage Score on Admission for palliative care episodes**
* **Number of leave days for each phase of care for palliative care episodes**
	+ **Leave days – Phase of Care on Admission**
	+ **Leave days – Phase of Care Change**
	+ **Leave days – Final Phase of Care**

**Amendments to existing data elements**

* Add emergency use codes to Admission Source, Contract/Spoke identifier, Funding Arrangement, Program Identifier, Separation Mode
* Add Accommodation Type codes for Intensive Care Unit, Neonatal Intensive Care Unit, Paediatric Intensive Unit and Special Care Nursery
* Add Separation Mode codes for separation and transfer to residential aged care facility, usual residence, and not usual residence

**2020-21**

Amendment to concept: Change definition of Palliative Care

Amendments to existing data elements

* Amend reporting guide for Procedure Start Date to include ECT performed in private hospitals
* Add code for Contract Type BAB
* Add code STRO Stroke Unit to Admitting/Discharging Unit/Specialty code set
* Reporting Proceduralist ID remains optional

**2019-20**

Amendments to existing data items

* Add Accommodation Type code for Mental Health and AOD hub Short Stay Unit, and amend Care Type 0 Alcohol and Drug Program
* Amend residential aged care facility description for Admission Source / Separation Mode
* Amend reporting guide for Advance Care Directive Alert
* Amend reporting guide for Intention to Re-admit, removing restriction for transferred patients
* Continue optional reporting for Proceduralist ID in 2019-20 (mandatory in 2020-21)
* Amend Trailer Records to make reporting of hospital calculated statistics optional

**Validations**

* New validation 721 FIM score on separation unexpectedly low
* Amend validation 334 Hospital generated DRG ≠ PRS2 DRG, restricting to public hospitals only
* Amend validation 423 Invalid combination Fund / Contract / Transfer
* Additional explanatory diagnosis codes for validations 450 Code incompatible with female sex and 451 Code incompatible with male sex

ICD-10-AM/ACHI/ACS 2019-20 library file updated to 11th edition

**2018-19**

Addition of data items

* Add Proceduralist ID for episodes where Procedure Start Date Time is reported
* Add Admitting Unit/Specialty for all admitted episodes
* Add Discharging Unit/Specialty for all admitted episodes

Amendment to existing data items

* Add Program ID code 10 Specialist spinal rehabilitation service
* Add Accommodation Type code P for Psychiatric Assessment and Planning Unit (PAPU)
* Amend reporting guide for mental health Care Types
* Amend Advance Care Plan Alert data item name (change to Advance Care Directive Alert), definition and reporting guide
* Reporting of Mental Health Legal Status made optional

New validations

714 Proceduralist ID / Procedure Start Date Time mismatch

715 Invalid Admitting Unit/Specialty

716 Invalid Discharging Unit/Specialty

717 Accom Type P, no registered PAPU

718 Delivery episode, Sep Referral is not E or F

Remove redundant Duration of Non-invasive Ventilation (NIV) in ICU validations 442 and 583

**2017-18**

New data item

* Addition of Preferred Death Place for palliative care episodes

Amendments to existing data items

* Addition of Program Identifier for National Disability Insurance Scheme (NDIS) participants
* Amendment to Advance Care Plan Alert reporting guide making reporting mandatory for all episodes
* Amendment to Duration of Non-invasive Ventilation (NIV) in ICU definition and reporting guide, making reporting mandatory for NIV provided in public ICUs
* Amendment to Criterion for Admission definition and new code for patient admitted from Emergency Department (ED) to Short Stay Unit (SSU)
* Amendment to Sex code descriptor and reporting guide to include option for Other
* Amendment to reporting guide for Date/Time fields to allow reporting of time 0000

Reference file updates

* Updated country of birth and country of residence code set
* Updated preferred language code set
* VAED ICD-10-AM/ACHI 2017-18 library file updated to 10th edition

