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| Proposals for revisions to the Victorian Perinatal Data Collection (VPDC) for 1 July 2024 |
| September 2023 |
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# Executive summary

Each year the Department of Health manages the review of the Victorian Perinatal Data Collection (VPDC) on behalf of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM). This review seeks to ensure that the VPDC supports CCOPMM’s objectives, the department’s planning, policy development and state and national reporting obligations, and incorporates appropriate feedback from data providers on improvements.

Proposals for revisions to the VPDC for 1 July 2024 were invited from stakeholders in July 2023. All proposals received were reviewed by CCOPMM which determined that the proposals published in this document should be distributed for feedback from health services, software vendors and other relevant stakeholders including Safer Care Victoria and the wider health sector.

All feedback submitted will be forwarded to the CCOPMM for its consideration in determining the final changes to be made to the VPDC for births from 1 July 2024. Criteria for evaluating these proposals are included in this document.

Final acceptance of any proposal is dependent on endorsement by CCOPMM.

**Comments are invited from all stakeholders** regarding the feasibility of gathering and reporting the proposed new data items, and/or the proposed changes to existing data items.

**Feedback should be emailed by 5.00pm on Friday 20 October 2023** to the [HDSS HelpDesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>. Please attachthe feedback template distributed with this Proposals document, which is also accessible at the [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) < https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection> .

The proposals for revisions to the VPDC for 1 July 2024 that involve significant change and on which feedback is invited include:

## Proposals of significant change

**Add new data item:**

* Aneuploidy screening (new)
* Aneuploidy screening type (new)
* Aneuploidy screening result (new)
* High risk aneuploidy screening result (new)
* Vaping in the first 20 weeks of pregnancy (new)
* Vaping at 20 or more weeks of pregnancy (new)
* Maternal tobacco smoking in the first 20 weeks of pregnancy (new)
* Number of standard drinks consumed when drinking alcohol in the first 20 weeks of pregnancy (new)
* Number of standard drinks consumed when drinking alcohol at 20 or more weeks of pregnancy (new)

**Significantly amend scope or code set of an existing data item:**

* Amend definition of ‘Antenatal care visit’ in Section 2 of the VPDC manual - Concept and derived item definitions
* Amend existing data item Resuscitation method – mechanical
* Amend existing data item Time to established respiration
* Amend existing data item Maternal tobacco smoking at more than or equal to 20 weeks of pregnancy
* Amend definition of ‘Hospital in the Home (HITH)’ in Section 2 of the VPDC manual – Concept and derived item definitions, and amend the following existing data items:
  + Reason for transfer out – baby
  + Reason for transfer out – mother
  + Separation date – baby
  + Separation date – mother
  + Separation status – baby
  + Separation status – mother
  + Hospital in the home (HITH) – Amend concept and derived item definition
* Amend existing data item Sex – baby

**Delete existing data item:**

* Maternal alcohol volume intake at less than 20 weeks:  
  *Proposal to replace existing data item with a new data item*
* Maternal alcohol volume intake at 20 or more weeks:  
  *Proposal to replace existing data item with a new data item*
* Maternal smoking at less than 20 weeks:  
  *Proposal to replace existing data item with a new data item*

## Other proposals

Other proposals were received that would result in significant change to the VPDC. The CCOPMM has determined feedback is not required on these proposals as they are not currently being considered for implementation in the VPDC for 1 July 2024:

**Add new data item:**

* Indication for induction or elective caesarean if birth is less than 39 weeks gestation (new)
* Oral health assessment (new)
* Dental referral (new)

**Significantly amend scope or code set of an existing data item:**

* Revise existing smoking data items to include non-cigarette smoking.
* Revise existing smoking data items to extend ‘smoking’ to include nicotine use and vaping/e-cigarette use (i.e., remove specificity of ‘tobacco’)

# Introduction – this document and its role in the VPDC annual changes process

Each year the Department of Health manages the review of the Victorian Perinatal Data Collection (VPDC) on behalf of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM). This review seeks to ensure that the VPDC supports CCOPMM’s objectives, the department’s planning and policy development, and state and national reporting obligations, and incorporates appropriate feedback from data providers on improvements.

Proposals for revisions to the VPDC for 1 July 2024 were invited from stakeholders in July 2023. All submitted proposals have been reviewed by the CCOPMM. This document includes all proposals that would result in new data items, significant amendments to, or removal of existing data items, and which the CCOPMM has invited feedback from health services, software vendors and other relevant stakeholders including Safer Care Victoria and the wider health sector.

All feedback will be provided to the CCOPMM for their consideration in determining the final changes to the VPDC from 1 July 2024. Criteria for evaluating these proposals are included in this document.

**All stakeholders are invited to provide feedback on these proposals**, regarding the feasibility of gathering and reporting the proposed new data items, and/or the proposed changes to existing data items.

**Feedback should be emailed by 5.00pm on Friday 20 October 2023** to the [HDSS HelpDesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>. Please attachthe feedback template distributed with this Proposals document, which is also accessible at the [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) < https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection> .

The Specifications for revisions to the VPDC for 1 July 2024 will be released in December 2023 and the VPDC manual will be updated with the final changes and published before July 2024.

Final acceptance of any proposal is dependent on endorsement by CCOPMM.

## Draft status and format of this document

This document is complete at the time of release, however proposals in this document may be removed or amended, and other proposals may be added, before the final specifications for changes are released.

This document sets out the proposals as submitted by their proponents but does not include the full implications of implementing proposals. Amendments to the VPDC often require significant and complex effort to update related data specifications, reporting guides, business rules and validations, data extracts and staff training, by software vendors, hospital clinicians, the department and Safer Care Victoria. This effort has not been estimated in this document but should be a factor in considering these proposals.

When reviewing these proposals, please refer to VPDC manual v11.0, applicable for births on and from 1 July 2023, which is accessible at the VPDC website [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) < https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection >.

## Orientation to this document

* New data items are marked as (new).
* Changes to existing data items are highlighted in green
* Redundant values and definitions relating to existing items are ~~struck through~~.

## Evaluation criteria

Criteria considered when deciding whether to recommend an annual change proposal include:

| Category | Considerations |
| --- | --- |
| Scope | The change should be within the scope of the collection. |
| Collectability | The data should already be collected by the service.  There should be value for the service in collecting the data.  Collection of the data should align with normal business processes in the service.  It should be legal for the service to collect the data. |
| Intended Use | Sufficient business justification must be submitted in the proposal.  The change must be consistent with departmental policy.  There should not be a limited time-period for use of the data. If there is, other avenues of collection should be investigated to ensure this is the most appropriate. |
| Best Practice | The collection of the data should comply with relevant standards and policies. |
| Implementation | The proposal must be clearly specified to enable implementation.  It should be technically possible for services and the Department of Health to implement without significant issues. |
| Data Quality | There should be a person, unit or organisation identified to monitor quality.  There should be minimal transformation of data required by services to meet reporting requirements.  Reporting of the data should be mandatory for a specified cohort. |
| Consequential impact | The impact on other data already collected, or proposed to be collected, must be articulated.  There should be no adverse effect on the reputation or integrity of the collection.  Any dependencies on other projects or plans must be identified.  The impact on time-series data must be quantified.  The impact on reports, extracts or automated processes must be quantified. |
| Cost and burden of collection | All options for the collection of this data should be assessed and the most appropriate method of collection selected. |

