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| Victorian Admitted Episodes Dataset (VAED) manual 2025-26  Section 3 Data definitions |
| 35th edition |
| OFFICIAL |

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| To receive this document in another format, [email HDSS help desk](mailto:HDSS.Helpdesk@health.vic.gov.au) <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 2025.  **ISBN** 978-1-76131-789-7 **(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

This section provides the specifications for each data element submitted to the VAED. Information about each data element is presented in the following structured format:

## Data element name

### Specification

|  |  |
| --- | --- |
| Definition | A concise statement that expresses the essential nature of the data element and its differentiation from other data elements |
| Field size | The maximum number of characters accommodated by this field |
| Layout | The layout of characters for the data element, expressed by a character string representation |
| Location | The Transaction Record in which this data element is submitted to the VAED |
| Reported by | Criteria for reporting data element |
| Reported for | The specific circumstances when this data element must be reported |
| Reported when | The stage in the episode/data submission cycle when this data element is reported |
| Code set | The set of valid values for the data element |
| Reporting guide | Additional comments or advice on reporting the data element |
| Validations | A list of validations (numbers and titles) that relate to this data element |
| Related items | Other data elements that relate to this data element |

### Administration

|  |  |
| --- | --- |
| Purpose | The main reason/s for the collection of this data element |
| Principal data users | Identifies the primary user/s of the data collected |
| Collection start | The year the collection of this data element commenced |
| Definition source | Identifies the authority that defined this data element |
| Code set source | Identifies the authority that developed the code set for this data element |

# 

## ACAS Status

### Specification

|  |  |
| --- | --- |
| Definition | The type of involvement of the Aged Care Assessment Service (ACAS) in patient separation |
| Field size | 1 |
| Layout | N or space |
| Location | Episode Record |
| Reported by | Public hospitals  Private hospitals – Optional |
| Reported for | Episodes with:   * Care Type 1, 4, 6, 8, 9, or MC, **and** * Where the patient’s age is equal to or greater than 50, **and** * Where the episode is not a same day episode.   For Care Types P, 0, 5x, 10 and U, report spaces in this field. |
| Reported when | A Separation Date is reported in the Episode Record |
| Codes / descriptors | 1 ACAS Assessment completed during this episode  2 ACAS Assessment incomplete: referral to Subacute services  3 ACAS Assessment incomplete: other reason  4 ACAS Consultation only during this episode  5 No ACAS involvement during this episode |
| Reporting guide | Select the first appropriate code  This information should be noted in the patient’s health record by staff members or by ACAS.  **1 ACAS Assessment completed during this episode**  The patient has received a comprehensive assessment by a member of the ACAS of their physical, medical, psychological, social, and restorative care needs with a recommendation for the patient’s long-term care setting and all the relevant paperwork completed (for example, 2624 certificate completed and signed if required).  **2 ACAS Assessment incomplete: referral to Subacute services**  The patient was seen by the ACAS who referred the patient to sub-acute services (for example, GEM or rehabilitation) at this hospital or another campus/hospital.  Excludes when the assessment was not completed because the patient:   * Required further acute care to become medically stable (use 3) * Began an assessment that was completed in a subsequent statistical episode (use 3) |
| Reporting guide | * Died (use 3) * Left against medical advice (use 3)   **3 ACAS Assessment incomplete: other reason**  The patient was seen by the ACAS, but a final care plan and long-term care setting recommendation could not be made.  Includes when the assessment was not completed because the patient:   * Required further acute care to become medically stable. * Began an assessment that was completed in a subsequent statistical episode. * Died. * Left against medical advice   Excludes when the assessment was not completed because the patient:  Was referred to sub-acute services (eg GEM or rehabilitation) (use 2)  **4 ACAS Consultation only during this episode**  ACAS were consulted or gave advice to the hospital staff (discharge planner, social worker) about a patient’s discharge and long-term care setting and care plan options but did not conduct a full assessment.  **5 No ACAS involvement during this episode**  When ACAS was not involved with the patient.  Includes:  Patient referred to ACAS for a home-based assessment (report in Separation Referral). |
| Validations | 460 Invalid ACAS Status  461 ACAS Status not Required  462 Incompat ACAS Status and Sep Referral  533 ACAS Status Code Required |

### Administration

|  |  |
| --- | --- |
| Purpose | Assist in measuring demand, and for planning of future services |
| Principal data users | Department of Health |
| Collection start | 2003-04 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Accommodation Type (a)

## Accommodation Type on Separation (b)

### Specification

|  |  |
| --- | --- |
| Definition | (a) The accommodation type or types occupied by the patient during their admission, including changes to this item during the episode  (b) The accommodation type last occupied by the patient on the day of separation |
| Field size | 1 |
| Layout | N or A |
| Location | (a) Status Segments of the Episode Record  (b) Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | (a) The Episode Record is reported  (b) A Separation Date is reported in the Episode Record |
| Code set | For data elements (a) and (b), select the first appropriate category:  R Off-site  4 In the Home (Hospital - HITH)  7 Ward Based/Medi-Hotel combination  S ED Short Stay Unit  M Medical Assessment and Planning Unit  H Mental Health and AOD Hub Short Stay Unit  P Psychiatric Assessment and Planning Unit  6 Emergency Department  K Paediatric Intensive Care Unit (PICU)  U Intensive Care Unit (ICU)  N Neonatal Intensive Care Unit (NICU)  A Special Care Nursery (SCN)  B Other nursery accommodation or mother’s bedside (rooming in)  3 Same Day accommodation  2 Overnight accommodation: single room  1 Overnight accommodation: shared room |
| Reporting guide | Status Segments are used to record changes of Accommodation Type during the episode. If more than one change occurs on the same day, do not report the first change; only report the patient’s status as of midnight.  **R Off-site**  Care delivered in an off-site facility which is not the patient’s usual place of residence.  Excludes:   * Hospital in the Home (HITH) program (use code 4) * Maintenance care provided in the hospital (use code 1 or 2)   **4 In the Home (Hospital - HITH)**  When care is provided to hospital admitted patients in their place of residence as a substitute for traditional hospital accommodation.  Includes*:*   * Under the Hospital in the Home (HITH) program * Geriatric Evaluation and Management Program (home based)   Excludes*:*  Accommodation in a Medi-Hotel (use code 7)  **7 Ward Based/Medi-Hotel combination**  For multi-day stay patients, where the patient receives treatment as an inpatient in a traditional hospital setting (ward) during the day and resides in the hospital’s Medi-Hotel overnight.  Includes:   * Accommodation in same day facilities during the day * Where the patient is cared for in the Medi-Hotel by someone not arranged for, provided by, or paid for by the hospital, such as a relative or other carer   Excludes:  Accommodation in the Home (HITH) (use code 4)  **S ED Short Stay Unit**  Accommodation within an approved ED Short Stay Unit ED SSU. Refer to ED Short Stay Unit Guidelines 2017  Excludes:   * Short stay facilities designated specifically for elective surgical and radiological procedures * Medical Assessment and Planning Unit admissions (use code M) * Mental Health and AOD Hub Short Stay Unit (use code H) * Psychiatric Assessment and Planning Unit (use code P) * Other assessment unit such as Rapid Chest Pain Assessment Unit (use code M) |
|  | **M Medical assessment and Planning Unit**  Accommodation within an approved Medical Assessment and Planning Unit (MAPU). MAPUs concentrate on admissions for general medical conditions in one geographical area to streamline the care planning processes. Planned length of stay in the Medical Assessment and Planning Unit may be up to 48 hours prior to transfer to another Accommodation Type (ward) or separation home.  Includes:  Any other assessment unit such as Rapid Chest Pain Assessment Unit  Excludes:   * ED Short Stay Unit (use code S) * Mental Health and AOD Hub Short Stay Unit (use code H)   **H Mental health and AOD short Stay Unit**  Accommodation within a Mental Health and AOD Hub Short Stay Unit  **P Psychiatric Assessment and Planning Unit**  Accommodation within a Psychiatric Assessment and Planning Unit (PAPU)  Excludes:  Medical Assessment and Planning Unit (use code M)  Any other assessment unit such as Rapid Chest Pain Assessment Unit (use code M)  **6 Emergency Department**  Accommodation provided in the emergency department or urgent care centre  **K Paediatric Intensive Care Unit (PICU)**  Accommodation provided to critically ill infants, children and young people in a facility approved by the Department of Health for the purpose of provision of dedicated paediatric intensive care  Includes:  Royal Children’s Hospital and Monash Children’s Hospital  Excludes:  Accommodation provided within a combined ICU/PICU services (use code U)  **U Intensive Care Unit (ICU)**  Accommodation provided to critically ill patients in a designated stand-alone adult/general/combined intensive care unit approved by the Department of Health for the purpose of providing intensive care.  Includes:  Combined ICU/CCU/HDU and children within combined ICU/PICU services  Excludes:  Accommodation provided within stand-alone Coronary Care/Acute Cardiology Units |
|  | **N Neonatal Intensive Care Unit (NICU)**  Accommodation provided to any infant in a facility approved by the Commonwealth Minister for the purpose of provision of neonatal intensive care.  Includes:  Combined NICU/SCN  Royal Women’s Hospital, Monash Clayton, Royal Children’s Hospital, Mercy Hospital for Women and Sunshine Hospital  Excludes:  Accommodation provided within units that provide SCN services only (use code A)  **A Special Care Nursery only (SCN)**  Accommodation provided to any infant in a facility approved by the Commonwealth Minister for the purpose of provision of special care.  Excludes:  Accommodation provided within units that provide NICU and SCN services (use code N)  **B Other nursery accommodation or mother’s bedside (rooming in)**  Accommodation provided to any infant in a postnatal ward, either in a nursery that is not an approved NICU or SCN or by its mother’s bedside (that is ‘rooming in’)  For infants in paediatric wards, report code 1, 2 or 3 as appropriate.  **3 Same Day accommodation**  Same day bed or accommodation such as a renal dialysis chair, regardless of whether this bed/chair is in a single or shared room.  Excludes:  Where a same day patient is accommodated in a ward or bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full.  **2 Overnight accommodation: single room**  For sole occupation of a room intended for the overnight accommodation of a single patient but only when the patient has requested single accommodation.  Includes:   * Where the patient has requested single accommodation and occupies a room intended for single occupancy, but her newborn is rooming-in * Where a same day patient is accommodated in a ward/bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full * Maintenance care delivered in this hospital   Excludes:   * Where the patient is the only person occupying a room intended for shared occupancy, such as the isolation of a patient for medical reasons, or where there is no available shared room (use code 1) * Where the patient occupies a single room but has not requested single accommodation (use code 1) * Infant by its mother’s bedside, ‘rooming in’ (use code B)   **1 Overnight accommodation: shared room**  For occupation of a room intended for the overnight accommodation of more than one patient.  Includes:   * Where the patient is the only person occupying a room intended for shared occupancy * Where the patient and her rooming-in newborn are the only people occupying a room intended for occupancy by more than one adult patient * Where the patient has not requested single accommodation but occupies a single room because of a clinical decision * Where a same day patient accommodated in a ward/bed not designated as a same day ward/bed either because the hospital has no such designated accommodation or because that accommodation is full * Maintenance care delivered in this hospital |
| Validations for (a) | 076 Not Sufficient Fields First Status  077 Not Sufficient Fields Other Status  084 Invalid Accom Type  240 Newborn Accom But Over 4 Months  432 MAPU or ED SSU >48 Hours  434 NICU or SCN Accom But Unqual Newborn  455 Inconsist Newborn Transferred/Unqual Data  464 Accom Type 7, not Care Type 4  520 Accom Type 7, not approved for Medi-hotel  521 Accom Type M, no registered MAPU  522 Accom Type S, no registered ED SSU  602 Newborn Accom but Over 12 Months  706 Accom Type 7: First Status or Accom on Sep  717 Accom Type P, no registered PAPU  719 Accom Type H, no Mental Health and AOD SSU  720 Accom Type H, Care Type not 4  728 Accom Type K, no approved PICU  729 Accom Type U, no approved ICU  730 Accom Type N, no approved NICU  731 Accom Type A, no approved SCN |
| **Validations for (b)** | 106 Invalid Sep Accom  108 Field(s) Missing from Sep  401 Accom Type on Sep – Emerg  706 Accom Type 7: First Status or Accom on Sep  717 Accom Type P, no registered PAPU  719 Accom Type H, no Mental Health and AOD SSU  720 Accom Type H, Care Type not 4  728 Accom Type K, no approved PICU  729 Accom Type U, no approved ICU  730 Accom Type N, no approved NICU  731 Accom Type A, no approved SCN |

### Administration

|  |  |
| --- | --- |
| Purpose | For analysis of patient movement during an episode |
| Principal data users | Multiple internal and external data users |
| Collection start | 1991-92 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Account Class (a)