**2016-17**

Amendments to existing data items and associated validations

* Amendment to Advance Care Plan Alert to make reporting conditional mandatory
* Amendment to Procedure Start Date Time to make reporting of time mandatory for emergency admissions to VEMD reporting campuses
* Removal of Funding Arrangement code 5 Rural Patients Initiative
* Removal of Program Identifier code 06 Competitive Elective Surgery Funding Initiative (CESFI)
* Removal of A prefix from Diagnosis Codes

Amendments to validations

390 Incompatible Care Type, Carer Availability and Separation Mode – effect changed from warning to rejection

709 NHT Account Class / Care Type mismatch amended

**2015-16**

New record introduced (public hospitals only)

* Extra Episode Record (J5)

New data items (public hospitals only)

* Advance Care Plan Alert
* Clinical Group – free text data item for health services to record either a clinical/discharging unit, doctor code or any other clinical group

Amendments to existing data items

* Reporting of Carer Availability restricted to episodes with Separation Mode H and effect of associated validations changed from rejection to warning
* New Program Identifier code for ABI rehabilitation services
* Amendment to Separation Referral code set including new code for Health Independence Program
* Amendment to reporting guide for Duration of Stay in ICU to include HDU activity that occurs in ICU
* Amendment to reporting guide for Leave so that leave is not reported for a patient transferred between campuses
* Reporting of Funding Arrangement code 8 National Bowel Cancer Screening Program restricted to designated providers and validation 424 Not Separated: Fund Arr S/Be Spaces removed
* Removal of lithotripsy service codes from Contract/Spoke Identifier code set
* Removal of Account Class MR Geriatric respite care and associated validation 329 Geri Respite – Invalid Comb
* Addition of Funding Arrangement code for Healthlinks program

Amendments to validation tables

* Amendments to validation tables with ambiguous definitions for age (no change to the function of the validations)

Amendments to validations

* Notifiable validations – removed (12), effect changed to warning (31), effect changed to rejection (3)
* Amendment to validation 590 Diagnosis Code Prefix M, not Morph to also check for morphology codes not prefixed M

New validations

707 Invalid Advance Care Plan Alert

708 Funding Arrangement 8, not NBCSP designated provider

709 NHT Account Class / Care Type mismatch

710 Care Type MC, not approved for Maintenance Care

**2014-15**

Data elements removed from collection

* Hospital Insurance Fund
* Barthel Index Score on Admission/Separation
* Admission/Re-admission to Rehabilitation

Amendments to data element code sets and business rules

* Admission Type - combining codes L and X into a single elective admission code P.
* Accommodation Type code R Restorative Off-site changed to R Off-site and removal of edit.
* Care Type code set including removal of codes for Restorative Care: Off-site and Designated Rehabilitation Program/Unit: Level 1 and providing codes for Maintenance Care and Designated Rehabilitation Program.
* Addition of requirement to collect RUG ADL on Admission/Separation for maintenance care.
* Update to Impairment code set to align with AROC impairment codes.

Amendments to edits

* Change in effect of edits relating to reporting of ACAS Status from rejection to warning.
* Modification of edit 094 Invalid Combination A/C Accom Care Med Suff to check valid reporting combinations of Account Class and Medicare Suffix only, and addition of new simplified editing table.
* Removal of two edits relating to Palliative Care and inclusion of the edit functions in other edits.

New edit

New warning edit where Accommodation Type 7 Ward based/Medi Hotel combination is either the first or last reported Accommodation Type.