## Proposals of significant change

| Proposal # | Impact of proposal | | | Data item, concept definition or business rule title |
| --- | --- | --- | --- | --- |
| Add new data item | Amend existing data item | Delete existing data item |
|  | | | | ***Add new data items for Vaping and e-cigarette*** |
| 1. i) | X |  |  | Vaping in the first 20 weeks of pregnancy (new) |
| 1. ii) | X |  |  | Vaping from 20 weeks of pregnancy (new) |
|  | | | | ***Revise tobacco smoking data items*** |
| 4. i) | X |  |  | Maternal tobacco smoking in the first 20 weeks of pregnancy (new) |
| 4. ii) |  | X |  | Maternal tobacco smoking after ~~at more than or equal to~~ 20 weeks of pregnancy – amend existing item |
| 4. iii) |  |  | X | ~~Maternal smoking at less than 20 weeks~~ (delete existing data item) |
|  | | | | ***Add new data items for Aneuploidy screening*** |
| 6. i) | X |  |  | Aneuploidy screening (new) |
| 6. ii) | X |  |  | Aneuploidy screening type (new) |
| 6. iii) | X |  |  | Aneuploidy screening result (new) |
| 6. iv) | X |  |  | High risk aneuploidy screening result (new) |
|  | | | | ***Amend existing data definition and data item code set*** |
| 8. | NA | NA | NA | Antenatal care visit (VPDC manual Section 2 – Concept and derived item definitions) – amend inclusion |
| 9. |  | X |  | Resuscitation method – mechanical – amend code set |
|  | | | | ***Amend data items reporting Alcohol consumption – add new, revise/delete existing data items*** |
| 10. i) | X |  |  | Number of standard drinks consumed when drinking alcohol in the first 20 weeks of pregnancy (new) |
| 10. ii) | X |  |  | Number of standard drinks consumed when drinking alcohol at 20 or more weeks (new) |
| 10. iii) |  |  | X | ~~Maternal alcohol volume intake at less than 20 weeks~~ (delete existing data item) |
| 10. iv) |  |  | X | ~~Maternal alcohol volume intake at 20 or more weeks~~ (delete existing data item) |
|  | | | | ***Amend existing data item code set*** |
| 11. |  | X |  | Time to established respiration – amend data item code set |
|  | | | | ***Amend existing data items and definition to include Hospital in the Home (HITH) days*** |
| 12. i) |  | X |  | Separation date – baby (amend existing data item) |
| 12. ii) |  | X |  | Separation date – mother (amend existing data item) |
| 12. iii) |  | X |  | Separation status – baby (amend existing data item) |
| 12. iv) |  | X |  | Separation status – mother (amend existing data item) |
| 12. v) |  | X |  | Reason for transfer out – baby (amend existing data item) |
| 12. vi) |  | X |  | Reason for transfer out – mother (amend existing data item) |
| 12. vii) | NA | NA | NA | Hospital in the home (HITH) (VPDC manual Section 2 – Concept and derived item definitions) – amend |
|  | | | | ***Amend existing data item code descriptor*** |
| 13. |  | X |  | Sex – baby – amend definition and code descriptor |

## Other proposals received on which CCOPMM has decided feedback is not required

| Proposal # | Impact of proposal | | | Data item, concept definition or business rule title |
| --- | --- | --- | --- | --- |
| Add new data item | Amend existing data item | Delete existing data item |
| 2. | X |  |  | WITHDRAWN - Electronic cigarette usage frequency in pregnancy (new) |
| 3. i) |  | X |  | Revise existing smoking data items to include nicotine use and vaping/e-cigarette use (i.e., remove specificity of ‘tobacco’) |
| 3. ii) |  | X |  | Revise existing smoking data items to include non-cigarette smoking. |
| 5. i) | X |  |  | Oral health assessment (new) |
| 5. ii) | X |  |  | Dental referral (new) |
| 7. | X |  |  | Indication for induction or elective caesarean if birth is less than 39 weeks gestation – (new) |

# Proposals of significant change

## Proposal 1 – Vaping in pregnancy

### Proposed change

Add two new dichotomous variables to report whether the woman vaped during this pregnancy:

1. Add new data item: Vaping in the first 20 weeks of pregnancy (new)
2. Add new data item: Vaping at 20 or more weeks of pregnancy (new)

### i) Add new data item

#### Vaping in the first 20 weeks of pregnancy (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether the woman used vapes or electronic cigarettes during the first 20 weeks of pregnancy, regardless of the type and frequency. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | TBC |
| Permissible values | **Code Descriptor**  1 No, did not vape during the first 20 weeks of pregnancy  2 Yes, vaped during the first 20 weeks of pregnancy  9 Not stated/inadequately described | | |
| Reporting guide | Vape, vaping, electronic cigarettes and e-cigarettes are synonymous and should be included when reporting this data item.  The first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.  To ensure consistency of results, this data item should be collected after the first 20 weeks of pregnancy. | | |
| Reported by | All Victorian hospitals where a birth occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

### ii) Add new data item

#### Vaping at 20 or more weeks of pregnancy (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether the woman used vapes or electronic cigarettes from 20 weeks of pregnancy until the birth, regardless of the type and frequency. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | TBC |
| Permissible values | **Code Descriptor**  1 No, did not vape after 20 weeks of pregnancy  2 Yes, vaped after 20 weeks of pregnancy  9 Not stated/inadequately described | | |
| Reporting guide | Vape, vaping, electronic cigarettes and e-cigarettes are synonymous and should be included when reporting this data item.  After 20 weeks of pregnancy is defined as greater than or equal to 20 weeks + 0 days.  To be collected during the birth admission. | | |
| Reported by | All Victorian hospitals where a birth occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

### Proposed by

Consultative Councils Unit, Safer Care Victoria

### Reasons for proposed change

Vaping has become more common, including during pregnancy. It will be important to investigate outcomes following vaping. There is no clear method of asking about quantity of vaping, as devices vary in size. It is also not always known whether a vape contains nicotine. For these reasons, the simple Yes/No question will be asked at this point in time.

### How will the data be used?

To investigate maternal and neonatal outcomes in women who vape compared to those who do not vape and compared with other exposures.

### How will the proposed change impact health services?

Midwives will need to ask this question of all women during their birth admission.

Birthing information systems will need to add a field.

This may already be collected in some services.

## Proposal 4 – Revise existing data items: Maternal smoking at less than 20 weeks; and Maternal smoking at more than or equal to 20 weeks

### Proposed change

Revise the two existing VPDC smoking data items to align with the AIHW’s Perinatal National Minimum Data Set (NMDS) for 2023-24, on which AIHW reporting specifications are based:

1. Add new data item: Maternal tobacco smoking in the first 20 weeks of pregnancy
2. Amend existing data item: Maternal tobacco smoking after 20 weeks of pregnancy
3. Delete existing data item: ~~Maternal smoking at less than 20 weeks~~.   
   This data item is no longer consistent with AIHW’s definition or specifications.