## Account Class on Separation (b)

### Specification

|  |  |
| --- | --- |
| Definition | (a) The agency/individual chargeable for this episode, and associated subcategories, for this episode of care, including changes to this item during the episode  (b) The agency/individual chargeable for this episode, and associated subcategories, on the last (counted) patient day |
| Field size | 2 |
| Layout | AA or AN |
| Location | (a) Status Segments of the Episode Record  (b) Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | (a) The Episode Record is reported  (b) Once the Separation Date is reported in the Episode Record |
| Code set | **Posthumous Organ Procurement episode**  KK Posthumous Organ Procurement episode  **Unqualified Newborns (Not Birth Episode)**  NT Newborn (Unqualified, not birth episode)  **Public (Acute Care) Patient**  MP Public: Eligible  ME Ineligible: hospital exempt  MF Ineligible: Asylum Seeker  MN Public NHT – without NH5  M5 Public NHT - with NH5  MA Reciprocal Health Care Agreement  JP Prisoner  JN Prisoner Non-Acute  **Private Patient**  PA Advanced surgery 1 (1-14 days)  PB Advanced surgery 2 (15+ days)  PC Surgery (1-14 days)  PD Surgery 2 (15+ days)  PE Medical 1 (1-14 days)  PF Medical 2 (15+ days)  PG Obstetric 1 (1-14 days)  PH Obstetric 2 (15+ days) |
|  | PI Rehabilitation 1 (1-49 days)  PJ Rehabilitation 2 (50-65 days)  PK Rehabilitation 3 (66+ days)  PL Psychiatric 1 (1-42 days)  PM Psychiatric 2 (43-65 days)  PN Psychiatric 3 (66+ days)  PO Same Day (Band 1)  PP Same Day (Band 2)  PQ Same Day (Band 3)  PR Same Day (Band 4)  PS Private NHT - with general care-without NH5  PT Private NHT - with general care-with NH5  PU Private NHT - with extensive care-without NH5  PV Private NHT - with extensive care-with NH5  **Department of Veterans’ Affairs Patient**  VX Department of Veterans’ Affairs (DVA)  VN Department of Veterans Affairs NHT-without NH5  V5 Department of Veterans’ Affairs NHT-with NH5  **Compensable Patient**  WC WorkSafe Victoria  WN WorkSafe Victoria - Non-Acute  TA Transport Accident Commission (TAC)  TN Transport Accident Commission (TAC) - Non-Acute  AS Armed Services  AN Armed Services - Non-Acute  SS Seamen  SN Seamen - Non-Acute  CL Common Law Recoveries  CN Common Law Recoveries - Non-Acute  OO Other compensable  ON Other compensable - Non-Acute  **Ineligible**  XX Ineligible non-Australian residents (not exempted from fees)  XN Ineligible non-Australian residents (not exempted from fees) - Non-Acute |
| Reporting guide | Status Segments are used to record changes of Account Class during the episode.  If more than one change occurs within the same day, do not report the first change; only report the patient’s status as of midnight each day.  Note: An episode cannot have both public and compensable Account Classes in different status segments.  **KK Posthumous Organ Procurement**  All Posthumous Organ Procurement episodes in public hospitals.  Use this code only for episodes in which human tissue is to be procured for the purpose of transplantation from a donor who has been declared brain dead prior to the commencement of this episode. |
| Reporting guide | **Newborns** are expected to have the same Account Class as their mother for the birth episode. In certain circumstances in public hospitals, the mother may be public and the baby private, or the mother private and the baby public.  For example:  Where the mother does not have private insurance and elects for the baby to be treated as private and pay all expenses; and  Where the mother has single private insurance and elects to be private, the baby can be a public patient.  Where the newborn is unqualified, and it is not the birth episode, report NT  **NT Newborn (Unqualified, not birth episode)**  A newborn (under 10 days old at admission), admitted subsequent to the birth episode (where the Account Class should be the same as the mother’s) who does not meet the criteria for a qualified newborn. Usually, these babies are transferred from another hospital.  Note: The newborn may have been reported as qualified or unqualified at a prior hospital  **MP Public: Eligible**  An eligible person, who, on admission to a recognised hospital or a private hospital for services provided under contract, or as soon as possible thereafter, elects to be treated as a public patient. The hospital provides comprehensive care including all necessary medical, nursing, and diagnostic services and, if available, dental, and paramedical services, by means of its own staff or by other agreed arrangements, without charge to the patient.  Includes:  Persons holding a current Interim Medicare Card  Excludes:  Persons holding an expired Interim Medicare Card (report XX Ineligible)  A person admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient’s treatment  **ME Ineligible: Hospital Exempt**  An ineligible non-Australian resident:  Specifically referred to Australia for hospital services not available in the patient’s own country and for whom the Secretary of the Department has determined that no fee be charged; or  Declared a safe haven resident and whose treatment is provided or arranged by a designated hospital  **MF Ineligible: Asylum Seeker**  A Medicare ineligible asylum seeker.  Admitted for immediately necessary medical treatment (but only as a public patient); and  Has met the criteria for Medicare Ineligible Asylum Seeker  **MN Public NHT – without Aged Care Client Record**  A patient as defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation, the patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care.  For example:  Professional attention for an acute phase of the patient’s condition; or  Active rehabilitation; or  Continued management, for medical reasons, as an admitted patient.  **N Compensable Non-Acute Patient**  A person, who has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not a compensable patient, would be deemed to be a Nursing Home Type patient.  **XX Ineligible Non-Australian Resident Patient**  A person who is an admitted patient but who is not eligible for Medicare and therefore not exempted from fees.  Includes:  Persons holding expired Interim Medicare Cards (should be billed for services)  **XN Ineligible Non-Australian Resident - Non Acute Patient**  A person, who has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not an ineligible patient, would be deemed to be a Nursing Home Type patient.  **Public hospitals:**  Report the patient’s Account Class according to: [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>  The patient elects to be treated as a Public or Private patient or may be eligible for DVA or a compensable class or may be ineligible. Refer to above document for the correct wording for the ‘Form of Election for Admission to Public Hospital’  After admission and initial election, patient election status can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to:   * Patients who are admitted for a procedure but are found to have complications requiring additional procedures * Patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health professional * Patients whose social circumstances change while in hospital (for example, loss of job).   Inadequate private health insurance cover is not sufficient reason for changing a patient’s election status.  **Private** **Patients:**  Within each broad Account Class, categorisation of patients is a medical decision and is performed by medical staff at the hospital or the referring medical practitioner; patients cannot elect to be charged as a particular Account Class as this will depend on what surgery, if any, is performed and complexity of the care.  **Private hospitals:**  Record patient Account Class as ‘best fit’ Account Class according to the Fees and Charges for Acute Health Services in Victoria - A Handbook for Public Hospitals document.  Because of the many patient account options used in private hospitals, and the limited applicability of the comparatively small range of VAED Account Classes, private hospitals and day procedure centres are not required to supply comprehensive Account Class data. Only the following broad categories apply:  Contracted patients: Use the appropriate Account Class from the range of valid codes. Where public patients are admitted under contract, use code MP.  A patient admitted to a private facility where the hospital and/or clinician bulk bill Medicare for the patient’s treatment is not considered to be a public patient. These patients should be reported using an appropriate private account class.  For all private acute same day patients, use any code respectively, from the following list:  PO, PP, PQ, PR  For all private acute overnight/multi-day patients, use a code starting P, with any valid combination of second character, from the following list:  PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN  Nursing Home Type patients (Private and Department of Veterans’ Affairs) must be classed to the existing range of codes:  PS, PT, PU, PV, VN, V5  However, accurate specification of general or extensive care level or NH5 status is not required for private hospital NHT or Department of Veterans’ Affairs NHT patients.  Compensable or Ineligible patients should be identified as such, including detail of the relevant funder. These patients need only be classified to the following level of detail:  WC, TA, AS, SS, CL, OO, XX  There is no requirement to use the codes with second-character N. |
| Validations (a) | 076 Not Sufficient Fields First Status  077 Not Sufficient Fields Other Status  083 Invalid Account Class  094 Invalid Combination A/C Med Suff  111 Same Day A/C Stat Not The Only Status  113 Same Day Status: Total Pt Days Not 1  116 Sep A/C Class Not In A Status Seg  222 Unqual Newborn; Adm Date Not Birth  324 Incompat ICU Hrs, A/C Class  325 Incompat MV Hrs, Acct Class  372 Episode Deletion: Multiple Epis Trans  374 Episode DVA/TAC: No V5 Transaction  375 Episode DVA/TAC: V5 Trans Rejected  377 Episode DVA/TAC: Multiple E5 Trans  378 Episode DVA/TAC: Multiple V5 Trans  379 Epis Not DVA/TAC: V5 Trans Present  380 Epis Not DVA/TAC: V5 Trans: Multiple E5s  382 Epis Not DVA/TAC: Multiple V5 Trans  391 Recip HCA Account, Not O/Seas P/Code  392 Recip HCA Account, Not O/Seas Born  393 Recip HCA Account, Indig Stat A or TI |
|  | 491 Incompat Fields for ESAS  532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U  571 Acct Recip, Pcode Oseas, Locality Not RHCA  572 Postcode Overseas, Account Not Recip, or Inelig  573 Postcode Overseas, Account Public  574 Postcode Overseas, Locality RHCA, Acct Not RHCA  626 Invalid Combination for Funding Arrangement PHESI  637 Illegal Combination of Account Classes  638 Private Hosp, Public Account Without Contract  709 NHT Account Class / Care Type mismatch |
| **Validations (b)** | 105 Invalid Sep Account Class  108 Field(s) missing From Sep  116 Sep A/C Class not in a Status Seg  455 Inconsist Newborn Transferred/Unqual Data  709 NHT Account Class / Care Type mismatch |
| Related items | Section 4: Newborn Reporting; Posthumous Organ Procurement; Reporting history of code changes – status segments |

### Administration

|  |  |
| --- | --- |
| Purpose | (a) To distinguish between broad categories (public, private, DVA, compensable); identify patients with DVA account classes (for accounting purposes); identify certain compensable patients (so DRG Statements are raised); verify other fields for consistency  (b) To identify the Account Class of a patient at separation for use in summary analyses; to place patients into broad account categories for reporting to the Commonwealth; to identify posthumous organ procurement episodes |
| Principal data users | Department of Health (DHHS); Department of Veterans’ Affairs (DVA); Transport Accident Commission (TAC); WorkCover (VWA) |
| Collection start | 1979-80 |
| Definition source | Department of Health |
| Code set source | Department of Health |

Account Classes on Separation mapped to Separation patient type code (derived item)

| Account Class on Separation (first character) | Separation patient type |
| --- | --- |
| M, N, J | H Public |
| P | P Private |
| V | V DVA |
| W, T, A, S, C, O | S Compensable |
| X | X Ineligible |
| K | K Posthumous organ procurement |

## Admission Date

### Specification

|  |  |
| --- | --- |
| Definition | Date on which an admitted patient commences an episode of care (formal or statistical) |
| Field size | 8 |
| Location | Episode Record  DVA and TAC Record |
| Layout | DDMMYYYY |
| Reported by | All Victorian hospitals (public and private)  Private hospitals do not report a DVA and TAC Record |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record or DVA and TAC Record is reported |
| Reporting guide | **Admission of Birth Episode**  For the first episode of a Newborn, the Admission Date will be the Date of Birth, except in the unusual circumstance where the newborn is born before arrival at this hospital, and where the birth occurs just before midnight and the newborn arrives at this hospital after midnight.  **Admission from Non-admitted Services**  Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall not be regarded as part of the admitted episode.  **Statistical Admissions**  Statistical admissions must have an Admission Date equalling the previous episode’s Separation Date. Statistical separations and admissions cannot occur over midnight. |
| Validations | 026 Zero Sep; Existing Not Discharged  027 Adm Record; Overlaps Existing  028 Prior Adm; No Sep Date  035 Invalid Date of Birth  038 Invalid Adm Date  039 Invalid Adm Date; > Header  057 Incompat Adm Type/Age  062 Duplicate Pt ID, Adm Date Time, Diff. Unique  063 Prior Not Discharged  064 Duplicate Pt ID, Date Time  069 Newborn from Overseas  102 Sep Date < Adm Date  112 Calc Los + Leave Not = Adm/Sep  115 Adm Time Not< Sep Time  122 Sameday Adm Source/Sep Mode Mismatch  127 Nil Value DRG  160 AR-DRG Grouper GST Code> Zero  178 Trans Adm Not Same as Episode  186 Neonate MDC But Age > = 28 days  187 Adm Weight Too Low  188 Adm Weight Too High  189 Age < 1 Year but Adm Weight Missing  190 Adm Wt present but not aged < 1 Year  222 Unqual Newborn; Adm Date Not Birth  226 Adm Date Before Birth Date  227 Age Calculated As 120 Years & Over  240 Newborn Accom But Over 4 Months  245 Adm Wt >=9Kg But Age >=5 Mth  255 Rehab: Invalid Onset Date  261 Newborn Care Type but age >9 days  262 Invalid Care Type for Newborn  289 Adm Sc T’fer & Onset =Adm Date  290 Stat Adm Sc, & Onset = Adm Date  322 ICU/CCU Stay > Total Stay  323 MV Duration > Total Stay  353 Code & Age Incompatible  397 Sep Referral Postnatal, Incompat Age/Sex at birth  438 NIV Duration > Total Stay  447 Unqual Newborn; Age at Sep > 10 Days  461 ACAS Status not Required  465 Adm Duration < 15 Mins  467 Adm Wt <1000g, LOS <28 Days, Sep Mode ≠ T or D  468 Care Type ≠ 1 or F, LOS >365 Days  479 Incompat Adm Source/Age  480 Incompat Adm Source/Age <15  481 Incompat Adm Source/Age <55  486 Incompat Age/Crit for Adm  487 Incompat Age/Qual Stat  493 Incompat Sep Mode/Age <15  494 Incompat Sep Mode/Age <55  505 Stat Episode: Previous Episode > 1 Minute Apart  518 Medicare IRN = 0, Age > 6 Months  519 Medicare IRN = 0, Age > 12 Months  533 ACAS Status Code Required  549 Type B Crit for Adm, LOS >1  550 Type C Crit for Adm, LOS >1  551 Type C Crit for Adm, LOS >4 hrs  552 Type E Crit for Adm, LOS >1  553 Type E Crit for Adm, LOS <4 hrs  554 Date of Accident > Adm Date  596 Same Day ECT: Not in Care Type 4  598 Same Day Rehabilitation: Not in Scope  602 Newborn Accom but over 12 Months |
| Related items | Section 2: Age  Section 4: Length of Stay |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable calculation of length of stay and age |
| Principal data users | Multiple internal and external data users. |
| Collection start | 1979-80 |
| Definition source | NHDD |