**2013-14**

* Amendment to reporting guide for Admission Time for admission from non-admitted service to exclude time spent in non-admitted service from the admitted episode. Associated change to business rule for reporting Criterion for Admission E Extended Medical Treatment.
* Amendment to allow the principal diagnosis for a birth episode to be prefixed C Complication
* Amendment to Accommodation Type on Separation to allow reporting of the accommodation type last occupied by the patient on the day of separation
* Amendment to edit 308 Admission Criterion O but Intended Same Day to remove out of date reference to specific lens procedure codes
* Clarification of Phase of Care reporting for Palliative Care episodes including two additional data elements for Final Phase of Care reported when more than 10 changes of Phase of Care occur.
* Amendment to edit 094 Combination A/C Accom Care Med Suffix to allow reporting of Restorative Care for DVA patients and clarify that Medicare Suffix ‘name’ includes ‘BAB’ for unnamed neonates
* Removal of Clinical Sub-Program
* Addition of Program Identifier 06 Competitive Elective Surgery Funding Initiative (CESFI) plus two unspecified codes 07 and 08 for future use

**2012-13**

* Reporting of Barthel Scores restricted to Care Type 6 only
* Addition of Phase of Care on admission, separation and up to 10 changes in Palliative record
* Addition of Care Plan Documented Date for relevant sub-acute episodes
* Removal of Care Types 7, K, E and F
* Addition of Care Types R1 Restorative Care: On-site and R2 Restorative Care: Off-site
* Addition of Care Type 10 for Posthumous organ procurement episodes. Additional codes for Account Class, Admission Source, Admission Type, Criterion for Admission and Separation Mode have also been provided
* Addition of Separation Referral code for Decline of referral to post-natal domiciliary care
* File structure changes from E4, X/Y4, S4, V4 to E5, X/Y5, S5, P5 Palliative record and V5

**2011-12**

* Addition of code to identify home birthing patients to Program Identifier code set
* Change from optional to mandatory reporting of FIMTM Scores on Admission and Separation, for relevant sub-acute episodes.
* Updated WIES calculations and weights (WIES 18).

**2010-11**

* Removal of Emergency Medical Unit code from Accommodation Type and Accommodation Type on Separation fields.
* Removal of Home Based Interim Care code from Separation Referral field.
* Removal of Account Class codes for Private patients’ Intensive Care, Coronary Care and High Dependency Units; removal of these codes also from Account Class on Separation field.
* Removal of Winter Demand Strategy from Program Identifier field.
* Addition of Separation and transfer to Restorative Care bed-based program to Separation Mode.
* Identification in the ICD-10-AM/ACHI Library File of procedures requiring a Procedure Start Date Time.
* New ICD-10-AM/ACHI/ACS library file for Seventh Edition.
* Updated WIES calculations and weights (WIES 17).

**2009-10**

* Introduction of fields for reporting Impairment, and FIMTM Scores on Admission and Separation, for relevant sub-acute episodes.
* Introduction of Program Identifier for specific programs, and Procedure Start Datetime for operating room procedures.
* Introduction of reporting of Mother’s UR Number within the Episode Record reporting the baby’s episode.
* The second edition of the SACC Country of Birth code set was introduced.
* Changes were made to Admission Type code definitions.
* Reporting of Mental Health Statewide Patient Identifier was extended to include Care Type 4 episodes where ECT was performed.
* Statistical admission/separation to/from Palliative Care (Care Type 8) was allowed, and the need to report Palliative Care Days was therefore removed.
* The deadline for submission of Diagnosis Records was brought forward to one month and ten days after the month of separation. The final consolidation date was also advanced to 10 September.
* Updated WIES calculations and weights (WIES 16).

**2008-09**

* Introduction of Date of Birth Accuracy Code.
* Removal of Country of Birth Version Flag.
* Change to codesets for Interpreter Required, Marital Status and Indigenous Status.
* New ICD-10-AM/ACHI/ACS library file for Sixth Edition. Updated WIES calculations and weights (WIES 15).