### i) Add new data item

#### Maternal tobacco smoking in the first 20 weeks of pregnancy (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The self-reported number of cigarettes usually smoked daily by a female in the first 20 weeks of pregnancy. | | |
| Representation class | Total | Data type | Number |
| Format | N[N] | Field size | 2 |
| Location | Episode record | Position | TBC |
| Permissible values | Range: zero to 97 (inclusive)  **Code Descriptor**  0 No smoking in first 20 weeks of pregnancy  98 Occasional smoking (less than one per day)  99 Not stated / inadequately described | | |
| Reporting guide | Record 0 if a female did not smoke tobacco during the first 20 weeks of pregnancy.  CODE 98 Occasional smoking (less than one per day)  Includes females who report that they usually smoked less than one tobacco cigarette per day.  The first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.  ‘Usually’ is defined as ‘according to established, or frequent usage; commonly, ordinarily; as a rule’. If a female reports having quit smoking at some point during the first 20 weeks of pregnancy, the value recorded should be the number of tobacco cigarettes usually smoked daily prior to quitting.  This data item is self-reported.  To ensure consistency of results, this data item should be collected after the first 20 weeks of pregnancy.  If the woman smokes tobacco, but not cigarettes, estimate the number of cigarettes that would approximate the amount of tobacco used, for example, in a pipe.  Do not include vapes or e-cigarettes in this count. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

### ii) Amend existing data item

#### Maternal tobacco smoking after ~~at more than or equal to~~ 20 weeks of pregnancy

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The self-reported number of cigarettes usually smoked daily by a female ~~pregnant woman~~ after the first 20 weeks of pregnancy until the birth. | | |
| Representation class | Total | Data type | Number |
| Format | N~~N~~[N] | Field size | 2 |
| Location | Episode record | Position | 32 |
| Permissible values | Range: zero to 97 (inclusive)  **Code Descriptor**  0 No smoking after 20 weeks of pregnancy  98 Occasional smoking (less than one per day)  99 Not stated / inadequately described | | |
| Reporting guide | Record 0 if a female did not smoke tobacco after 20 weeks of pregnancy until the birth.  CODE 98 Occasional smoking (less than one per day) Includes females who report that they usually smoked less than one tobacco cigarette per day.  Data should be collected after the birth.  After 20 weeks is defined as greater than or equal to 20 completed weeks’ gestation (>=20 weeks + 0 days).  ‘Usually’ is defined as ‘according to established or frequent usage, commonly, ordinarily, as a rule’.  If a ~~woman~~ female reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.  If the ~~woman~~ female smokes tobacco, but not cigarettes, estimate the number of cigarettes that would approximate the amount of tobacco used, for example, in a pipe.  Do not include vapes or e-cigarettes in this count. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

### iii) Delete existing data item

#### ~~Maternal smoking at less than 20 weeks~~

**~~Specification~~**

|  |  |  |  |
| --- | --- | --- | --- |
| ~~Definition~~ | ~~A self-reported indicator of whether a pregnant woman smoked tobacco at any time during the first 20 weeks of her pregnancy.~~ | | |
| ~~Representation class~~ | ~~Code~~ | ~~Data type~~ | ~~Number~~ |
| ~~Format~~ | ~~N~~ | ~~Field size~~ | ~~1~~ |
| ~~Location~~ | ~~Episode record~~ | ~~Position~~ | ~~31~~ |
| ~~Permissible values~~ | **~~Code Descriptor~~**  ~~1 No smoking at all before 20 weeks of pregnancy~~  ~~2 Quit smoking during pregnancy (before 20 weeks)~~  ~~3 Continued smoking before 20 weeks of pregnancy~~  ~~9 Not stated / inadequately described~~ | | |
| ~~Reporting guide~~ | ~~Report the statement that best describes maternal smoking behaviour before 20 weeks’ gestation.~~  ~~Code 2 Quit smoking during pregnancy (before 20 weeks):~~  ~~Describes the mother who ceased smoking on learning she was pregnant or gave up prior to the 20 week gestation. This does not include mothers who give up smoking prior to falling pregnant.~~ | | |
| ~~Reported by~~ | ~~All Victorian hospitals where a birth has occurred and homebirth practitioners~~ | | |
| ~~Reported for~~ | ~~All birth episodes~~ | | |

Proposed by

Data Collections Unit, Victorian Agency for Health Information

Reasons for proposed change

To align with the data items, definitions and code sets for the [Perinatal NMDS 2023-24](https://meteor.aihw.gov.au/content/756062) (Meteor ID 365441 and Meteor ID 695382), including deriving mandatory tobacco smoking data items, which cannot be met using the existing VPDC data items. This proposal would result in two tobacco smoking data items in the VPDC to report the number of cigarettes smoked daily for the first 20 weeks of pregnancy, and after 20 weeks gestation. This will allow derivation of tobacco smoking indicators (yes/no) for those periods as required to meet the state’s reporting obligations to AIHW, while limiting the data collection burden on clinicians.

### How will the data be used?

The proposed data will be used to enable reporting of all tobacco smoking specifications for the annual National Perinatal Data Collection.

### How will the proposed change impact health services?

There should be minimal impact on health services as the existing two smoking data items are mandatory to report. This proposal does not increase the number of smoking data items.

## Proposal 6 – Add four new data items to report Aneuploidy screening status, test type and results

### Proposed change

Four new data items to report Aneuploidy screening, test types and results, and a related business rule:

1. Aneuploidy screening status (new)
2. Aneuploidy screening type (new)
3. Aneuploidy screening result (new)
4. High risk aneuploidy screening result (new)

### i) Add new data item

#### Aneuploidy screening status (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether aneuploidy screening was offered | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | TBC |
| Permissible values | **Code Descriptor**  1 Ordered  2 Declined  3 Not offered  9 Not stated / inadequately described | | |
| Reporting guide | Report whether aneuploidy screening was offered, and if so, whether it was declined. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

### ii) Add new data item

#### Aneuploidy screening type (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Type of aneuploidy screening ordered | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | TBC |
| Permissible values | **Code Descriptor**  1 NIPT  2 First trimester combined screening  3 Second trimester maternal serum screening  4 Other aneuploidy screening  9 Not stated / inadequately described | | |
| Reporting guide | If more than one type of screening was used, then the person should select the first type of screening test used (chronologically).  Code 1 NIPT Non-invasive prenatal testing, cell-free DNA based prenatal screening  Code 2 First trimester combined screening  Nuchal translucency measurement and maternal serum PaPP-A and bHCG measurements  Code 3 Second trimester maternal serum screening Maternal serum screening including estriol, HCG, alpha-fetoprotein +/- inhibin A | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where Aneuploidy screening status was 1 Ordered | | |

### iii) Add new data item

#### Aneuploidy screening result (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Result of the Aneuploidy screening test | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | TBC |
| Permissible values | **Code Descriptor**  1 Low risk  2 High risk  3 Not reportable / failed NIPT  4 Ordered but results unavailable / unknown  9 Not stated / inadequately described | | |
| Reporting guide | Code 3 Not reportable / failed NIPT Where an NIPT result is “No call”, “No result”, “Failed NIPT” | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where Aneuploidy screening status was 1 Ordered | | |