## Admission Source

### Specification

|  |  |
| --- | --- |
| Definition | Describes where the patient was residing/living prior to admission |
| Field size | 1 |
| Layout | A |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Select the first appropriate category:  Code Descriptor  K Posthumous Organ Procurement  S Statistical Admission (change in Care Type within the hospital)  Y Birth episode  T Transfer from acute hospital / extended care / rehabilitation / geriatric centre  B Transfer from Transition Care bed-based program  A Transfer from mental health residential facility  N Transfer from residential aged care facility  H Admission from private residence/accommodation  Q Emergency use |
| Reporting guide | **K Posthumous Organ Procurement**  Assign this code for posthumous organ procurement episodes (Care Type 10)  **S Statistical Admission (change in Care Type within this hospital)**  Assign this code when a new episode of care has commenced within the same hospital stay on the same hospital campus.  Excludes:  Patients who die in hospital and a new episode is created for organ procurement (use code K)  Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns are recorded in Status Segments using the Qualification Status field. Refer to Section 4: Newborn.  Change between Rehabilitation Program/Units - Care Types (6, P).  **Y Birth episode**  Admission of newborn at or directly after birth.  Excludes second or subsequent admissions in the newborn period:  Newborns admitted after the birth episode, while still nine (9) days old or less (use code T or H). |

|  |  |
| --- | --- |
|  | **T Transfer from acute hospital / extended care / rehabilitation / geriatric centre**  Admission to this hospital, directly from another acute hospital, extended care, rehabilitation, or geriatric centre, regardless of whether the patient was admitted or not at the transferring hospital. RequiresTransfer Source.  Includes:  Public and private acute, extended care and mental health admitted patient units.  Excludes:   * Transition Care bed-based program (use code B) * Residential aged care facility (use code N) * Mental health residential facility (use code A).   **B Transfer from Transition Care bed-based program**  Admission to hospital directly from a Transition Care bed-based program.  Excludes:   * Home-based Transition Care   **A Transfer from mental health residential facility**  Transfer from mental health residential facility (includes Psychogeriatric nursing homes, community care units and prevention and recovery care (PARC) units) funded by Mental Health Services.  Includes:   * Mental health aged care residential facility.   Excludes:   * Mental health admitted patient units (use code T).   **N Transfer from residential aged care facility**  Includes:  Any of the following terms: nursing home, hostel, high care and low care  Only those facilities that are in receipt of subsidies from the Commonwealth Government under the *Aged Care Act 1997* and provide accommodation and supported care (ranging from help with daily tasks and personal care to 24-hour nursing care) to eligible people.  Excludes:   * Transition Care bed-based program (use code B) * Mental health aged care residential facility (use code A).   **H Private Residence/Accommodation**  Place of residence immediately prior to admission.  Includes:   * Home or home of relative or friend * Supported residential facilities. * Special accommodation houses * Training centres for intellectually disabled persons * Prison * Forensic hospital (Thomas Embling) * Juvenile detention centre * Armed forces base camp/hospital * Homeless (shelters, halfway houses)   Excludes:   * Transition Care bed-based program (use code B) * Residential aged care facility (use code N) * Mental health residential facility (use code A)   **Q Emergency use**  Only to be used under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
|  |
| Validations | 041 Invalid Adm Source  051 Transfer Source Blank  056 Incompatible Adm Type/Source  122 Same day Adm Source/Sep Mode Mismatch  289 Adm Sc T’fer & Onset = Adm Date  290 Stat Adm Sc & Onset Date = Adm Date  328 Early Parenting Centre – Invalid Comb  423 Invalid Comb Fund/Contract/Transfer  479 Incompat Adm Source/Age  480 Incompat Adm Source/Age <15  481 Incompat Adm Source/Age <55  482 Incompat Adm Source/Crit for Adm  483 Incompat Adm Source/Qual Stat  488 Incompat Care Type/Adm Source Statistical  491 Incompat Fields for ESAS  499 Stat Admission: No Prev Episode  501 Stat Episode: Adm Source ≠ Sep Mode Prev Episode  503 Stat Episode: Care Type same as Prior Episode  505 Stat Episode: Previous Episode > 1 Minute Apart  626 Invalid Combination for Funding Arrangement PHESI  629 Incompatible Adm Source/Indigenous Status |
| Related items | Section 4: Transfer reporting, Validation tables relating to Admission Source |

### Administration

|  |  |
| --- | --- |
| Purpose | To analyse patient movement |
| Principal data users | Multiple internal and external data users. |
| Collection start | 1979-80 |
| Definition source | NHDD |
| Code set source | Department of Health |

## Admission Time

### Specification

|  |  |
| --- | --- |
| Definition | Time at which an admitted patient commences an episode of care |
| Field size | 4 |
| Layout | HHMM |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care. |
| Reported when | The Episode Record is reported. |
| Reporting guide | A valid 24-hour time (0000 to 2359)  For a **formal admission**, the Admission Time is the actual time at which patient was admitted (at the admission desk), the time of birth, or the time the patient leaves the clinical area of the Emergency Department (see below).  For a **statistical admission** (Care Type change), a dummy Admission Time is acceptable to enable the times to be automatically recorded. Care Type changes could be recorded as occurring at midday. The Admission Time must be one minute later than the Separation Time of the preceding episode (for example, if Separation Time of the earlier episode was made to be 1200, Admission Time of the new episode would be 1201).  **Posthumous organ procurement**  For episodes for posthumous organ procurement (Care Type 10), report Admission Time as after the donor’s certified time of death.  **Newborns**   * For newborns born in this hospital, the Admission Time is the time of birth. * For newborns born before arrival or transferred to this hospital from another, the Admission Time is time of arrival at this hospital.   **Admission from Non-admitted Services**  Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall not be regarded as part of the admitted episode. For example, when a patient is admitted from the Emergency Department or outpatient clinic, then the Admission Time is the time the patient physically leaves the clinical area of the Emergency Department or outpatient clinic for immediate transfer to a ward or operating theatre/procedure room at the same hospital.  **Note**  Admission Time must not be prior to the time the patient leaves the non-admitted service. |
| Validations | 027 Adm Record; Overlaps Existing  040 Invalid Adm Time  062 Duplicate Pt ID, Adm Date Time, Diff Unique  064 Duplicate Pt ID, Date Time  115 Adm Time not < Sep Time  322 ICU/CCU Stay > Total Stay  323 MV Duration > Total Stay  438 NIV Duration >Total Stay  465 Adm Duration < 15 Mins  505 Stat Episode: Previous Episode > 1 Minute Apart  551 Type C Crit for Adm, LOS >4 hrs  553 Type E Crit for Adm, LOS <4 hrs |
| Related items | Section 3: Admission Date |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable the exact Length of Stay to be determined. |
| Principal data users | Multiple internal and external data users. |
| Collection start | 1990-91 |
| Definition source | NHDD |

## Admission Type

### Specification

|  |  |
| --- | --- |
| Definition | The category of admission (patient characteristic) relating to this episode of care. |
| Field size | 1 |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private). |
| Reported for | All admitted episodes of care. |
| Reported when | The Episode Record is reported. |
| Code set | Code Descriptor  K Posthumous Organ Procurement  S Statistical admission (change in Care Type within this hospital)  Y Birth episode  M Maternity  C Emergency admission through Emergency Department at this campus  O Other emergency admission  P Elective admission |
| Reporting guide | **K Posthumous Organ Procurement**  Assign this code for posthumous organ procurement episodes (Care Type 10)  **S Statistical admission (change in Care Type within this campus)**  Used for statistical admissions.  Excludes:  Patients who die in hospital and a new episode is then created for posthumous organ procurement (use code K).  **Y Birth episode**  Admission of newborn at or directly after birth.  Includes:   * Birth in Emergency Department * Birth on way to hospital   Excludes:   * Second or subsequent admissions in the newborn period. Newborns admitted after the birth episode, while still nine (9) days old or less (use code C, O or P).   **M Maternity**  Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy. |
|  | **C Emergency admission through Emergency Department at this campus**  Admission of an emergency patient, arising from presentation at the Emergency Department or Urgent Care Centre at this campus.  Includes:  **Threatened miscarriage before 20 weeks.**  Excludes:   * Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M). * Birth in Emergency Department * Birth on way to hospital   Note: An emergency admission is for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.  **O Other emergency admission**  Admission of an emergency patient, not arising from presentation at the Emergency Department or Urgent Care Centre at this campus.  Includes:   * GP‑referred admission or self-referral for acute illness (such as unstable diabetes, CCF, pneumonia, asthma attack) directly for emergency admission. * Threatened miscarriage before 20 weeks. * Crisis Assessment and Treatment Team (CATT) referred admission * Emergency transfer from another campus * Admission from Outpatient Department where patient is an emergency patient.   Excludes:   * Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M). * Admission via the emergency department at this campus (use C). * A person who is ‘dead on arrival’ who then proceeds to a posthumous organ procurement episode (report only the Posthumous Organ Procurement episode (use code K)   **P Elective admission**  Routine or elective admission for medical or surgical treatment.  Includes:   * Admission from a hospital waiting list. * Planned admission for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy. * Planned transfer from another campus * Admission from Outpatient Department where patient is an elective patient. * Follow‑up admission following a previous emergency admission or presentation.   Excludes:   * Admission of a pregnant female of 20 or more weeks' gestation, or a female within 42 days of her having given birth, for a condition primarily related to her current or recent pregnancy (use M).   Note: An elective admission is for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours |
| Validations | 052 Invalid Adm Type  056 Incompatible Adm Type/Source  057 Incompat Adm Type/Age  059 Maternity - Not Female  455 Inconsist Newborn Transferred/Unqual Data  484 Incompat Adm Type/Crit for Adm  485 Incompat Adm Type/Qual Stat  491 Incompat Fields for ESAS  626 Invalid Combination for Funding Arrangement PHESI  633 Delivery Episode, Adm Type not M |
| Related items | Section 2: Admission, Newborn.  Section 4: Newborn Reporting, Admission Source and Admission Type; Admission Type and Age; Admission Type and Criterion For Admission; Admission Type and Qualification Status; Care Type: Organ Procurement – posthumous (10). |

### Administration

|  |  |
| --- | --- |
| Purpose | To:   * Distinguish between emergency and non-emergency admissions. * Identify data for maternity and birth episodes. * Identify episodes for posthumous organ procurement. |
| Principal data users | Department of Health |
| Collection start | 1979-80 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Admitting Unit/Specialty (a)

## Discharging Unit/Specialty (b)

### Specification

|  |  |
| --- | --- |
| Definition | (a) Unit/Specialty patient is admitted under  (b) Unit/Specialty at separation |
| Layout | AAAA or AAAspace | |
| Location | Episode Record | |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | (a) The Episode Record is reported  (b) A Separation Date is reported in the Episode Record |
| Code set | Code Descriptor  ADDU Alcohol & Drug Dependency  ANAE Anaesthetic  BIRT Birthing Unit  CARS Cardiac Surgical  CART Cardio Thoracic Surgical  CARD Cardiology  CCU Coronary Care Unit  DENT Dental/Oral  DERM Dermatology  ENT Ear Nose and Throat  EMED Emergency Medicine  ENDO Endocrinology and Diabetes  ENDS Endoscopy  EPCS Early Parenting Centre Services  GAST Gastroenterology  GENM General Medical  GENO General Medical/Surgical  GENS General Surgical  GERI Geriatric  GYNA Gynaecology Medical  GYNC Gynaecology Medical/Surgical  GYNO Gynaecology Oncology  GYNS Gynaecology Surgical  HAEM Haematology  HITH Hospital in the Home  HYPE Hyperbaric  IMMU Immunology  INFE Infectious Diseases  ICU Intensive Care  MAXI Maxillofacial  NEON Neonatology  NEUR Neurology  NSUR Neurosurgery  OBSG Obstetric/Gynaecology  OBST Obstetric/Maternity  ONCM Oncology - Medical  ONCR Oncology - Radiation  ONCS Oncology - Surgical  OPHT Ophthalmology  ORTH Orthopaedic  PECS Paediatric - Cardiac Surgical  PECA Paediatric - Cardiology  PECY Paediatric - Cystic Fibrosis  PEDE Paediatric - Dental/Oral  PEDR Paediatric - Dermatology  PEDV Paediatric - Developmental  PEEN Paediatric - Ear Nose and Throat  PEED Paediatric - Endocrinology/Diabetics  PEGA Paediatric - Gastroenterology  PEGE Paediatric - General  PELT Paediatric - Liver Transplant  PEMA Paediatric - Maxillofacial  PENE Paediatric - Nephrology  PENL Paediatric - Neurology  PENS Paediatric - Neurosurgery  PEON Paediatric - Oncology  PEOP Paediatric - Ophthalmology  PEOR Paediatric - Orthopaedic  PEPL Paediatric - Plastic/Reconstructive Surgery/Burns  PERE Paediatric - Respiratory Medicine  PERH Paediatric - Rheumatology  PESP Paediatric - Spinal  PESU Paediatric - Surgery  PEUR Paediatric - Urology  PALL Palliative - Designated Unit  PALG Palliative - General  PAIN Persistent Pain  PLAS Plastic/Reconstructive Surgery/Burns  PYYA Psychiatric Adolescent Acute Unit  PYYW Psychiatric Adolescent Acute Unit in Adult Ward  PYAA Psychiatric Adult Acute Unit  PYAQ Psychiatric Adult Extended - Acquired Brain Damage Unit  PYDD Psychiatric Adult Extended - Dual Diagnosis Unit  PYSH Psychiatric Adult Extended - High Security Unit  PYPG Psychiatric Adult Extended - Older Persons Unit  PYSM Psychiatric Adult Extended - Secure Unit  PYET Psychiatric Adult Extended - Treatment Rehab Unit  PYRA Psychiatric Adult Residential  PYAW Psychiatric Adult Special Care Suite  PYCA Psychiatric Child Acute Unit  PYCW Psychiatric Child Acute Unit in Paediatric Ward  PYFA Psychiatric Forensic Acute  PYGE Psychiatric Older Persons - Acute  PYOA Psychiatric Young Persons (Youth) Acute Unit  RADI Radiology  REHD Rehabilitation - Designated Unit  REHG Rehabilitation - General  REHA Rehabilitation - Geriatric  RENA Renal/Nephrology  RESP Respite  RHEU Rheumatology  SLEP Sleep Centre  SPIN Spinal Injuries  STRO Stroke Unit  THOS Thoracic Surgery  THOR Thoracic/Respiratory Medical  TRAB Transplantation Unit - Bone  TRAM Transplantation Unit - Bone Marrow  TRAH Transplantation Unit - Heart/Lung  TRAL Transplantation Unit - Liver  TRAP Transplantation Unit - Pancreas  TRAR Transplantation Unit - Renal  UROL Urology  VASC Vascular |
| Reporting guide | Report the most appropriate category that best reflects the hospital unit’s activity. There is no requirement for hospitals to further split their own units to match the standard unit codes. Hospitals without separate specialty units should report the most appropriate general medical or surgical code.  Stroke Unit care is organised care within a specific ward in a hospital provided by a multidisciplinary team who specialise in stroke management (*National Acute Stroke Services Framework 2019*).  Early Parenting Centres must use code EPCS. |
| Validations | 715 Invalid Admitting Unit/Specialty  716 Invalid Discharging Unit/Specialty  749 Invalid Admitting Unit/Specialty campus not approved EPC  750 Invalid Discharge Unit/Specialty campus not approved EPC |