**2007-08**

* Introduction of SACC Country of Birth codeset (replacing ACCSS Country of Birth codeset).
* Introduction of ASCL Preferred Language codeset (replacing DH Preferred Language codeset).
* Addition of new Contract/Spoke ID codes to identify dialysis activity performed at ‘satellite’ sites.
* Addition of new Care Type code ‘P’ for Paediatric Rehabilitation.
* Amendment of DVA number format to disallow spaces between characters.
* Amendment to Level of Insurance codeset (removal of codes 1, 3, 6, 8 and introduction of codes 2 and 4).
* Change of name from ‘Health Insurance Fund’ to ‘Hospital Insurance Fund’.
* Version 5.2 AR-DRG introduced. Updated WIES calculations and weights.
* Diagnosis Outstanding report made a standard inclusion in each submission’s Control Report, where it had previously been produced only as a Request Report.
* WIES values printed alongside every record.
* Admission weights between 100-399g no longer rounded to 400g for grouping.

**2006-07**

* Site Identifier was changed to include the three-digit Campus Code and the existing one-digit Site Identifier, removing the requirement for hospitals to change codes when merging or splitting from a service.
* The designation of all PRS/2 transaction records changed from ‘2’ to ‘3’, for example E2 changed to E3.
* Two new data items were added: Functional Assessment Date on Admission and Functional Assessment Date on Separation, related to Barthel Index Score on Admission/Separation.
* Reason for Critical Care Transfer was removed. This item was not collected in 2005-06 and related definitions, data items, edit tables and edits were removed in 2006-07.
* Intention to Readmit was moved from the diagnosis to the episode record to avoid the existing editing problems.
* Version 5.1 AR-DRG introduced. Updated WIES calculations and weights.
* New ICD-10-AM/ACHI/ACS library file for Fifth Edition.

**2005-06**

This year saw the removal of the Rehabilitation in the Home (RITH) Care Type, as this was no longer considered to be within the scope of the VAED.

A new data item Palliative Care Patient Days was added.

Amendments were made to:

* Admission Source, Separation Mode and Separation Referral for Transition Care, to capture data related to Transition Care
* Indigenous Status, with the addition of two new codes to better describe non-response
* Account Class, with the addition of three new private Account Classes
* Accommodation Type, to remove the reference to age less than three months for newborns
* Duration of Non-Invasive Ventilation (NIV), for which reporting requirements were relaxed.

A new type of Notifiable edit (the Fatal edit) was added.

Changes to the ICD-10-AM Library File included updated edit parameters, addition of a new concept to indicate codes that may sometimes be followed by a morphology code, and the removal of two redundant concepts.

**2004-05**

This year saw a revision of 24 data items, largely relating to 3 different areas: Admission Policy issues such as recording of Leave and Patient Days, reporting of zero versus null (affecting duration fields), and changes affecting Mental Health episodes.

Diagnosis and Procedure Codes changed from ICD-10-AM Third Edition to Fourth Edition and were grouped by AR-DRG version 5.0 rather than version 4.2, seven additional Care Types were introduced, and one Care Type deleted.

New data items introduced were Mental Health Statewide Patient Identifier and Leave Without Permission Days reported for Month-to-Date, Financial Year-To-Date, and in Total.

An extensive review of the edits was undertaken.

**2003-04**

This year saw a revision of 23 code sets, including an extensive revision of Admission Source, Admission Type, Separation Type (now Separation Mode), Funding Arrangement, and Carer Availability.

The maximum number of Diagnosis and Procedure Codes increased to 40 for each category, and a new Rehabilitation Care Type was introduced.

Three new data items were also introduced: ACAS Status, Preferred Language and Interpreter Required, and one data item was deleted: Program Funding Source.

An extensive review of the edits was undertaken, including the implementation of edits between episodes.

**2002-03**

This year saw new fields for Duration of Non-Invasive Ventilation, Date of Accident and TAC Claim Number. Code sets that were revised included Care Type (for Interim Care patients), Account Class, Account Class on Separation, Contract/Spoke Identifier, Duration of Mechanical Ventilation, Patient Identifier and Program Funding Source. Additionally, changes were made to the V2 record, to enable collection of information for the Transport Accident Commission (TAC).