### iv) Add new data item

#### High risk aneuploidy screening result (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | If the Aneuploidy screening result was high risk, report the high risk condition result | | |
| Representation class | Code | Data type | Number |
| Format | N[N] | Field size | 2 (x2) |
| Location | Episode record | Position | TBC |
| Permissible values | **Code Descriptor**  1 Trisomy 21  2 Trisomy 18  3 Trisomy 13  4 Turner’s syndrome  5 Klinefelter’s syndrome  6 Other male or female chromosome abnormalities, not elsewhere classified  7 Di George’s syndrome  8 Other trisomies and partial trisomies of the autosomes, not elsewhere classified  9 Monosomies and deletions from the autosomes, not elsewhere classified  10 Chromosome abnormalities, unspecified | | |
| Reporting guide | Up to 2 unique codes can be reported.   |  |  |  | | --- | --- | --- | | **VPDC code** | **ICD-10-AM codes** | **Descriptor** | | 1 | Q90- | Trisomy 21 (Down syndrome) | | 2 | Q910, Q912, Q913 | Trisomy 18 (Edward syndrome) | | 3 | Q914, Q915, Q916, Q917 | Trisomy 13 (Patau syndrome) | | 4 | Q96- | Turner’s syndrome | | 5 | Q980, Q981, Q982, Q984, Q985 | Klinefelter’s syndrome | | 6 | Q97-, Q986, Q987, Q988, Q989 | Other male or female chromosome abnormalities, not elsewhere classified | | 7 | D821 | Di George’s syndrome | | 8 | Q92- | Other trisomies and partial trisomies of the autosomes, not elsewhere classified | | 9 | Q93- | Monosomies and deletions from the autosomes, not elsewhere classified | | 10 | Q999 | Chromosome abnormalities, unspecified |  |  |  | | --- | --- | | **ICD-10-AM codes** | **Common NIPT report terminology** | | D821 Di George’s syndrome | 22q11.2 deletion syndrome | | Q92- Other trisomies and partial trisomies of the autosomes, not elsewhere classified | Rare autosomal trisomy, partial chromosome or segmental duplication, triploidy | | Q93- Monosomies and deletions from the autosomes, not elsewhere classified | Monosomy, partial chromosome or segmental deletion, microdeletion syndromes other than Di George syndrome | | Q999 Chromosome abnormalities, unspecified |  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where Aneuploidy screening result was 2 High risk | | |

#### Proposed new business rule

**Aneuploidy screening – conditionally mandatory data item (new)**

|  |  |
| --- | --- |
| **If Aneuploidy screening status is:** | **then the following items cannot be blank:** |
| 1 Ordered | Aneuploidy screening type  Aneuploidy screening result |
| **If Aneuploidy screening result is:** | **then the following item cannot be blank:** |
| 2 High risk | High risk aneuploidy screening result |

### Proposed by

Murdoch Children’s Research Institute

### Reasons for proposed change

The proposed change will allow capture of data about aneuploidy screening, a routine element of early pregnancy antenatal investigations – whether screening was offered, the type of screening test, and the test result, as well as conditions for which a high risk result is identified.

All pregnant women should be offered screening for these conditions, however there is no current state-wide data collection on compliance and performance of this screening program. This screening is typically arranged by general practitioners during early pregnancy, before the woman has her first booking visit with the hospital. As this is usually performed by GPs, this field will provide an important performance indicator for early pregnancy care and communication between GPs and the hospitals.

The proposed change is also a performance measure that will enable monitoring and evaluation of prenatal screening. This change will allow Safer Care Victoria and individual health services to audit whether they are complying with RANZCOG and the Commonwealth government recommendations that all pregnant women be offered aneuploidy screening.1

The Australian government outlines the key principles for the implementation and management of a screening program in the Australian Population Based Screening Framework.2 A key area of potential concern identified in this Framework was genomic screening, including *“the pressure to introduce new genomic screening technologies before adequate frameworks are in place to monitor their quality and effectiveness.”* Victoria currently lacks any state-wide aneuploidy screening data to permit monitoring of quality and effectiveness.

Cell-free DNA screening, or non-invasive prenatal testing (NIPT) is an example of a new genomic screening technology that was introduced in 2012 without an adequate framework for monitoring quality and effectiveness. It does not receive any Medicare rebate and is the most accurate test, but also the most expensive screening test for our population.3

The two key principles underpinning the Australian Population Based Screening Framework are access and equity. We have previously reported an apparent disparity in the utilization of aneuploidy screening tests by maternal socioeconomic status when examining Victorian prenatal diagnosis data.4,5 To more accurately determine if there are health care inequities in prenatal screening, we need population-based date on prenatal screening utilization.

We therefore require this change to meet government obligations to monitor the utilization of prenatal screening and determine if clinical quality and equity of access are being achieved.

Hospitals routinely collect this data and record it in various locations in the medical record. A dedicated data collection field for aneuploidy screening was introduced into the Birthing Outcomes System (BOS), in July 2021, so many health services are already familiar with this data collection.

This change will capture how many women elect to have this voluntary screening, the type of test they choose, and the results of the screening.

### **Additional background information provided by proposer**

The proposed new data item High risk aneuploidy screening result cannot be collected in the existing VPDC data item Congenital anomalies – ICD-10-AM code as these are not confirmed diagnoses – often they are false positive screening results.

Congenital anomalies cannot be captured in the data item Congenital anomalies – ICD-10-AM code unless there is a confirmed diagnosis on diagnostic testing. Many aneuploidy conditions aren’t included in the ICD-10-AM codes.

If more than one screening test is performed, record the first screening test performed chronologically. On a population basis we want to know what the utilization of the primary screening test is. Very few people have more than one type of test (1%).

### How will the data be used?

Incorporating prenatal aneuploidy screening into the VPDC would meet government obligations to monitor the clinical quality of screening programs. Through linkage with other Department of Health datasets, it will be possible to answer the following clinical quality questions:

* Are all women being offered aneuploidy screening in accordance with current clinical guidelines?
* What are the utilization patterns of the various screening tests?
* Is access to aneuploidy screening equitable?
* Is aneuploidy screening effective? (high detection rate, low false positive rates)

Data quality review is planned through supervised clinical placements of Murdoch Children’s Research Institute research staff and students, working with health services such as Mercy Health.

### How will the proposed change impact health services?

Health services already collect data on aneuploidy screening as part of the routine booking visit, so no additional resources or training are required to start collecting these data. There may be some training required if adjustments to electronic medical record systems are needed, but the collection of the information is already performed for routine clinical care by midwives and doctors.

Dedicated data fields for aneuploidy screening were introduced to the Birthing Outcomes system (BOS) on 1st July 2021. Our research dataset that compiles BOS data from the maternity hospitals in Melbourne that use this software shows that this data field is complete for 54% of births.6 This data is also recorded elsewhere in the medical record including the antenatal progress notes, and within the pathology records.