### Administration

|  |  |
| --- | --- |
| Purpose | To monitor quality and safety |
| Principal data users | Victorian Agency for Health Information (VAHI) |
| Collection start | 1 July 2018 |
| Definition source | VAHI |
| Code set source | VAHI |

## Admission Weight

### Specification

|  |  |
| --- | --- |
| Definition | The birth weight of the live baby or the weight of the neonate or infant (under one year of age) on the date admitted, if this is different from the date of birth |
| Field size | 4 |
| Layout | NNNN or spaces  Right justify, leading zeros |
| Location | Diagnosis Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted patients under 1 year of age |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Valid weight in grams, 100-9999.  If Admission Weight is not required, report spaces, not zeros. |
| Reporting guide | Admission Weight is required for all infants under 1 year of age at admission (that is, admitted on a date earlier than the infant’s first birthday).  Where admission is on the day of birth, the birth weight is the Admission Weight.  If Admission Weight is unknown or heavier than 9999, and the patient is aged greater than 27 days, use 9999. If the patient is less than 28 days, estimate the weight. |
| Validations | 187 Adm Weight Too Low  188 Adm Weight Too High  189 Age < 1 Year but Adm Weight Missing  190 Adm Wt Present but Not Aged < 1 Year  245 Adm Wt >= 9kg But Age <= 5 Mth  411 Adm Wt < 1000g, no Matching Dx Code  412 Adm Wt is 1000‑2499g, no Matching Dx Code  413 Adm Wt > 6000g, No Matching Dx Code  467 Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D  534 Invalid Adm Weight |
| Related items | Section 3: Admission Date and Date of Birth |

### Administration

|  |  |
| --- | --- |
| Purpose | To monitor the weight of patients <1 year of age. Weight is a major risk factor for neonatal morbidity and mortality; and is required to analyse perinatal services for high-risk infants.  To enable accurate grouping in DRG systems. |
| Principal data users | Department of Health |
| Collection start | 1993-94 |
| Definition source | Department of Health |

## Advance Care Directive Alert

### Specification

|  |  |
| --- | --- |
| Definition | An alert, flag or similar is obvious to any treating team across the health service that indicates: an advance care directive is on file, and/or; medical treatment decision maker has been recorded |
| Field size | 1 |
| Location | Extra Episode Record |
| Reported by | Public hospitals |
| Reported for | All admitted episodes except Care Types 10 and U |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | 1 No advance care directive alert  2 Presence of an advance care directive alert  3 Presence of a medical treatment decision maker alert  4 Presence of both an advance care directive alert and a medical treatment decision maker alert |
| Reporting guide | An advance care directive alert will be identified by any of the following:   * A completed Refusal of Treatment Certificate completed prior to 12 March 2018 * An advance care directive * Other advance care planning documentation (documentation of a person’s future wishes such as a written letter, use of varying forms, or advance care planning discussion record) * Advance Statement of Preferences under the Mental Health and Wellbeing Act (Vic) 2022   A medical treatment decision maker alert will be identified by:   * Medical treatment decision maker appointment * Guardian appointed by VCAT with powers to consent to medical treatment * Identification of the medical treatment decision maker as per the ‘medical treatment decision maker hierarchy’ * Enduring power of attorney (medical treatment) appointed prior to 12 March 2018   Refer to [advance care planning](https://www.health.vic.gov.au/patient-care/advance-care-planning-1) <https://www.health.vic.gov.au/patient-care/advance-care-planning-1> |
| Validations | 707 Invalid Advance Care Directive Alert |

### Administration

|  |  |
| --- | --- |
| Purpose | To provide data on advance care planning that will quantify activity and enable benchmarking across the service system. |
| Principal data users | Department of Health |
| Collection start | 2015 |
| Definition source | Department of Health |

## Campus Code

### Specification

|  |  |
| --- | --- |
| Definition | Indicates the hospital campus where the episode of care was provided.  Patient activity must be reported under the campus code at which it occurred. |
| Field size | 4 |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care. |
| Reported when | The Episode Record is reported. |
| Code set | Campus code table available on the HDSS website at: [HDSS reference files](https://www.health.vic.gov.au/data-reporting/reference-files) <https://www.health.vic.gov.au/data-reporting/reference-files> |
| Reporting guide | Report patient activity under the campus code at which it occurred. |
| Validations | 330 Invalid Campus Code  420 Contract/Spoke = Campus Code  472 Pall Care, not approved for Palliative Care Program  473 Care Type 9, not approved for GEM  478 Funding Arrangement 6, not approved for ESAS  520 Accom Type 7, not approved for Medi-hotel  521 Accom Type M, no registered MAPU  522 Accom Type S, no registered ED SSU  523 CCU Hrs, no Approved CCU  526 ICU Hrs, not approved ICU or NICU  630 Contract/Spoke Identifier cannot be reported for this campus  628 Cannot report for this campus  631 Care Type P not approved for Paediatric Rehabilitation  651 Program Identifier, campus not approved for program  728 Accom Type K, no approved PICU  729 Accom Type U, no approved ICU  730 Accom Type N, no approved NICU  731 Accom Type A, no approved SCN |
| Related items | Section 2: Campus, and Hospital |

### Administration

|  |  |
| --- | --- |
| Purpose | To identify the specific campus of a hospital providing this episode of care, for use in policy and planning development. |
| Principal data users | Department of Health |
| Collection start | 1998-99 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Care Plan Documented Date

### Specification

|  |  |
| --- | --- |
| Definition | The date of documentation that either a multidisciplinary care plan or an interdisciplinary care plan was first agreed. |
| Field size | 8 |
| Layout | DDMMYYYY |
| Location | Diagnosis Record |
| Reported by | Public hospitals. Private hospitals, report spaces |
| Reported for | Care Types 6, P, 8, 9 and MC with Separation Date 7 days or more after Admission Date.  For Care Types 6, P, 8, 9 and MC with Separation Date less than 7 days after Admission Date, report spaces.  For Care Types 1, 4, 5x, 0, U or 10, report spaces. |
| Reported when | A Separation Date is reported in the Episode Record |
| Reporting guide | Care Plan Documented Date should be within the first 7 days of the sub-acute episode.  Where a Care Plan was documented prior to the start of this Episode (for example where this episode is a statistical change from a previous Care Type) and another has not been completed within 7 days of the Admission Date of the current episode, report the Care Plan Documented Date as being the Date of Admission for this episode.  Where a Care Plan is not documented during a stay that exceeds 7 days in duration, report spaces in this field.  Where a Care Plan is documented in this stay, but this is not done in the first 7 days after the Admission Date, report the date on which the Care Plan was documented.  Where a Care Plan is documented in the first 7 days of stay, but it is not a multidisciplinary or interdisciplinary Care Plan, report spaces in this field.  The first 7 days of stay is interpreted as the day of admission and the next 6 days; if the patient goes on leave in that period, the count of days for the purposes of Care Plan Documented Date does not stop. |
| ****Validations**** | 668 Care Plan Doc Date reported but Care Type not sub-acute  669 Care Plan Doc Date reported > 7 days after Adm Date  670 Care Type Sub-acute, Separated, Care Plan Doc Date is null  671 Care Plan Doc Date < Adm Date or > Sep Date  672 Invalid Care Plan Documented Date |
| ****Related items**** | Section 2: Care Plans, Section 3: Care Type |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable reporting against the Timeliness of Care Key Performance Indicator required under the National Partnerships Agreement Subacute Care Performance Indicators. |
| Principal data users | Multiple internal and external data users. |
| Collection start | 2012 |
| Definition source | Department of Health |

## Care Type

### Specification

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | | The nature of the clinical service provided to an admitted patient during an episode of care | |
| Field size | | 2 | |
| Layout | | AA, NN, NA Left justified, trailing spaces | |
| Location | | Episode Record | |
| Reported by | | All Victorian hospitals (public and private) | |
| Reported for | | All admitted episodes of care | |
| Reported when | | The Episode Record is reported | |
| Code set | | Select the first appropriate category:  Code Descriptor  10 Posthumous Organ Procurement  1 NHT/Non Acute  P Designated Paediatric Rehabilitation Program/Unit  6 Designated Rehabilitation Program/Unit  8 Palliative Care Program  5x Mental Health Service:  5T – Mental Health Nursing Home Type  5E – Mental Health Secure Extended Care Unit (SECU)  5K – Acute, Child and Adolescent Mental Health (CAMHS)  5G – Acute, Aged Persons Mental Health (APMH)  5S – Acute, Specialist Mental Health  5A – Acute, Adult Mental Health  9 Geriatric Evaluation and Management Program  MC Maintenance Care  0 Alcohol and Drug Program  4 Other care (Acute) including Qualified newborn  U Unqualified newborn | |
| Reporting guide | | Care Type reported should reflect the treatment the patient receives, not the location of the bed in the facility.  **10 Posthumous Organ Procurement**  Reportable by public hospitals only  Posthumous Organ Procurement is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.  Episodes in which posthumous organ procurement is conducted are registered by the hospital, and reported to the VAED, although they are not admitted episodes. Diagnosis and procedure codes for activity to facilitate posthumous organ procurement, including mechanical ventilation and tissue procurement, are recorded in accordance with the relevant ICD-10-AM Australian Coding Standards.  **1 NHT/Non Acute**  This Care Type occurs after an admitted patient has been designated NHT or Non-Acute: NHT  After 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner provides certification documented in the medical record that the patient is in need of acute care.  Non-Acute  The patient has been in one or more hospitals (public and private) for a continuous period of more than 35 days (with a maximum break of seven consecutive days). If this patient had not been a compensable/ineligible patient, they would be deemed to be a Non-Acute patient.  Such a patient may or may not have been assessed by an Aged Care Assessment Team and may or may not have an approved Aged Care Client Record (ACCR) (formerly ‘2624 certificate’).  Excludes:  Mental Health Nursing Home Type (5T)  **P Designated Paediatric Rehabilitation Program/Unit**  A patient who is admitted to, or transferred to, a designated Paediatric Rehabilitation Program/Unit. Use code P only if the public hospital’s Health Service Agreement and/or Statement of Priorities specifies that the hospital has such a designated unit.  Private hospitals: Do not use code P.  **6 Designated Rehabilitation Program/Unit**  A patient who is admitted to, or transferred to, a designated Rehabilitation Program/Unit. Use code 6 only if the public hospital’s Health Service Agreement and/or Statement of Priorities specifies that the hospital has such a designated unit.  Private hospitals: Use code 6 only if registered under the Health Services Act 1988 to provide this category of care.  **8 Palliative Care Program**  Applies to a patient who is admitted or transferred to a designated Palliative Care Program/Unit.  Private hospitals: If the hospital operates a similar program and wishes to identify episodes of care using code 8, they may. | |
|  | | **5x Mental Health Service**  A patient who is admitted or transferred to, a mental health service, where the care received is principally mental health.  Public hospitals: Use code 5x only if your service is a designated mental health service as defined by the *Mental Health Act 2014 (Vic)*  Private hospitals: Use code 5x only if registered under the Health Services Act 1988 to provide this category of care.  Excludes:  Patient admitted to PAPU unit where the care received is predominantly general medical (Refer to 2017 PAPU-ED guidelines)  **5T Mental Health Nursing Home Type**  This Care Type occurs after an admitted patient has been designated NHT or Non‑Acute:  NHT  Defined in section 3 of Commonwealth Health Insurance Act: after 35 days continuous hospitalisation (with a maximum break of seven consecutive days), the patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care.  Such a patient may or may not have been assessed by an Aged Psychiatric Assessment and Treatment Team (APATT) or an Aged Care Assessment Service (ACAS) and may or may not have an approved Aged Care Client Record (ACCC) (formerly 2624 certificate).  Excludes:  NHT/Non-Acute (1)  **5E Mental Health Secure Extended Care Unit (SECU)**  This Care Type occurs when a patient is admitted to a unit designed to accommodate persons who require active clinical mental health care in the secure/safe environment of a locked ward, often with the intention of longer term (extended) care.  Excludes:   * Mental Health Nursing Home Type (5T) * Community Care Units (CCU) including Vahland CCU * Aged Person’s Mental Health Nursing Homes (APMHNH) * Psychogeriatric Nursing Homes (PGNH)   **5K Acute, Child and Adolescent Mental Health (CAMHS)**  Where the therapeutic service received is acute child and adolescent mental health  Includes:  CAMHS unit admission  **5G Acute, Aged Persons Mental Health (APMH)**  Where the therapeutic service received is acute aged mental health  Includes:  APMH unit admission  Excludes:   * Aged Person’s Mental Health Nursing Home (APMHNH) * Psychogeriatric Nursing Home (PGNH)   **5S Acute, Specialist Mental Health**  A patient who is admitted to a Specialist Mental Health Service  Includes:   * Brain Disorder Unit * Eating Disorders Unit * Forensic Unit * Mother and Baby Unit (mother) * Neurological Unit   Excludes:   * Child and Adolescent Mental Health Service (5K) * Baby less than 10 days old with mother in Mother and Baby Unit (U) * Baby 10 days or older with mother in Mother and Baby Unit   **5A Acute, Adult Mental Health**  Where the therapeutic service received is adult acute mental health  Includes:  Acute adult mental health unit admission  Excludes:   * Community Care Units (Residential) * Mental Health Nursing Home Type (5T)   **MC Maintenance Care**  A patient who is admitted for Maintenance Care. Aims of maintenance care include:   * to prevent deterioration in the function and health status of a patient who is assessed as not requiring acute or subacute care * to provide a person-centred approach to care evidenced by an individualised assessment and case management plan * to provide a time limited and low-level therapy program developed by an allied health professional that promotes patient's independence and case management to determine long term care planning.   Use only if the health service provides Maintenance Care.  **9 Geriatric Evaluation and Management Program**  A patient who is admitted to, or transferred, to a Geriatric Evaluation and Management Program. Use code 9 only if the public hospital’s Health Service Agreement and/or Statement of Priorities specify that the hospital has a Geriatric Evaluation and Management Program. This program excludes Nursing Home Type/Non-Acute patients.  Private hospitals: If the hospital operates a similar program and wishes to identify episodes of care using code 9, they may  **0 Alcohol and Drug Program**  A patient who is admitted to an Alcohol and Drug Program. Use code 0 only if the patient receives treatment by a specialist physician for an alcohol or drug related condition that is the principal diagnosis. Report this Care Type on admission but not for a change of Care Type following another episode of care.  Private hospitals: Use if the hospital operates a similar program and wishes to identify episodes of care as such.  **4 Other (Acute) Care including Qualified newborn**  Other types of patient:  Includes:   * Same day and acute (except mental health) * Same day ECT episodes * Acute episodes in which an ECT has been performed but the care is not principally mental health * Person presenting with urgent mental health, alcohol and drug issues admitted to Mental Health and AOD Hub Short Stay Unit * Newborn who has been a Qualified newborn for some or all the duration of this episode   Excludes:   * Patients admitted to designated units and programs covered by other Care Types * Newborn who has been an Unqualified newborn for the entire duration of this stay (U)   **U Unqualified newborn**  A newborn who has been an Unqualified newborn for the entire duration of this episode.  Includes:  Baby less than 10 days old with mother in Mother and Baby Unit (U)  Excludes:  A newborn who has had any period as a Qualified newborn during this episode (4) |
| Validations | 107 Invalid Care Type  222 Unqual Newborn; Adm Date Not Birth  250 Deleted – Episode is Sub-Acute  253 Rehab: Invalid Impairment  255 Rehab: Invalid Onset Date  258 Sub- Acute: No Sub – Acute Record  260 Invalid Care for Qual  261 Newborn Care but Age > 9 Days  262 Invalid Care Type for Newborn  285 Sub-Acute Record not required  289 Adm Sce T’fer & Onset = Adm Date  290 Stat Adm Sc & Onset = Adm Date  293 Impairment Present  294 Onset Date Present  297 Sep Rug ADL & Sep Mode Incompatible  390 Incompat Care Type, Carer Avail and Sep Mode  406 Rehab Care Type W/Out Rehab Diag  437 NIV Duration for Unqual Newborn  447 Unqual Newborn; Age at Sep  448 ICU Stay but Care Type not Acute  455 Inconsist Newborn Transferred/Unqual Data  461 ACAS Status not Required  464 Accom Type 7, not Care Type 4  468 Not NHT, LOS >365 Days  471 Care Type 5x, not usual Sep Referral  472 Pall Care, not approved for Palliative Care Program  473 Care Type 9, not approved for GEM  488 Incompat Care Type/Adm Source Statistical  489 Incompat Care Type/Sep Mode Statistical  491 Incompat Fields for ESAS  498 Pall Care without Pall care Diag  503 Stat Episode: Care Type same as Prior Episode  532 Account Class MA: not 4, 5E, 5K, 5G, 5S, 5A or U  533 ACAS Status Code Required  535 Care Type 5E, not approved for SECU  536 Care Type 5T, not approved for NHT  537 Care Type 5K, not approved for CAMHS  538 Care Type 5G, not approved for Aged Acute  539 Care Type 5S, not approved for Specialist Acute  540 Care Type 5A, not approved for Adult Acute  575 Care Type 5x, MHSWPI Blank  587 Care Type 6, not approved for Rehab  596 Same Day ECT: Not in Care Type 4  597 Mental Health Episode: Sep Mode = S  598 Same Day Rehabilitation: Not in Scope  599 Carer Availability Not Required  626 Invalid Combination for Funding Arrangement PHESI  631 Care Type P, not approved for Paediatric Rehabilitation  660 Care Type not equal to 5x, Procedure Code 14224-xx MHSWPI mismatch  667 Incompat Care Type/Crit for Adm  709 NHT Account Class / Care Type mismatch  710 Care Type MC, not approved for Maintenance care  720 Accom Type H, Care Type not 4 | |
| Related items | Section 2:  Acute Care, Care, Geriatric Evaluation and Management Program, Mother and Baby Mental Health Units, Nursing Home Type/Non-Acute Care, Palliative Care, Posthumous Organ Procurement, Maintenance Care, Rehabilitation Care and Subacute Care.  Section 4: Episode of Care, Newborn Reporting, Validation tables | |