**2001-02**

This year saw the revision of the Accommodation Type/Accommodation Type on Separation (to incorporate the concepts of NICU/SCN, Other accommodation for newborns, Short Stay Observation Units and Medical Assessment and Planning Units), Program Funding Source and Hospital Generated DRG (to incorporate AR-DRG Version 4.2) code sets.

**2000-01**

This year saw the maximum number of diagnosis and procedure codes increased to 25 for each category. The field Carer Availability was limited only to subacute Care Types and the field Reason for Critical Care was now reported by both sending and receiving hospitals.

**1999-00**

This year saw a revised file structure, new fields for Carer Availability and Separation Referral, revised fields for contracted hospital care and changes to the format for hospital codes, representing site and also used to report transfers and contracted care.

**1998-99**

This year saw the introduction of data items on site identifier (for multi-campus hospitals), Duration of Stay in CCU and Reason for Critical Care Transfers.

**1997-98**

There were no changes this year.

**1996-97**

This year saw the introduction of data items related to contracted hospital care.

**1995-96**

This year saw the introduction of the reporting by public hospitals of all newborn babies to the VAED as either ‘qualified’ or ‘unqualified’ newborns; previously hospitals reported only newborns defined as qualified in the Health Insurance Act 1973. Reporting all newborns enabled casemix payments to be provided for all newborn episodes. The two neonatal Version 1 AN DRGs were mapped to four Victoria-only DRGs, to give a more accurate representation of clinical resource utilisation for funding purposes.

New data items were introduced for all episodes with a Rehabilitation Care Type.

**1994-95**

For 1 July 1994, minor changes were implemented to reflect the development of new streams of care in geriatric centres. These were incorporated into the Care Type field.

**1993-94**

On 1 July 1993, significant revisions were made to the data collected in the VAED, to enable the introduction of casemix-based funding and to ensure consistency with the National Health Data Dictionary.

The criteria for the commencement of a new episode of care were extended to encompass all changes in Care Type (including changes to Nursing Home Type).

**1992-93**

This period saw the introduction of episodes of care as the basic unit of measurement, ahead of the 1994 National Health Data Dictionary. New episodes of care occurred when the patient was admitted to the hospital or when a change in Care Type occurred. Each episode of care was reported in a separate Episode Record, however changes to ‘Nursing Home Type’ did not constitute a new episode of care, with the NHT days being recorded as the final days of an acute episode.

**1989-90 to 1991-92**

This period saw the introduction of Care Type as a sub-category of the patient’s stay; this was achieved by a major change to the structure of the VAED with the introduction of Status Segments.

In each Episode Record submitted to the VAED, there can be up to seven Status Segments, each of which contains a combination of Account Classification, Accommodation Type and, during this period, Care Type, for the episode, together with a count of the Patient Days for each such combination, all reported in the Status Segment. However, data extracts of the VAED will usually be provided showing only the Account Class, Accommodation Type and Care Type at separation, together with the total length of stay, omitting all Status Segments.

During this period, the Care Type field distinguished between four broad types of care the patient may have received during an admission: Nursing Home Type (NHT), Rehabilitation care (in a designated unit), Psychiatric care (in a designated unit), Other care – Acute

**1987-88 and 1988-89**

Annual consolidated files are available for these years in a consistent format. This period predates the episode of care concept and it is not possible to identify reliably all periods of non-acute care: particularly periods of Nursing Home Type care that occurred following periods of acute care. This may limit the usefulness of the data obtained from the VAED in this time for certain types of analysis that require accurate counts of length of stay for acute care.

**1979-80 to 1986-87**

The collection started from 1 January 1979 with data from approximately 50 public hospitals, with more public hospitals gradually brought in to achieve full public hospital coverage. The availability of data from this period is limited. Data from this period may be available but only in hard copy in the form of standard reports and publications.