This change therefore meetings the following assessment criteria:

1. The data is already collected by maternity services.
2. There is value for the service in collecting the data. These data would benefit individual health services for internal clinical quality monitoring, ensuring that screening results (which are usually ordered by GPs prior to first visit to the hospital) are followed up and recorded by the health service in a timely manner.
3. Collection of the data aligns with normal business processes in health services.
4. It is legal for the service to collect the data.
5. There is minimal transformation of data required by services to meet reporting requirements, especially since BOS already has dedicated data fields for this information.
6. Reporting of the data should be mandatory for all births since this testing should be offered to all women.
7. There will be no impact on other data already collected, since this is a new field that is not dependent on other data fields.

**References**

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## Proposal 8 – Amend existing definition ‘Antenatal care visit’

### Proposed change

Add ‘telehealth’ as a clinical setting for the Concept ‘Antenatal care visit’ in VPDC manual Section 2 Concept and derived item definitions.

### Proposal specification

VPDC manual Section 2 Concept and derived item definitions

|  |  |
| --- | --- |
| Antenatal care visit | |
| **Definition/guide for use** | An intentional encounter between a pregnant woman and a midwife or doctor to assess and improve maternal and fetal well-being throughout pregnancy and prior to labour.  An antenatal care visit may occur in the following clinical settings:   * antenatal outpatients clinic * specialist outpatient clinic * general practitioner surgery * obstetrician private room * community health centre * rural and remote health clinic * independent midwife practice setting including home of pregnant female. * Telehealth with a specialist outpatient clinic or antenatal outpatient clinic |
| **Related data items (Section 3)** | Discipline of antenatal care provider; Gestational age at first antenatal visit; Number of antenatal care visits |

### Proposed by

Maternity and Newborn Learning Health Network, Safer Care Victoria

### Reasons for proposed change

To record how antenatal appointments are being offered to patients within the VPDC dataset. Health service clinicians have indicated to the Safer Care Victoria Maternal and Newborn Learning Health Network that patients are being reviewed in antenatal clinic appointments by telehealth. This reflects practice change that has occurred since 2020 (COVID). At present, this information is not captured accurately, and the number of patients being assessed via telehealth is unknown.

### Details of change/Additional background information provided by proposer

We wish to be able to capture the extent of women attending their first antenatal appointment as a telehealth appointment.

This proposal relates to the current [PSPI indicator 9: Rate of women attending their first antenatal visit prior to 12 weeks gestation.](https://www.safercare.vic.gov.au/sites/default/files/2022-08/PSPI%20report%202020-21.pdf)

The intention is that women attend with their booked maternity service (their intended place of birth) within 12 weeks (although the revised indicator is to extend this to 16 weeks reflecting the practice change).

We found two things relating to this indicator during our consultation process:

* that many services (particularly tertiary) were not seeing women until later in pregnancy (14 to 18 weeks) – and that perhaps the appointments captured in BOS/etc was actually their first GP appointment and not a health service appointment as intended by that measure, and
* that some services (tertiary services again were implied) were booking that first appointment as a telehealth appointment rather than face to face.

We’re hoping the addition of telehealth may reflect the true nature of these antenatal appointments.

AIHW currently has no telehealth data definition or reporting component. We also acknowledge that telehealth is still a relatively new concept. We would want to capture all telehealth appointments if possible (although the primary objective would be first appointment).

### How will the data be used?

Unclear at present. Extent of telehealth appointments on a state-wide basis is unknown. This data may assist to capture the extent, advise organisations on possible benchmarking and appropriateness of telehealth for antenatal appointments.

### How will the proposed change impact health services?

Unclear how this data is already collected, however many organisations are offering telehealth for antenatal appointments.

If approved, this proposal will impact reporting of two existing data items which refer to the definition of ‘Antenatal care visit’:

* Number of antenatal care visits
* Gestational age at first antenatal visit

## Proposal 9 – Amend code set of existing data item Resuscitation method – mechanical

### Proposed change

Amend code set of existing data item Resuscitation method – mechanical.

### Proposal specification

#### Resuscitation method – mechanical

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Active measures taken immediately after birth to establish the baby’s independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances. | | |
| Representation class | Code | Data type | String |
| Format | NN | Field size | 2 (x10) |
| Location | Episode record | Position | 105 |
| Permissible values | **Code Descriptor**  01 None  02 Suction  03 Oxygen therapy  04 Intermittent positive pressure ventilation (IPPV) ~~respiration bag and mask~~ with air  05 ~~Endotracheal~~ intubation ~~and IPPR~~ with air  06 External cardiac compressions ~~massage and ventilation~~  07 Continuous positive airway pressure (CPAP) ventilation with air  14 Intermittent positive pressure ventilation (IPPV) ~~respiration bag and mask~~ with oxygen  15 ~~Endotracheal~~ intubation ~~and IPPR~~ with oxygen  17 Continuous positive airway pressure (CPAP) ventilation with oxygen  88 Other  99 Not stated / inadequately described | | |
| Reporting guide | Report up to ten codes. Do not report any code more than once.  If during resuscitation both air and oxygen are given, report both codes.  ~~A combination of up to ten valid types of mechanical resuscitation methods can be used.~~  ~~Code 01 None: includes such strategies as tactile stimulation.~~  Code 01 None Report when active resuscitation measures were not used.  Includes airway positioning only, such as jaw thrust or chin lift. Report for stillbirths, or livebirths where resuscitation measures were not used due to palliative direction of care.  The following codes may include flow-driven pressure-limited device, such as Neopuff© (an infant T-piece resuscitator): - Code 04 Intermittent positive pressure ventilation (IPPV) with air - Code 07 Continuous positive airway pressure (CPAP) ventilation with air - Code 14 Intermittent positive pressure ventilation (IPPV) with oxygen - Code 17 Continuous positive airway pressure (CPAP) ventilation with  oxygen | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

### Proposed by

Data Collections Unit, Victorian Agency for Health Information

### Reasons for proposed change

Amendment of code descriptors for existing data item Resuscitation method – mechanical will align the VPDC with AIHW reporting guide for the equivalent data item (Meteor ID 732883), in the Perinatal NMDS 2023-24 while maintaining existing codes. This data item enables derivation of the AIHW indicator for Active resuscitation, required in the [Perinatal NMDS 2023-24](https://meteor.aihw.gov.au/content/756062). The proposal also seeks to clarify for health services the appropriate code to report if active resuscitation methods is not used for liveborns who receive palliative care from birth.

### How will the data be used?

No change to current usage is expected. Better alignment with national reporting requirements.

### How will the proposed change impact health services?

Minimal impact on the health service that currently collect and report this mandatory data item. The amendments provide more contemporary terms and reporting guides, adding clarity for clinicians and improving data quality.