### Administration

|  |  |
| --- | --- |
| Purpose | To distinguish various types of care to:  apply the appropriate funding formula to the episode  group episodes to facilitate analysis |
| Principal data users | Department of Health |
| Collection start | 1995-96 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Carer Availability

### Specification

|  |  |
| --- | --- |
| Definition | A record of whether a person, such as a family member, friend or neighbour has been identified as providing regular on-going care or assistance, not linked to a formal service |
| Field size | 1 |
| Location | Episode Record |
| Reported by | Public hospitals  Private hospitals: Report a space in this field |
| Reported for | Admitted episodes with a Care Type of 1, P, 6, 8, 9 or MC and Separation Mode is H Separation to private residence/accommodation  For all other Care Types and Separation Modes, report a space in this field. |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Code Descriptor  1 Carer not needed/not applicable  2 Lives alone, has a carer  3 Lives alone, has no carer  4 Lives with another, has no carer  5 Lives with another, has a resident carer  6 Lives with another, has a non-resident carer  7 Lives in a mutually dependent situation  8 Missing or not recorded |
| Reporting guide | Availability infers carer willingness and ability to undertake the caring role and can apply when there are several carers. Where a potential carer is not prepared to undertake the role, or when their capacity to carry out necessary tasks is minimal, then the patient must be reported as not having an *informal* carer (report code 3 or 4).  Where there are several carers, a decision should be taken as to which of these is the main or primary carer and report accordingly.  Excludes:  Formal services such as meals on wheels, personal support or household support provided by local council  **1 Carer not needed/not applicable**  Person able to self-care and/or their therapeutic regime does not require the input of an informal carer.  Includes:   * Those circumstances where it may be inappropriate for a carer at home to undertake a complex medical procedure requiring a high level of nursing skill. * Person who is discharged to supported accommodation or other care facility that will provide the formal care required.   Excludes:  Circumstances where a relative or friend is available but is unwilling or unable to undertake a carer role (report 3 or 4).  **2 Lives alone, has a carer**  Person lives alone and has an informal carer who is able and willing to attend to the person’s recuperative needs on an ongoing basis.  **3 Lives alone, has no carer**  Person lives alone and does not have an informal carer willing and/or able to visit for the purpose of assisting with care on an arranged and regular basis.  **4 Lives with another, has no carer**  Person does not live alone but the co-resident/s is/are unable or unwilling to provide the care needed and there is no other external informal carer available.  **5 Lives with another, has a resident carer**  Household where the person lives with another who is willing and able to provide the care required for recuperation.  Excludes:  Person whose potential co-resident carer is mutually dependent (7).  **6 Lives with another, has a non-resident carer**  Person does not live alone but the co-resident/s is/are unable and/or unwilling to provide the care needed, but there is an external informal carer who is willing and able to provide this care.  **7 Lives in a mutually dependent situation**  Households where the service recipient and another person are mutually dependent. The critical aspect of such households is that if either member becomes unavailable for any reason, the other is either at high risk or unable to remain at home.  **8 Missing or not recorded**  Insufficient information to determine Carer Availability |
| Validations | 390 Incompat Care Type, Carer Avail and Sep Mode  591 Invalid Carer Availability  599 Carer Availability Not Required |
| Related items | Section 3 Separation Mode |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable monitoring of the impact of Carer Availability on separation timing and use of ambulatory services, to support policy development and planning |
| Principal data users | Department of Health |
| Collection start | 1999-00 |
| Definition source | NHDD |
| Code set source | NHDD (DH modified) |

## Clinical group

### Specification

|  |  |
| --- | --- |
| Definition | A free text field that hospitals can use to record a clinical or discharge unit or clinician to allow sub-hospital analysis of dr foster ® performance indicators |
| Field size | 12 |
| Layout | Characters or spaces |
| Location | Extra Episode Record |
| Reported by | Public hospitals |
| Reported for | All admitted episodes of care (optional) |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Free text field |
| Reporting guide | None |
| Validations | Not applicable |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate sub-hospital analysis of dr foster ® performance indicators |
| Principal data users | Health Services |
| Collection start | 2015 |
| Definition source | Department of Health |

## Clinically Ready for Discharge Date

### Specification

|  |  |
| --- | --- |
| Definition | Date on which the medical team responsible for the patient’s clinical care deems that the patient has no acute or subacute care needs requiring hospitalisation and is clinically ready to be discharged. |
| Field size | 8 |
| Layout | DDMMYYYY |
| Location | Extra Episode Record |
| Reported by | Public hospitals |
| Reported for | Multiday episodes for Care Type 1, 4, 5X, 6, 8, 9, P, and MC |
| Reported when | A Separation Date is reported in the Episode Record |
| Reporting guide | A Clinically Ready for Discharge Date should be reported where there is an administrative or non-clinical reason delaying discharge from hospital.  Clinical assessment of the Ready for Discharge date should be made by the primary consultant responsible for the patient’s care. The Ready for Discharge date may change during an episode of care due to a change in the patient’s health status or condition. Only the final Ready for Discharge date should be reported.  Examples of administrative arrangements delaying discharge:   * NDIS eligibility determination, plan approval, implementation of supports (including equipment/home modifications) and other disability services/accommodation * Equipment/home modifications (non-NDIS) * ACAS * Commonwealth Aged Care Service * Guardianship determination (VCAT/OPA) * Ambulatory or community service (non-NDIS) * Homelessness service/accommodation |
| Validations | 736 Clinically Ready for Discharge Date invalid  745 Clinically Ready for Discharge Date < Admission Date or ≥ Separation Date  746 Reason for Discharge Delay and Clinically Ready for Discharge Date mismatch  748 Clinically Ready for Discharge Date not required |
| Related items | Separation Date  NDIS Participant Flag  NDIS Participant Identifier  Reason for Discharge Delay |

### Administration

|  |  |
| --- | --- |
| Purpose | To collect information on exit block from health services to systematically monitor the situation, quantify the impact that this is having and where in the hospital system and the impact of any changes in the system or outside of it resulting from external policy and service changes. |
| Principal data users | Department of Health |
| Collection start | 1 July 2022 |
| Definition source | Department of Health |

## Contract Leave Days Financial Year-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of days during this episode of care that the patient was out of hospital on ‘contract leave’ in the financial year being reported (includes the month being reported). |
| Field size | 2 |
| Layout | NN or spaces Right justified, zero filled |
| Location | Episode Record |
| Reported by | Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchasers of contracted care).  All other sites, report spaces in this field. |
| Reported for | Episodes where:   * Funding Arrangement is 1 Contract and * Contract Type is 2 Contract Type ABA, 3 Contract Type AB, 5 Contract Type BA or 8 Contract Type BAB and * Contract Role A Hospital A.   Contract leave is not reported where a patient goes on contract leave and returns on the same day. |
| Reported when | during the patient’s stay and must be present when the Separation Date is reported in the Episode Record. |
| Code set | Number equal to or greater than month-to-date contract leave days.  The minimum valid number is 01. If there are no Contract Leave Days, report spaces, not zeros. |
| Reporting guide | Contacted Leave Days are included in Patient Days.  Contract Leave Days Financial Year-to-Date must be equal to or greater than Contracted Leave Days Month-to-Date and equal to or less than Contract Leave Days Total. |
| Validations | 278 Contract Lve YTD Not Num/Blank  282 Contract Lve YTD < MTD  284 Contract Lve Total < YTD  456 Contract Leave, No Contract |
| Related items | Section 3: Contract Leave Days Month-to-Date, Contract Leave Days Total  Section 4: Contracted Care, |

### Administration

|  |  |
| --- | --- |
| Purpose | To identify days (in this financial year to date) a patient was on contract leave from this hospital (not on leave with or without permission). |
| Principal data users | Department of Health |
| Collection start | 1996-97 |
| Definition source | Department of Health |

## Contract Leave Days Month-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of days during this episode of care that the patient was out of hospital on ‘contract leave’ in the month being reported (month‑to‑date). |
| Field size | 2 |
| Layout | NN or spaces Right justified, zero filled |
| Location | Episode Record |
| Reported by | Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchasers of contracted care).  All other sites, report spaces in this field. |
| Reported for | Episodes where:   * Funding Arrangement is 1 Contract and * Contract Type is 2 Contract Type ABA, 3 Contract Type AB, 5 Contract Type BA or 8 Contract Type BAB and * Contract Role A Hospital A.   Contract leave is not reported where a patient goes on contract leave and returns on the same day. |
| Reported when | This field can be reported during the patient’s stay and must be present when the Separation Date is reported in the Episode Record. |
| Code set | Number less than or equal to the number of month-to-date patient days.  The minimum valid number is 01. If there are no Contract Leave Days, report spaces, not zeros. |
| Reporting guide | Contacted Leave Days are included in Patient Days.  Contract Leave Days Month-to-Date must be equal to or less than Contracted Leave Days Financial Year-to-Date and Contract Leave Days Total. |
| Validations | 277 Contract Lve MTD Not num/blank  282 Contract Lve YTD < MTD  283 Contract Lve Total < MTD  456 Contract Leave, No Contract |
| Related items | Section 3: Contract Leave Days Total  Section 4: Contracted Care |

### Specification

|  |  |
| --- | --- |
| Purpose | To identify days (in this month to date) that a patient was on contract leave from this hospital (not on leave with or without permission). |
| Principal data users | Department of Health |
| Collection start | 1996-97 |
| Definition source | Department of Health |