## Proposal 10 – Revise alcohol volume intake data items: Delete two existing data items and add two new data items

### Proposed change

Add two new VPDC data items for alcohol volume to report specific number of standard drinks:

1. Number of standard drinks consumed when drinking alcohol in the first 20 weeks of pregnancy (new)
2. Number of standard drinks consumed when drinking alcohol at 20 or more weeks (new)

Delete two existing data items that report grouped numbers of standard drinks:

1. Delete: ~~Maternal alcohol volume intake at less than 20 weeks~~
2. Delete: ~~Maternal alcohol volume intake at 20 or more weeks~~

### i) Add new data item

#### Number of standard drinks consumed when drinking alcohol in the first 20 weeks of pregnancy (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The total number of standard drinks consumed on a typical day when drinking alcohol by a female in the first 20 weeks of pregnancy. | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | TBC |
| Permissible values | Range: 01 to 97 (inclusive)  **Code Descriptor**  98 Occasional drinking (less than one per day)  99 Not stated / inadequately described | | |
| Reporting guide | Alcohol consumption is usually measured in standard drinks.  An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol. The numbers of Australian standard drinks in common containers of various alcoholic beverages is presented in the National Health and Medical Research Council (NHMRC) 2009 guidelines.  This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the NHMRC, consumed per day. When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g., report 2.4 standard drinks per day as 03).  The first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.  Data should be gathered after 20 weeks of pregnancy.  Report only where data item ‘Maternal alcohol use at less than 20 weeks’ is not Code 1 Never or Code 9 Not stated / inadequately described.  Leave blank where data item ‘Maternal alcohol use at less than 20 weeks’ is reported as Code 1 Never or Code 9 Not stated / inadequately described. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes reporting any alcohol use in the first 20 weeks of pregnancy | | |

### ii) Add new data item

#### Number of standard drinks consumed when drinking alcohol at 20 or more weeks (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The total number of standard drinks consumed on a typical day when drinking alcohol by a female after 20 weeks of pregnancy until the birth | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | TBC |
| Permissible values | Range: 01 to 97 (inclusive)  **Code Descriptor**  98 Occasional drinking (less than one per day)  99 Not stated / inadequately described | | |
| Reporting guide | Data should be collected after the birth.  Alcohol consumption is usually measured in standard drinks.  An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol. The numbers of Australian standard drinks in common containers of various alcoholic beverages is presented in the National Health and Medical Research Council (NHMRC) 2009 guidelines.  This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the NHMRC, consumed per day. When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g., report 2.4 standard drinks per day as 03).≥  After 20 weeks’ is defined as greater than or equal to 20 completed weeks’ gestation (≥ 20 weeks + 0 days).  Report only where data item ‘Maternal alcohol use at 20 weeks or more’ is not Code 1 Never or Code 9 Not stated / inadequately described.  Leave blank where data item ‘Maternal alcohol use at 20 weeks or more’ is reported as Code 1 Never or Code 9 Not stated / inadequately described. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes who report any alcohol use at 20 or more weeks’ gestation | | |

### iii) Delete existing data item

#### ~~Maternal alcohol volume intake at less than 20 weeks~~

**~~Specification~~**

|  |  |  |  |
| --- | --- | --- | --- |
| ~~Definition~~ | ~~A self-reported indicator of alcohol volume intake at any time during the first 20 weeks of her pregnancy~~ | | |
| ~~Representation class~~ | ~~Code~~ | ~~Data type~~ | ~~Number~~ |
| ~~Format~~ | ~~N~~ | ~~Field size~~ | ~~1~~ |
| ~~Location~~ | ~~Episode record~~ | ~~Position~~ | ~~136~~ |
| ~~Permissible values~~ | **~~Code Descriptor~~**  ~~1 1 or 2 standard drinks~~  ~~2 3 or 4 standard drinks~~  ~~3 5 or 6 standard drinks~~  ~~4 7 to 9 standard drinks~~  ~~5 10 or more standard drinks~~  ~~9 Not stated / inadequately described~~ | | |
| ~~Reporting guide~~ | ~~Report the average amount of standard drinks consumed per occasion when drinking~~ | | |
| ~~Reported by~~ | ~~All Victorian hospitals where a birth has occurred and homebirth practitioners~~ | | |
| ~~Reported for~~ | ~~All birth episodes who report any alcohol intake in the first 20 weeks of pregnancy~~ | | |
| ~~Related concepts (Section 2):~~ | ~~None specified~~ | | |
| ~~Related data items (this section):~~ | ~~Maternal alcohol use at less than 20 weeks~~ | | |
| ~~Related business rules (Section 4):~~ | ~~Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 or more weeks valid combinations~~ | | |

### iv) Delete existing data item

#### ~~Maternal alcohol volume intake at 20 or more weeks~~

**~~Specification~~**

|  |  |  |  |
| --- | --- | --- | --- |
| ~~Definition~~ | ~~A self-reported indicator of alcohol volume intake at 20 or more weeks of her pregnancy~~ | | |
| ~~Representation class~~ | ~~Code~~ | ~~Data type~~ | ~~Number~~ |
| ~~Format~~ | ~~N~~ | ~~Field size~~ | ~~1~~ |
| ~~Location~~ | ~~Episode record~~ | ~~Position~~ | ~~138~~ |
| ~~Permissible values~~ | **~~Code Descriptor~~**  ~~1 1 or 2 standard drinks~~  ~~2 3 or 4 standard drinks~~  ~~3 5 or 6 standard drinks~~  ~~4 7 to 9 standard drinks~~  ~~5 10 or more standard drinks~~  ~~9 Not stated / inadequately described~~ | | |
| ~~Reporting guide~~ | ~~Report the average amount of standard drinks consumed per occasion when drinking~~ | | |
| ~~Reported by~~ | ~~All Victorian hospitals where a birth has occurred and homebirth practitioners~~ | | |
| ~~Reported for~~ | ~~All birth episodes who report any alcohol intake at 20 or more weeks’ gestation~~ | | |

### Proposed by

Data Collections Unit, Victorian Agency for Health Information

### Reasons for proposed change

To align the VPDC with the Perinatal NBEDS 2023-24 alcohol data items and definitions, enabling Victoria to report accurately to the National Perinatal Data Collection.

### **Details of change/Additional background information provided by proposer**

The existing data items reporting Maternal alcohol volume intake at less than 20 weeks, and at 20 or more weeks, are based on the World Health Organization's Alcohol Use Disorders Identification Test-C (AUDIT-C) screening instrument, and group consumption of standard drinks. While that was consistent with the direction of the National Perinatal Data Development Committee (NPDDC), the AIHW National Best Endeavours Data Set (NBEDS) specifications for reporting alcohol consumption (Meteor ID 690993 and Meteor ID 691039) now requires Number of standard drinks reported in whole numbers from 0 to 997 (plus 2 supplementary values). The current VPDC data items reporting ranges of consumption (e.g., 1 or 2 standard drinks) do not allow reporting of the specific number of standard drinks (i.e., 1 or 2) required by the AIHW for the Perinatal NBEDS. This proposal will align the VPDC with Meteor/AIHW data items and specifications in the NBEDS.

No change is proposed to the other two existing VPDC alcohol data items as they comply with the Perinatal NBEDS for frequency of alcohol intake during pregnancy:

* Maternal alcohol use at less than 20 weeks
* Maternal alcohol use at 20 or more weeks

### How will the data be used?

The data will enable reporting of alcohol data items consistent with the AIHW’s specifications for the National Perinatal Data Collection.

### How will the proposed change impact health services?

There will be minimal impact on the health service as they are currently required to collect and report mandatory alcohol data items in pregnancy.

## Proposal 11 – Amend existing data item ‘Time to established respiration’

Proposed change

Amend existing data item Time to established respiration to include a supplementary code for liveborns that did not establish respiration and were not intubated or ventilated, such as those receiving palliative care from birth.