## Contract Leave Days Total

### Specification

|  |  |
| --- | --- |
| Definition | The total number of days during this episode of care that the patient was out of hospital on ‘contract leave’, including days from the previous financial year(s) |
| Field size | 2 |
| Layout | NN or spaces Right justified, zero filled |
| Location | Episode Record |
| Reported by | Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchasers of contracted care).  All other sites, report a space in this field. |
| Reported for | Episodes where:   * Funding Arrangement is 1 Contract and * Contract Type is 2 Contract Type ABA, 3 Contract Type AB, 5 Contract Type BA or 8 Contract Type BAB and * Contract Role A Hospital A.   Contract leave is not reported where a patient goes on contract leave and returns on the same day. |
| Reported when | This field can be reported during the patient’s stay and must be present when the Separation Date is reported in the Episode Record. |
| Code set | Number equal to or greater than financial year-to-date contract leave days.  The minimum valid number is 01. If there are no Contract Leave Days, report spaces, not zeros. |
| Reporting guide | Contacted Leave Days are included in Patient Days.  Contract Leave Days Total must be equal to or greater than Contracted Leave Days Month-to-Date and Contract Leave Days Year-to-Date. |
| Validations | 279 Contract Lve Total Not num/Blank  283 Contract Lve Total < MTD  284 Contract Lve Total < YTD  456 Contract Leave, No Contract |
| Related items | Section 3: Contract Leave Days Month-to-Date  Section 4: Contracted Care |

### Administration

|  |  |
| --- | --- |
| Purpose | To identify the total days that a patient was on contract leave from this hospital (not on leave with or without permission). |
| Principal data users | Department of Health |
| Collection start | 1996-97 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Contract Role

### Specification

|  |  |
| --- | --- |
| Definition | Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital) |
| Field size | 1 |
| Layout | A or space |
| Location | Episode Record |
| Reported by | Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchases and providers of contracted care).  All other sites, report a space in this field. |
| Reported for | This item is mandatory if Funding Arrangement is 1 Contract.  If Funding Arrangement is not 1, report a space in this field. |
| Reported when | At any time during the episode |
| Code set | Code Descriptor  A Hospital A (purchasing hospital)  B Hospital B (service provider hospital) |
| Reporting guide | A Hospital A (purchasing hospital)  This hospital is the contracting (purchasing) hospital.  B Hospital B (service provider hospital)  This hospital is the contracted (service provider) hospital. |
| Validations | 408 Contract Role ‘A’ W/Out Proc Flag  409 Proc Flag W/Out Contract Role ‘A’  410 Illegal Comb Fund Arrange & Contract  418 Invalid Contract Role  423 Invalid Comb Fund Arrange, Contract/Transfer  456 Contract Leave, No Contract |
| Related items | Section 3: Contract Type, Contract/Spoke Identifier, Funding Arrangement  Section 4: Contracted Care |

### Administration

|  |  |
| --- | --- |
| Purpose | To identify the reporting hospital as purchaser or provider  To make a public hospital casemix payment to the contracting hospital  To avoid double counting the episode (epidemiological & planning purposes) |
| Principal data users | Multiple internal and external data users. |
| Collection start | 1999-00 |
| Definition source | NHDD |
| Code set source | NHDD |

## Contract/Spoke Identifier

### Specification

|  |  |
| --- | --- |
| Definition | This field identifies:   * The public or private hospital or day procedure centre involved in contracted care arrangements with this hospital (as purchaser or provider of contracted care) * The Spoke hospital in a Hub and Spoke arrangement for this episode (the Spoke hospital does not report the episode unless it is a multi-day stay) * The exact nature of the contract involving an external purchaser. |
| Field size | 4 |
| Layout | NNNN or spaces |
| Location | Episode Record |
| Reported by | Victorian public and private hospitals involved in contracted care arrangements with other hospitals (purchasers and providers of contracted care).  All other sites, report a space in this field. |
| Reported for | This item is mandatory if Funding Arrangement is:  1 Contract or  2 Hub/Spoke  Otherwise, report a space in this field. |
| Reported when | At any time during the episode |
| Reporting guide | Where Funding Arrangement is 1 Contract, report the relevant Campus Code from the Campus code table available at [HDSS reference files](https://www.health.vic.gov.au/data-reporting/vemd-vaed-vinah-esis-reference-files) <https://www.health.vic.gov.au/data-reporting/vemd-vaed-vinah-esis-reference-files> which identifies the other party to the contracted service arrangement, with the following exception:  When   * Funding Arrangement 1 Contract and * Contract Type 1 Contract Type B, report the code from the list below that identifies the external purchaser/program relevant to the episode of care   Where the Funding Arrangement is 2 Hub/Spoke, report the relevant Contract/Spoke Identifier from the list below or relevant Campus Code.  **Emergency use codes**  Only to be used under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
| Code set | Code Descriptor  0010 Melbourne Health Same Day ECT – Northern  0011 Melbourne Health Same Day ECT - Sunshine  0012 Melbourne Health Same Day ECT - Broadmeadows  0030 Other Funding Source  0031 Emergency use  0032 Emergency use  0100 Australian Health Care Agreement (AHCA) - Elective Surgery  0200 Department of Health: HIV AIDS  0300 Department of Veterans’ Affairs: Veterans’ Cardiac Agreement  0311 Brunswick Dialysis Unit  0312 Coburg Dialysis Unit  0313 Broadmeadows Dialysis Unit  0314 Williamstown Dialysis Unit  0315 Sunshine Hospital Dialysis Unit  0316 Northern Hospital Dialysis Unit  0317 Craigieburn Health Service  0318 St George’s Dialysis  0319 Essendon Fields Dialysis Unit  0321 Caulfield General Medical Centre Dialysis Unit  0331 Austin Training Satellite Dialysis Unit  0332 Heidelberg Repatriation Hospital Dialysis Unit  0333 North East Kidney Service  0334 Epping Dialysis Unit  0351 Newcomb Dialysis Unit  0352 Rotary House Dialysis Unit  0353 South Geelong Renal Unit  0361 Maroondah Hospital Dialysis Unit  0362 Spring Street Dialysis Unit  0399 Big Red Kidney Bus  0400 Individual contracts with international patients  0500 Transport Accident Commission: Alfred Road Trauma Unit  0600 Department of Health: Rural & Remote Health Agency Program  0700 Department of Health: Bowen Centre - ARMC  0710 Department of Health: Interim Payment  0800 Victorian Maintenance Dialysis Program  0900 St Jude Pacemaker Replacement Program |
| Validations | 410 Illegal Comb Fund Arrange & Contract  419 Invalid Contract/Spoke Identifier  420 Contract/Spoke = Campus/Site  456 Contract Leave, No Contract |
| Related items | Section 3: Contract Role, Contract Type, Funding Arrangement  Section 4: Contracted Care |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable monitoring of health services provided under contract in Victoria. |
| Principal data users | Department of Health |
| Collection start | 1999-00 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Contract Type

### Specification

|  |  |
| --- | --- |
| Definition | Describes the contract arrangement between the contractor and the contracted hospital/facility. Contract Types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals. |
| Field size | 1 |
| Layout | N or space |
| Location | Episode Record |
| Reported by | Victorian public and private hospitals involved in contracted care arrangements (purchases and providers of contracted care).  All other sites, report a space in this field. |
| Reported for | This item is mandatory if Funding Arrangement is 1 Contract.  For all other episodes, report a space in this field. |
| Reported when | At any time during the episode. |
| Code set | Code Descriptor  1 Contract Type B  2 Contract Type ABA  3 Contract Type AB  4 Contract Type (A)B  5 Contract Type BA  6 Contract Type A(B)  8 Contract Type BAB |
| Reporting guide | The contracting (purchasing) hospital (or authority) is termed Hospital A.  The contracted (service provider) hospital is termed Hospital B.  Contract Types are described by the sequence of the A and B characters, representing the movement of the patient between the contracting and contracted entities. Brackets indicate the patient was not physically present in one of either the contracting or contracted hospital. For example, (A) means the patient was not physically present in the contracting hospital.  **1 Contract Type B**  A (health authority/other external purchaser) contracts B (hospital) for admitted service.  **2 Contract Type ABA**  Patient admitted by Hospital A.  Hospital A contracts Hospital B for admitted or non-admitted patient service.  Patient returns to Hospital A on completion of service by Hospital B.  **3 Contract Type AB**  Patient admitted by Hospital A.  Hospital A Contracts Hospital B for admitted or non-admitted patient service.  Patient does not return to Hospital A on completion of service by Hospital B |
|  | **4 Contract Type (A)B**  Patient is not present in the Contracting Hospital (A) at any time during the episode.  Hospital A contracts Hospital B for the whole admitted patient service.  An (A)B contract type cannot occur between two public hospitals unless approved by the Hospital & Health Service Performance Division of the Department of Health. Where two public hospitals enter into a contract, the contracting hospital must provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB and BA).  **5 Contract Type BA**  Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for the remainder of the care.  **6 Contract Type A(B)**  Hospital A contracts Hospital B for the whole admitted patient service.  Hospital B provides the service at Hospital A.  Patient is not present in the Contracted Hospital (B) at any time during the episode.  An A(B) contract type cannot occur between two public hospitals unless approved by the Hospital & Health Service Performance Division of the department. Where two public hospitals enter into a contract, the contracting hospital must admit and provide care or treatment for the patient as part of the overall service provided (Contract Types ABA, AB, BA, BAB).  **8 Contract Type BAB**  Patient is admitted to Hospital B under contract to Hospital A, then receives admitted care at Hospital A before returning to Hospital B for remainder of care. |
| Validations | 410 Illegal Comb Fund Arrange & Contract  417 Invalid Contract Type  423 Invalid Comb Fund/Contract/Transfer  456 Contract Leave, No Contract |
| Related items | Section 3: Contract Role, Contract/Spoke Identifier, Funding Arrangement  Section 4: Contracted Care |

### Administration

|  |  |
| --- | --- |
| Purpose | To identify the type of contract arrangement (if any) that applies to this episode, to make a link (if appropriate) to the record reported by the other party to the contract arrangement. |
| Principal data users | Department of Health |
| Collection start | 1999-00 |
| Definition source | NHDD |
| Code set source | NHDD |

## Country of Birth (SACC code set)

### Specification

|  |  |
| --- | --- |
| Definition | The country in which the person was born as represented by a code |
| Field size | 4 |
| Layout | NNNN |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private). |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Refer to Country of Birth and Country of Residence SACC code set 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> |
| Reporting guide | Report the country in which the patient was born, not the country of residence.  For patients born in Australia report code 1101 |
| Validations | 036 Invalid Country of Birth  069 Newborn from overseas  228 Unusual birthplace  234 Aboriginal/Ts Islander but not Aust born  392 Recip HCA Account, not o/seas born  571 Acct Recip, Pcode Oseas, Locality not RHCA  574 Postcode Overseas, Locality RHCA, Acct not RHCA |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate epidemiological studies. |
| Principal data users | Multiple internal and external data users. |
| Collection start | 1979-80 |
| Definition source | NHDD |
| Code set source | ABS Standard Australian Country Classification of Countries (SACC), 2016, DH modified |

## Criterion for Admission

### Specification

|  |  |
| --- | --- |
| Definition | The criterion which has been met to justify reporting the patient’s episode of care to the VAED |
| Field size | 1 |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Code Descriptor  K Posthumous Organ Procurement  N Qualified newborn  U Unqualified newborn  O Patient expected to require hospitalisation for minimum of one night  B Day-only Automatically Admitted Procedures  X ED Short Stay Unit  E Day-only Extended Medical Treatment  C Day-only Not Automatically Qualified Procedures  S Secondary family member |
| Reporting guide | Only a brief guide to Criterion for Admission (CFA) is provided below.  This document should be read in conjunction with the *Victorian Admitted Episodes Dataset: Criteria for Reporting* document and Procedure Code Lists, 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>  The appropriate criterion for admission is determined at the point of admission for all criteria except CFA E, determined retrospectively, and does not change even if the patient’s circumstances change.  **K Posthumous Organ Procurement**  A person who has been declared brain dead but from whom human tissue is being procured in this episode for the purpose of transplantation.  These episodes are required to be reported to the VAED although the activity is not regarded as care or treatment of an admitted patient.  Only public hospitals can report this category.  **N Qualified newborn**  The patient is nine days old or less at the time of admission and meets at least one of the following criteria:  admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the provision of special care in designated Neonatal Intensive Care Units (NICUs) and designated Special Care Nurseries (SCNs), or  is the second or subsequent live born of a multiple birth, or  remains in hospital after their mother is separated from hospital or is admitted to hospital without their mother.  **U Unqualified newborn**  The patient is nine days old or less at the time of admission but does not meet any of the criteria for CFA N.  Unqualified newborns who are still in the hospital when they turn 10 days old and are not receiving clinical care become boarders, and because boarders are not reported to the VAED, they must be separated.  Public hospitals are expected to admit all unqualified newborns.  **O Patient expected to require hospitalisation for minimum of one night**  The patient is expected to require overnight or multi-day hospitalisation. CFA O should be used where there is an expectation that the patient will require ongoing admitted care.  **B Day-only Automatically Admitted Procedures**  In order to meet CFA B, it must be the intention that the patient will:  Receive at least one procedure listed on the Automatically Admitted Procedure List; AND  Receive treatment on a day-only basis.  **X ED Short Stay Unit**  CFA X must be reported where:  the patient is transferred from an Emergency Department (ED) or Urgent Care Centre (UCC) to an ED SSU, and has a clearly documented clinical assessment, management and discharge plan as mandated in the *ED Short Stay Unit Guidelines 2017*.  Excludes:  patients who are transferred from an ED or UCC to an assessment unit such as a Rapid Chest Pain Assessment Unit, Psychiatric Assessment and Planning Unit etc (report CFA E)  **E Extended Medical Treatment**  CFA E is reported where:  a patient receives a minimum of four hours of continuous active management in a ward other than an ED SSU, consisting of regular observations (which may include diagnostic or investigative procedures) or continuous monitoring  Includes:  patients who are transferred from an ED or UCC to an assessment unit such as a Rapid Chest Pain Assessment Unit, Psychiatric Assessment and Planning Unit etc  Excludes:  patients who are transferred from the ED to the SSU (report CFA X)  **C Day-only Not Automatically Qualified Procedures**  The NAQAL identifies procedures that would normally be undertaken on a non-admitted basis and therefore not normally reported to the VAED.  To meet CFA C, a patient must:  receive a procedure on the NAQAL; AND  be intended to be treated on a day-only basis; AND  have their specific special circumstances documented in the medical record by the treating doctor to provide evidence that the admission is justified.  **S Secondary Family Member**  A patient qualifies for CFA S if:  they do not meet any other CFA but are accompanying a patient who is admitted, AND  the location is an Early Parenting Centre. |
| Validations | 072 Invalid Criterion for Adm  235 Adm Crit N but Care Not 4  308 Adm Crit O but Int’d Same Day  309 Adm Crit B & Int’d Overnight  310 Adm Crit C Int’d Overnight  311 Adm Crit N & Int’d Same Day  312 Adm Crit U Int’d Same Day  455 Inconsist Newborn Transferred/Unqual Data  482 Incompat Adm Source/Crit for Adm  484 Incompat Adm Type/Crit for Adm  486 Incompat Age/Crit for Adm  490 Incompat Crit For Adm/Qual Stat  491 Incompat Fields for ESAS  549 Type B Crit for Adm, LOS >1  550 Type C Crit for Adm, LOS >1  551 Type C Crit for Adm, LOS >4 hrs  552 Type E Crit for Adm, LOS >1  553 Type E Crit for Adm, LOS <4 hrs  667 Incompat Care Type/Crit for Adm |
| Related items | Section 4:  Newborn reporting  Admission Source and Criterion for Admission  Admission Type and Criterion for Admission  Age and Criterion for Admission  Care Type and Criterion for Admission  Criterion for Admission and Qualification Status |