Proposal specification

#### Time to established respiration

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Time in minutes taken to establish regular, spontaneous breathing. This is not the same as the time of first breath. | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 104 |
| Permissible values | Range: zero to 30 (inclusive)  **Code Descriptor**  97 Newborn does not establish spontaneous respirations and is not intubated or ventilated  98 Newborn does not take a breath is intubated and ventilated  99 Not stated / inadequately described | | |
| Reporting guide | Most newborns establish spontaneous respirations within one to two minutes of birth. If spontaneous respirations are not established within this time, active intervention is required.  Round up the time the baby took to establish regular spontaneous breathing to the next whole minute. For example, a baby who takes 2.5 minutes to establish regular breathing should have three minutes recorded.   * If the baby breathes immediately and continues to have regular spontaneous breathing upon delivery, report the TER as 1 minute. * If the baby does not take a breath and is intubated and ventilated and accurate assessment of time is not possible, report 98 Newborn does not take a breath – is intubated and ventilated. * If the baby is born before arrival, where the time to established respiration is unknown, report 99 Not stated / inadequately described. * For stillbirth episodes, report the time to established respiration as 00.   CODE 97 Newborn does not establish spontaneous respirations and is not intubated or ventilated Report for livebirths where the newborn does not establish spontaneous respirations and is not intubated or ventilated, such as those receiving palliative care from birth. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

Proposed by

Data Collections Unit, Victorian Agency for Health Information

### Reasons for proposed change

To provide clarity for clinicians and data users for reporting this mandatory data item for liveborns that did not establish respiration and were not intubated or ventilated, such as those receiving palliative care from birth. There is no specific code, nor reporting guidance, for those circumstances at present.

### How will the data be used?

No change is expected.

### How will the proposed change impact health services?

Clearer guidance for health services, but no additional reporting burden. This is a mandatory data item to be reported for all births.

## Proposal 12 – Amend existing data items and concept definition to include admitted care provided in Hospital in the Home (HITH) setting within the birth episode

Proposed change

Amend existing data items and concept definition to allow inclusion of care provided during the birth episode in both ward-based and Hospital in the Home (HITH) settings to be reported to the VPDC:

1. Separation date – baby and
2. Separation date – mother  
   change reporting guide for these existing data items to indicate that the Separation date is the date when admitted care ceases at the end of the birth episode, which includes care provided in ward-based and HITH settings, but excludes domiciliary post-discharge home nursing care visits
3. Separation status – baby, and
4. Separation status – mother:   
   change code set and reporting guide for these existing data items to clarify that a discharge by transfer is only reported where the baby or mother respectively leaves the birth setting for transfer to another health service, and that transfer does not include patients leaving a ward-based care setting for HITH
5. Reason for transfer out – baby, and
6. Reason for transfer out – mother:  
   amend code set to remove code for HITH, as HITH is a change of care setting, not cessation of the birth episode
7. Hospital in the home (HITH) – amend VPDC manual Section 2 – Concept and derived item definitions

i) Amend existing data item

#### Separation date – baby

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The date on which the baby is separated – i.e., discharged, transferred from the place of birth to another hospital or on which they died | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 119 |
| Permissible values | A valid calendar date | | |
| Reporting guide | The separation date is the date on which admitted care ends following the baby’s birth.  The relocation of the baby to another ward within the hospital of birth does not constitute a separation (or transfer).  Transfers from a private hospital located within a public hospital, to the public hospital for special or intensive care, are considered transfers (and therefore the baby is separated).  For babies whose care continues in ~~are transferred to~~ Hospital in the Home (HITH), the separation date is the date the admitted birth episode of care ends, whether that is the date the baby is discharged from the ward or from HITH, or is transferred to another hospital, or dies. Note that HITH is admitted care and does not include domiciliary post-discharge home nursing services. ~~transfer to HITH occurs~~. If a baby transfers from admitted HITH care back to the ward setting without any cessation of admitted care after the baby’s birth, the separation date is the date on which admitted care ends following the baby’s birth.  In the case of planned homebirths, occurring at home, the Separation date is the date that the baby's immediate post birth care is completed, and the midwife leaves the place of birth. This date may be different to the baby's date of birth, for example if the birth occurs shortly before midnight.  Do not report a value for stillbirth episodes, leave blank. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All live birth episodes | | |

ii) Amend existing data item

#### Separation date – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The date on which the mother is separated - i.e., discharged, transferred from the place of birth to another hospital or died after the birth episode | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 118 |
| Permissible values | A valid calendar date  **Code Descriptor**  99999999 Not stated / inadequately described | | |
| Reporting guide | The separation date is the date on which admitted care ends following the baby’s birth.  The relocation of the mother to another ward within the hospital of birth does not constitute a separation (or transfer).  Transfers from a private hospital located within a public hospital, to the public hospital for special or intensive care, are considered transfers (and therefore the mother is separated).  For mothers whose care continues in ~~are transferred to~~ Hospital in the Home (HITH), the separation date is the date the admitted birth episode of care ends, whether that is the date the mother is discharged from the ward or from HITH, or is transferred to another hospital, or dies. Note that HITH is admitted care and does not include domiciliary post-discharge home nursing services. ~~transfer to HITH occurs~~. If a mother transfers from admitted HITH care back to the ward setting without any cessation of admitted care after the baby’s birth, the separation date is the date on which admitted care ends following the baby’s birth.  In the case of planned homebirths, occurring at home, the Separation date is the date that the mother’s immediate post-birth care is completed, and the midwife leaves the place of birth. This date may differ from the baby's date of birth, for example, if the birth occurs shortly before midnight. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

iii) Amend existing data item

#### Separation status – baby

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Status at separation of baby (discharge/transfer to another hospital/death) | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 121 |
| Permissible values | **Code Descriptor**  1 Discharged  2 Died  ~~3 Transferred~~  4 Transferred to another hospital  9 Not stated / inadequately described | | |
| Reporting guide | Do not report a value for stillbirth episodes, leave blank.  ~~For babies who are transferred to Hospital in the Home (HITH), the Separation status – baby is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – baby should be left blank.~~  Babies remain admitted in ward-based settings as well as when receiving Hospital in the Home care. Report the Separation status at the Separation date, which is the date on which admitted services, including HITH, cease. Domiciliary care services are not admitted care and are not included in HITH. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All live birth episodes | | |

iv) Amend existing data item

#### Separation status – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Status at separation of mother (discharge/transfer to another hospital/death) | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 120 |
| Permissible values | Code Descriptor  1 Discharged  2 Died  ~~3 Transferred~~  4 Transferred to another hospital  9 Not stated / inadequately described | | |
| Reporting guide | ~~For mothers who are transferred to Hospital in the Home (HITH), Separation status – mother is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – mother should be left blank.~~  Mothers remain admitted in ward-based settings as well as when receiving Hospital in the Home (HITH) care. Report the Separation status at the Separation date, which is the date on which admitted services, including HITH, cease. Domiciliary care services are not admitted care and are not included in HITH. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