### Administration

|  |  |
| --- | --- |
| Purpose | To identify: patients admitted for procedures listed on AAPL; patients with special circumstances requiring admission (rather than treatment on a non-admitted basis); persons treated in an Early Parenting Centre (omitted from Commonwealth reporting) |
| Principal data users | Department of Health |
| Collection start | 1993-94 |
| Definition source | Commonwealth (DHHS modified) |
| Code set source | Department of Health |

## Date of Accident

### Specification

|  |  |
| --- | --- |
| Definition | The date of the transport accident causing the person to require hospitalisation |
| Field size | 8 |
| Layout | DDMMYYYY |
| Location | DVA and TAC Record |
| Reported by | Public hospitals |
| Reported for | Episodes with an Account Class of TAC (T-) |
| Reported when | The Episode Record is reported |
| Code set | Episodes with an Account Class of DVA (V-): blank  Episodes with an Account Class of TAC (T-): A valid date |
| Reporting guide | For all episodes with an Account Class of TAC (T-), Date of Accident must not be blank or later than Admission Date.  For most episodes with an Account Class of TAC (T-), Date of Accident should not be:   * Prior to the Date of Birth * Report unknown Date of Accident as 01011901 |
| Validations | 444 Invalid Date of Accident  446 Dt of Accid Incompat W TAC Claim Nbr - Warning  554 Date of Accident > Admission Date  555 Date of Accident < Date of Birth |
| Related items | Section 3: Account Class |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable TAC payment of relevant episodes of care. Date of Accidentis used in the matching process to link hospital admissions to TAC claims.  These data are held separately to other VAED data to ensure that personal information remains confidential. |
| Principal data users | Transport Accident Commission |
| Collection start | 2002-03 |
| Definition source | TAC |

## Date of Birth

### Specification

|  |  |
| --- | --- |
| Definition | The date of birth of the person |
| Field size | 8 |
| Layout | DDMMYYYY |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | A valid date |
| Reporting guide | The Date of Birth must be on or before Date of Admission  Year (YYYY) can only be 19xx or 20xx  If the Date of Birth is unknown or has been estimated, the appropriate value should be reported in the Date of Birth Accuracy field. |
| Validations | 035 Invalid Date of Birth  057 Incompat Adm Type/Age  069 Newborn from Overseas  127 Nil Value DRG  160 AR-DRG Grouper GST Code> Zero  186 Neonate MDC But Age>= 28 Days  187 Adm Weight Too Low  188 Adm Wt Too High  189 Age < 1 Year but Adm Weight Missing  190 Adm Wt Present but Not Aged < 1 Year  222 Unqual Newborn; Adm Date Not Birth  226 Adm Date Before Date of Birth  227 Age Calculated As 120 Yrs & Over  240 Newborn Accom but Over 4 Months  245 Adm Wt >= 9kg but Age is <= 5 Mth  255 Rehab: Invalid Onset Date  261 Newborn Care Type but Age > 9 Days  262 Invalid Care Type for Newborn  353 Code & Age Incompatible  397 Sep Referral Postnatal, Incompatible Age/Sex at birth  447 Unqual Newborn; Age at Sep > 10 Days  461 ACAS Status not Required  467 Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D  479 Incompat Adm Source/Age  480 Incompat Adm Source/Age <15  481 Incompat Adm Source/Age <55  486 Incompat Age/Crit for Adm  487 Incompat Age/Qual Stat/Care Type  493 Incompat Sep Mode/Age <15  494 Incompat Sep Mode/Age <55  518 Medicare IRN = 0, Age > 6 Months  519 Medicare IRN = 0, Age > 12 Months  533 ACAS Status Code Required  555 Date of Accident < Date of Birth  579 MHSWPI Valid, no Matching DOB  602 Newborn Accom but Over 12 Months 640 DOB Accuracy and DOB mismatch |
| Related items | Section 2: Age  Section 3: Admission Date, Date of Birth Accuracy  Section 4: Admission Source and Age, Admission Type and Age, Age and Criterion for Admission, and Age, Qualification Status and Care Type |

### Administration

|  |  |
| --- | --- |
| Purpose | To:   * enable calculation of ‘age at admission’ (difference between Date of Birth and Admission Date) that is used in the allocation of DRGs and for analysis of service utilisation, need for services and epidemiological studies. * verify other fields (such as diagnosis and procedure codes) for consistency with calculated age. |
| Principal data users | Multiple internal and external data users |
| Collection start | 1979-80 |
| Definition source | NHDD |

## Date of Birth Accuracy

### Specification

|  |  |
| --- | --- |
| Definition | A code representing the accuracy of the components of a date - day, month, year |
| Field size | 3 |
| Layout | AAA |
| Location | Episode Record |
| Reported by | All Victorian Health Services (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The episode record is reported |
| Value domain | This data element’s value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:  Code Descriptor  A The referred date component is accurate  E The referred date component is not known but is estimated  U The referred date component is not known and not estimated.  This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported Date of Birth.  Component Descriptor  1st – D Refers to the accuracy of the day component.  2nd – M Refers to the accuracy of the month component  3rd - Y Refers to the accuracy of the year component |
| Reporting guide | Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.  Where possible, report the accuracy of each date component. However, where software systems allow the collection of a binary value for Date of Birth Accuracy (that is the system has an ‘Estimated Date of Birth’ check box or similar) values such as ‘AAA’ and ‘EEE’ will be acceptable.  It is understood that the Date of Birth Accuracy Code will be reported as ‘AAA’ unless the date has been flagged as an estimated date. It is not necessary to validate the Date of Birth provided by every patient unless there is a reasonable suspicion that the date provided is not correct. Where there is a question over the date provided, or where the patient is unable or unwilling to provide their date of birth, the date should be estimated and flagged as such.  If the date of birth is provided by a reliable source (for example the patient or close relative) and is known as accurate, then the date accuracy indicator should be reported as ‘AAA’.  If the patient’s approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used. The Date of Birth Accuracy code would be reported as ‘UUE’, that is the day and month are ‘unknown’ and the year is ‘estimated’. |
|  | A Year component value of U – Unknown is not acceptable.  Where the date part is accurate or estimated, the date part cannot be ‘00’. Where the date part is unknown, the date part may be ‘00’ or ‘NN’.  Valid combinations include:  DOB Accuracy = ‘AAA’, DOB = ‘03/11/1956’  DOB Accuracy = ‘EEE’, DOB = ‘03/11/1956’  DOB Accuracy = ‘UUE’, DOB = ‘00/00/1945’  DOB Accuracy = ‘UUE’, DOB = ‘01/01/1945’  Invalid combinations include:  DOB Accuracy = ‘AAA’, DOB = ‘00/00/1956’  DOB Accuracy = ‘AAA’, DOB = ‘00/06/1956’  DOB Accuracy = ‘EEE’, DOB = ‘00/00/1956’  DOB Accuracy = ‘UUE’, DOB = ‘00/00/0000’  DOB Accuracy = ‘UEE’, DOB = ‘00/00/1956’ |
| Validations | 639 Invalid Date of Birth Accuracy code  640 DOB Accuracy and DOB mismatch |
| Related items | Section 2: Age  Section 3: Date of Birth |

### Administration

|  |  |
| --- | --- |
| Purpose | Used to derive age for demographic analyses and for analysis by age at a point of time |
| Principal data users | Multiple internal and external research users |
| Collection Start | 2008-09 |
| Definition source | NHDD (department modified) |
| Value Domain source | NHDD 294429 |

## Diagnosis Codes

### Specification

|  |  |
| --- | --- |
| Definition | At least one (principal diagnosis) and up to 100 ICD-10-AM codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care. |
| Field size | 8 (8 X 100) |
| Layout | AANNNN Left justified, trailing spaces |
| Location | Diagnosis Record (12)  Extra Diagnosis Record (88) |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | VAED ICD-10-AM/ACHI Library File is available on application to the HDSS help desk |
| Reporting guide | Report diagnoses in accordance with *Australian Coding Standards* and the *Victorian Additions to Australian Coding Standards*. The Victorian Additions to Australian Coding Standards are available at: [Victorian Additions to ACS](https://www.safercare.vic.gov.au/data-reports/clinical-coding-and-classifications/victorian-additions-to-australian-coding-standards) < https://www.safercare.vic.gov.au/data-reports/clinical-coding-and-classifications/victorian-additions-to-australian-coding-standards>  Omit punctuation as shown in ICD‑10‑AM books (that is, no dot or oblique in codes): for example, ICD‑10‑AM diagnosis code A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae must be entered as A000.  When a code is shown in ICD‑10‑AM with a symbol (dagger or asterisk), omit the symbol when transmitting to VAED.  The first character of the field is the prefix: P, C or M (see below for more information).  **In the first diagnosis code field:**   * Character 1 must be P (except for neonate in birth episode where it may be C). * Next five characters must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required). * Characters 7 and 8 must be spaces.   **For the remaining 99 diagnosis code fields, if a code is present:**  Character 1 must be P, C or M.   * Next six characters must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required). * Character 8 must be a space. |
|  | **Morphology codes (where first character is M)**  Submit without punctuation (oblique) and with M prefix: for example, MM80703  **Prefixes: Definitions for P, C, M**  All diagnosis codes require a prefix. Prefixes indicate whether the condition was present on, or arose during admission, and denote morphology codes. The department will map prefixes to the Condition Onset Flag to report to the Commonwealth *[Meteor identifier 686100]*.  Refer to the Victorian Additions to the Australian Coding Standards |
| Validations | 127 Nil Value DRG  160 AR-DRG Grouper GST Code > Zero  186 Neonate MDC But Age >= 28 Days  195 Blank X5  197 Embedded Blank Diag Oper  231 P - Diag Not Prefixed By P  334 Public Hosp DRG ≠ AR-DRG  351 Illegal Code Format  352 Code Not Found On Code File  353 Code & Age Incompatible  354 Code & Sex at birth Incompatible  355 Invalid Principal Diag - Rejection  355 Invalid Principal Diag - Warning  358 Rare diagnosis or procedure code  361 External Cause Code Missing  362 Morphology Code Missing  363 External Cause needs Place Code  364 External Cause/Activity Code Mismatch  403 Qual Newborn W/Out Justificat  406 Rehab Type W/Out Rehab Diag  411 Adm Wt < 1000g, No Matching Dx Code  412 Adm Wt 1000-2499g, No Matching Dx Code  413 Adm Wt > 6000g, No Matching Dx Code  426 Y5 Not Accompanied by X5  428 X5 Upd not Accompanied by Y5 Upd  447 Unqual Newborn; Age at Sep > 10 Days  452 Place/Activity W/Out External Cause Code  498 Pall Care without Pall care Diag  525 Diagnosis Code Indicates Boarder Episode  562 Prefix = C, Unusual Code Combination  590 Diag Prefix M, Morph Code mismatch  595 Neoplasm Code Missing  600 Invalid Code  601 Sequencing Error |
| Related items | Section 2: DRG Classification and Principal Diagnosis.  Section 3: Hospital Generated DRG.  Section 3: Diagnosis Cluster Identifier (DCID). |

### Administration

|  |  |
| --- | --- |
| Purpose | To:  Facilitate epidemiological studies and other research.  Identify episodes containing specified codes for co-payments.  Facilitate grouping for casemix purposes. |
| Principal data users | Multiple internal and external data users. |
| Collection start | 1979-80 |
| Definition source | Department of Health |
| Code set source | ICD-10-AM |