v) Amend existing data item

#### Reason for transfer out – baby

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Reason why the baby is transferred following separation from the birth hospital campus | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 132 |
| Permissible values | **Code Descriptor**   1. Higher level of care 2. Lower level of care 3. Same level of care 4. ~~HITH~~ | | |
| Reporting guide | Code 1 Higher level of care:  includes conditions where tertiary neonatal care is more appropriate to the baby’s needs. It also includes transfer where the intended birth hospital doesn’t have the capability level to care for this baby, for example, prematurity, multiple pregnancy, complications at birth.  Code 2 Lower level of care:  includes babies transferred back to their intended birth hospital following tertiary care, or from a hospital with increased capability to the intended birth hospital.  Code 3 Same level of care:  includes babies who may have been born at the nearest hospital whilst mother was on holidays or travelling and is now transferred to the intended birth hospital.  ~~Code 4 HITH:  includes babies referred to HITH. Please choose transferred rather than discharged in the baby’s separation status.~~ | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All episodes where Separation status – baby is code ~~3~~ 4 Transferred to another hospital | | |

vi) Amend existing data item

#### Reason for transfer out – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Reason why the mother is transferred following separation from this hospital campus | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 133 |
| Permissible values | **Code Descriptor**  1 Higher level of care  2 Lower level of care  3 Same level of care  ~~4 HITH~~ | | |
| Reporting guide | Code 1 Higher level of care:  includes conditions where tertiary maternity care is more appropriate to the mother’s needs. It also includes transfer where the intended birth hospital doesn’t have the capability level to care for this mother, for example, prematurity, multiple pregnancy, complications at birth.  Code 2 Lower level of care:  includes mothers transferred back to their intended birth hospital following tertiary care, or from a hospital with increased capability to the intended birth hospital  Code 3 Same level of care:  includes mothers who may have given birth at the nearest hospital whilst on holidays or travelling and is now transferred to the intended birth hospital.  ~~Code 4 HITH:  includes mothers referred to HITH. Please choose transferred rather than discharged in the mother’s separation status.~~ | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All episodes where Separation status – mother is code ~~3~~ 4 Transferred to another hospital | | |

vii) Amend existing concept definition

|  |  |
| --- | --- |
| Hospital in the home (HITH) | |
| **Definition/guide for use** | Hospital in the Home (HITH) is the provision of admitted-level care in the patient’s home or other suitable location as a substitute for care in a ward-based setting during a hospital admission.  That is, HITH is an alternative to an in-hospital stay. Patients receiving care in HITH are hospital inpatients, and remain under the care of their hospital doctor. Care may be provided by nurses, doctors, or allied health professionals, and additional home supports arranged as required.  Patients can be offered care in HITH as an option if the care they need can be delivered safely in their home or other place of residence. Participation is voluntary and is without additional charge to the patient.  Place of residence may be permanent or temporary, and includes residential facilities such as nursing homes, hostels or other forms of supported accommodation. Medi-hotels are excluded.  Criteria for inclusion as HITH include but are not limited to:   * without hospital-in-the-home care being available patients would be accommodated in the hospital; * the treatment forms all or part of an episode of care for an admitted patient; * the hospital medical record is maintained for the patient; * there is adequate provision for crisis care.   The admitted stay might be a combination of ward-based and HITH care or replace care provided in the ward-based setting completely.  Public hospitals should provide HITH services in line with the [Victorian HITH guidelines](https://www.health.vic.gov.au/patient-care/hospital-in-the-home) < https://www.health.vic.gov.au/patient-care/hospital-in-the-home >  Movement between ward and HITH accommodation is equivalent to moving between wards in a hospital setting, and is reported within the same admitted episode.  ~~Hospital in the home (HITH) services provide care in the home that would otherwise need to be delivered within a hospital as an admitted patient. HITH often provides an alternative to admission to a hospital or an opportunity for earlier relocation to the home than would otherwise be possible.~~  HITH suitability and assessment criteria are documented in the HITH guidelines available at the [Hospital in the Home webpage](https://www.health.vic.gov.au/patient-care/hospital-in-the-home) <https://www.health.vic.gov.au/patient-care/hospital-in-the-home>  References: AIHW <<https://meteor.aihw.gov.au/content/327308>> , <<https://meteor.aihw.gov.au/content/756062>> ; [VAED manual 2023-24, Section 2](https://www.health.vic.gov.au/publications/victorian-admitted-episodes-dataset-vaed-manual-2023-2024) < https://www.health.vic.gov.au/publications/victorian-admitted-episodes-dataset-vaed-manual-2023-2024> |

Proposed by

Data Collections Unit, Victorian Agency for Health Information

### Reasons for proposed change

To improve the accuracy of length of stay derived from the VPDC, including postnatal length of stay, which at present excludes days of Hospital in the Home (HITH). This is contrary to the AIHW Meteor definition (ID 327268) of ‘[Separation](https://meteor.aihw.gov.au/content/327268)’ which states that “…treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person’s home (for hospital-in-the-home patients).”

The VPDC currently reports transfer to HITH as a Transfer destination, equivalent to transfer to another hospital, rather than a continuation of ward-based care, and is therefore reporting reduced length of stay for every baby and mother whose birth episode includes admitted care provided in HITH setting, reducing comparability with other jurisdictions.

### How will the data be used?

Accurate data on length of stay will be able to be included in the NPDC submission to the AIHW, whereas at present, length of stay data derived from the VPDC excludes all HITH days.

### How will the proposed change impact health services?

This will be a change of practice for those reporting VPDC data who are accustomed to excluding HITH days in the VPDC record. Explanatory notes may be required to support this change.

## Proposal 13 – Amend definition and code set of existing data item Sex – baby

### Proposed change

Amend the definition and code set of existing VPDC data item Sex – baby.

### Proposal specification

#### Sex – baby

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | ~~The biological distinction between a male and female baby~~  The baby’s sex based on their sex characteristics, such as their chromosomes, hormones and reproductive organs. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 97 |
| Permissible values | **Code Descriptor**  1 Male  2 Female  3 ~~Indeterminate~~ Another term  9 Not stated / inadequately described | | |
| Reporting guide | The baby’s sex based on their sex characteristics, such as their chromosomes, hormones and reproductive organs.  ~~Sex is the biological distinction between male and female.~~  ~~Code 3 Indeterminate:  infants with ambiguous genitalia or macerated fetus where the biological sex is unable to be or has not yet been determined (genetic testing not yet complete).~~  Code 3 Another term:  Sex at birth that is recorded as another term (not male or female), or whose sex was reported as another term (not male or female) at the time of collection. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |

### Proposed by

Data Collections Unit, Victorian Agency for Health Information

### Reasons for proposed change

To maintain the VPDC’s alignment with the Perinatal NMDS and AIHW data items and definitions, and for consistency with Victoria’s other acute patient-level data collections where the same data item is being amended to replace the term ‘Indeterminate sex’ with ‘Another term’ effective 1 July 2023.

### How will the data be used?

No change to current data usage.

### How will the proposed change impact health services?

None to minimal impact on health services expected, as Sex – baby data item and code 3 are already being collected and are mandatory for all births. Health services may already be using ‘Another term’ for code 3 in practice and in their software as other data collections are moving or have already moved to adopt this new code descriptor.