## Diagnosis Cluster Identifier (DCID)

### Specification

|  |  |
| --- | --- |
| **Definition** | An identifier for each International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) code to indicate the relationship of that condition to other conditions within an episode of admitted patient care, as represented by a code.  Codes are considered ‘related’ when they connect the circumstances of an event together. For example, a fractured radius (injury/condition), of a pedestrian struck by motor vehicle (external cause), on the pedestrian crossing (place of occurrence), while walking their dog (activity). |
| **Field size** | 2 |
| **Layout** | AA, A, N Left justified, trailing space |
| **Location** | Diagnosis Record (12)  Extra Diagnosis Record (88) |
| **Reported by** | All Victorian hospitals (public and private) |
| **Reported for** | Separations on and from **1 July 2025**  If unable to report DCID, report spaces |
| **Reported when** | A separation date is reported in the Episode Record |
| **Code set** | Code Descriptor  A-ZZ (DCID A-ZZ) Diagnosis cluster identifier  0 Chronic condition cluster  8 Not clustered |
| **Reporting guide** | For Thirteenth Edition ICD-10-AM/ACHI/ACS a new Australian Coding Standard ACS 0004 Diagnosis cluster identifier (DCID) has been created to allow the clinical coder to assign a cluster code to each diagnosis reported to the Victorian Admitted Episodes Dataset (VAED).  While the application of ACS 0004 Diagnosis cluster identifier (DCID) is mandatory for separations on and from 1 July 2025, the department is aware that health services and hospitals both public and private are at different stages of software readiness. The term 'readiness' also includes operational readiness. While a health service or hospital may be ready from a technical perspective, there may be operational issues specific to a health service or private hospital to consider in terms of readiness.  To support reporting of accurate and interpretable coded data, the department instructs public and private health services and hospitals to:   * Apply ACS 0004 Diagnosis cluster identifier and report a valid DCID against each diagnosis code once both your coding software and Patient Administration System (PAS) are updated to collect and report DCID. * If you do not use coding software, apply ACS 0004 Diagnosis cluster identifier and report a valid DCID against each diagnosis code once your Patient Administration System (PAS) is updated to collect and report DCID. * Ensure operational readiness: While technical readiness is crucial, it is equally important to consider operational readiness. This means that all operational aspects should be fully prepared to support the implementation and reporting processes. * **Do not apply ACS 0004 Diagnosis cluster identifier and double code if you cannot report a valid DCID.** The department does not support double coding as per ACS 0004 if it cannot be interpreted with a valid DCID. * Report spaces for the DCID code against each diagnosis code if you cannot report a valid DCID.   Public and private health services and hospitals are also reminded that:   * A valid DCID must be reported against each diagnosis code; there cannot be a combination of spaces and a DCID within one diagnosis record * Once a site commences reporting of valid DCIDs, a DCID must be assigned to all diagnosis records reported to the VAED; there cannot be a combination of episodes with and without a DCID * Once a site commences reporting of valid DCIDs, you must continue to report DCIDs; you cannot stop reporting once started   The department is committed to meeting its national reporting obligations while balancing the constraints faced by public and private health services and hospitals in their ability to report valid DCIDs.  The department encourages clinical coders to undertake IHACPA’s Thirteenth Edition education to familiarise themselves with ACS 0004 even if a site is not ready to report DCIDs.    Where a diagnosis cluster is identified, the first diagnosis cluster identifier code (DCID) value assigned is A. Record the same DCID value against each ICD-10-AM code in the diagnosis cluster (e.g. injuries, procedural complications, and adverse effects) together with their associated external cause, place of occurrence codes and activity type codes.  Subsequent clusters in the same episode of care proceed to be allocated the next sequential alphabetic letter (i.e. B, C, D, etc through to Z, and then AA, AB through to ZZ if required). |
|  | **0 Chronic condition cluster**  ICD-10-AM code that represents a chronic condition assigned in accordance with *ACS 0003 Supplementary codes for chronic conditions.* ICD-10-AM codes with DCID 0 belong to the same cluster but do not describe the same condition. |
|  | **8 Not clustered**  ICD-10-AM code that has not been assigned to a diagnosis cluster or chronic condition cluster |
| **Validations** | 751 Total DCID codes < total number of diagnosis codes |
| **Related items** | Section 3 Diagnosis Codes |

Administration

|  |  |
| --- | --- |
| **Purpose** | To enable Victoria to meet national reporting requirements from 1 July 2025, and to prepare the clinical coding workforce for the implementation of ICD-11 (date yet to be determined by Australia) where the design of ICD-11 relies significantly on the linking of codes that are related to each other.  The implementation of the DCID assigned to each ICD-10-AM code will provide an opportunity to link related conditions and enhance the power of the information available for users of the data, such as researchers, policy and decision makers. When combined with data linkage of episodes of care, this will provide additional information regarding the burden of disease across the Australian population.  The DCID will be used to better inform data analysis of coded data such as injuries and complications both at state and national level. |
| **Principal data users** | Multiple internal and external data users |
| **Collection start** | 1 July 2025 |
| **Definition source** | Department of Health |
| **Code set source** | Meteor identifier 799079 |

## Duration of Mechanical Ventilation in ICU

### Specification

|  |  |
| --- | --- |
| Definition | Total duration of Mechanical Ventilation (MV) in hours provided in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care (NICU) during this episode of care |
| Field size | 4 |
| Layout | NNNN or spaces Right justified, zero filled |
| Location | Diagnosis Record |
| Reported by | Public and private hospitals with an approved ICU or NICU, and hospitals contracting with a hospital with an approved ICU.  Otherwise, report spaces |
| Reported for | Episodes where MV is provided in such an ICU or NICU.  Otherwise, report spaces. |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | A number in the range 0001 to 9999 |
| Reporting guide | If the patient has more than one period of MV in ICU during this episode, the total duration of all such periods is reported.  Duration is reported in hours, rounded to the nearest hour. For example, if the total duration of MV in ICU was 98 hours 15 minutes, report 98 hours. If the total duration of MV in ICU was 125 hours 30 minutes, report 126 hours. Only MV hours provided in an ICU are counted:   * Where a patient is intubated and MV starts in an operating theatre, for the purposes of the Duration of MV field, *the counting of the duration of MV commences when the patient enters the ICU*. * It is not necessary to stop the MV clock when a ventilated patient is transferred from the ICU to theatre and back; instead, the intervening hours will count towards the total MV hours. * Where a patient receives MV in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.   Duration of MV is validated against Duration of Stay in ICU.  **Contracted care**  A patient who receives MV in an ICU in Hospital B during a contracted service episode has the duration of that MV reported by Hospital B; Hospital A also reports the MV hours received in Hospital B in addition to any MV hours the patient received in an ICU at Hospital A.  Note: Duration of MV is not passed to the grouper; the grouper uses the duration from the ACHI ventilation procedure code. |
| Validations | 317 Invalid MV Duration  318 MV Duration >ICU Stay  319 MV Duration but No ICU Stay  320 MV Duration but No Proc Code  323 MV Duration >Total Stay  325 Incompat MV Hrs, A/C Class  641 MV Hours with incorrect Procedure Code |
| Related items | Section 2: Intensive Care Unit  Section 3: Duration of Stay in Intensive Care Unit |

### Administration

|  |  |
| --- | --- |
| Purpose | Although not used to facilitate a co-payment, this information could influence the national funding model (NWAU) in the future.  Previously used for a co-payment under the Victorian funding (WIES) model |
| Principal data users | Department of Health |
| Collection start | 1996-97 |
| Definition source | Department of Health |

## Duration of Non-invasive Ventilation (NIV) in ICU

### Specification

|  |  |
| --- | --- |
| Definition | Total number of hours of non-invasive ventilatory support (including High Flow Therapy) without the use of an ETT or tracheostomy provided to patients in an approved Intensive Care Unit (ICU). |
| Field size | 4 |
| Layout | NNNN or spaces Right justified, zero filled |
| Location | Diagnosis Record |
| Reported by | Mandatory for public hospitals providing NIV in an approved Intensive Care Unit (ICU) or combined Intensive Care Unit/Coronary Care Unit.  Includes:   * NIV provided in a Paediatric Intensive Care Unit (PICU)   Excludes:   * NIV provided in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN)   Private hospitals report spaces |
| Reported for | Episodes of care for patients receiving NIV in an ICU  Otherwise, report spaces. |
| Reported when | A Separation Date is reported in the Episode Record. |
| Code set | A number in the range 0001 to 9999 |
| Reporting guide | **Count all hours of NIV received in ICU:**   * Count NIV hours rounded to the nearest hour. For example, if the total duration of NIV in ICU was 98 hours 15 minutes, report 98 hours. If the total duration of NIV in ICU was 125 hours 30 minutes, report 126 hours. * Counting NIV starts when a patient first receives NIV in ICU * Counting NIV stops when a patient stops receiving NIV in ICU * Counting of NIV continues when a patient receiving NIV in ICU is transferred from ICU to theatre and back to ICU * If a patient is cycling on and off NIV whilst in ICU:   + When the patient cycles off NIV for periods of more than 1 hour, then count the actual number of NIV hours received   + When the patient cycles off NIV for periods of less than 1 hour, then count as though NIV received continuously * Counting contracted NIV hours. If a patient receives NIV in an ICU in Hospital B (service provider hospital) during a contracted service episode:   + Hospital B reports the duration of NIV in ICU during stay in Hospital B only   + Hospital A (purchasing hospital) reports NIV hours received in Hospital A plus NIV hours in Hospital B   Excludes:   * NIV given for purpose of weaning from mechanical ventilation * Where NIV starts outside ICU (such as in an operating theatre, ward or emergency department) the counting of the duration of NIV starts only when the patient enters ICU |
| Validations | 435 Invalid NIV Duration  437 NIV Duration for Unqual Newborn  438 NIV Duration > Total Stay  644 NIV Hours with incorrect Procedure Code  712 NIV Duration but no ICU stay  713 NIV Duration > ICU stay |
| Related items | Section 2: Intensive Care Unit  Section 3: Duration of Stay in Intensive Care Unit. |

### Administration

|  |  |
| --- | --- |
| Purpose | Although not used to facilitate a co-payment, this information could influence the national funding model (NWAU) in the future.  Previously used for a co-payment under the Victorian funding (WIES) model |
| Principal data users | Department of Health |
| Collection start | 2002-03 |
| Definition source | Department of Health |
| Version | 1 effective 1 July 2002  2 effective 1 July 2017  3 effective 1 July 2022 |

## Duration of Stay in Cardiac/Coronary Care Unit

### Specification

|  |  |
| --- | --- |
| Definition | Total duration of stay (hours) in an approved Cardiac/Coronary Care Unit (CCU), during this episode of care. |
| Field size | 4 |
| Layout | NNNN or spaces Right justified, zero filled |
| Location | Diagnosis Record |
| Reported by | Public and private hospitals with an approved CCU, and hospitals contracting with a hospital with an approved CCU.  Otherwise, report spaces. |
| Reported for | Episodes where time is spent in such a CCU. Otherwise, report spaces. |
| Reported when | A Separation Date is reported in the Episode Record. |
| Code set | A number in the range 0001 to 9999. |
| Reporting guide | If patient has more than one period in CCU during this episode, the total duration of all such periods is reported.  Duration is reported in hours, rounded up.  Where a hospital has a combined ICU/CCU, the duration of stay is reported in either the ICU field or the CCU field, not both. However, where a patient receives mechanical ventilation or non-invasive ventilation in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.  A patient admitted to a CCU in Hospital B during a contracted service episode has the duration of that CCU stay reported by Hospital B; Hospital A also reports the hours spent in CCU in Hospital B in addition to any hours spent in CCU at Hospital A. |
| Validations | 322 ICU/CCU Stay > Total Stay  328 Early Parenting Centre – Invalid Comb  333 Invalid CCU Stay  523 CCU Hrs, no Approved CCU  582 CCU Duration High |
| Related items | Section 2: Cardiac/Coronary Care Unit  Section 3: Duration of Mechanical Ventilation in ICU |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate a co-payment on specified DRGs. |
| Principal data users | Department of Health |
| Collection start | 1998-99 |
| Definition source | Department of Health |

## Duration of Stay in Intensive Care Unit

### Specification

|  |  |
| --- | --- |
| Definition | Total duration of stay (hours) in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU), during this episode of care. |
| Field size | 4 |
| Layout | NNNN or spaces Right-justified, zero-filled |
| Location | Diagnosis Record |
| Reported by | Public and private hospitals with an approved ICU/NICU, and hospitals contracting with a hospital with an approved ICU. Otherwise, report spaces. |
| Reported for | Episodes where time is spent in such an ICU/NICU. Otherwise, report spaces. |
| Reported when | A Separation Date is reported in the Episode Record. |
| Code set | A valid number in the range 0001 to 9999. |
| Reporting guide | If patient has more than one period in ICU/NICU during this episode, the total duration of all such periods is reported.  Duration is reported in hours, rounded to the nearest hour. For example, if the total duration of stay in ICU was 98 hours 15 minutes, report 98 hours. If the total duration of stay in ICU was 125 hours 30 minutes, report 126 hours.  Only the time in the ICU/NICU is counted, not time, for example, in an operating theatre.  Where a hospital has a combined ICU/CCU, the duration of stay is reported in either the ICU field or the CCU field, not both. However, where a patient receives mechanical ventilation or non-invasive ventilation in a combined ICU/CCU, report the ICU/CCU hours in the ICU field, not the CCU field.  A patient admitted to an ICU/NICU in Hospital B during a contracted service episode has the duration of that ICU/NICU stay reported by Hospital B; Hospital A also reports the hours spent in ICU/NICU in Hospital B in addition to any hours spent in ICU/NICU at Hospital A. |
| Validations | 316 Invalid ICU Duration  318 MV Duration >ICU Stay  319 MV but no ICU Stay  322 ICU/ CCU Stay > Total Stay  324 Incompat ICU Hrs, A/C Class  328 Early Parenting Centre – Invalid Comb  448 ICU Stay but Care Type not Acute  526 ICU Hrs, no approved ICU or NICU |
| Related items | Section 2: Intensive Care Unit, Section 3: Duration of MV in ICU |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate a co-payment on specified DRGs. |
| Principal data users | Department of Health |
| Collection start | 1996-97 |
| Definition source | Department of Health |

## DVA ID / TAC Claim Number (where Account Class is V- *DVA*)

### Specification

|  |  |
| --- | --- |
| Definition | The Department of Veterans’ Affairs file number of the person |
| Field size | 9 |
| Layout | AAAANNNX or AAAANNNXA |
| Location | DVA and TAC Record (Shared field DVA ID/TAC Claim Number) |
| Reported by | Public hospitals |
| Reported for | Episodes with an Account Class of DVA (V-) |
| Reported when | The Episode Record is reported |
| Code set | Obtained from the DVA card, held by those eligible for DVA benefits |
| Reporting guide | **Layout:**  Part 1 State identifier. Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA)  Part 2 War Group Code, (Alphanumeric characters) may be up to 3 characters  Part 3 Serial Number (numeric characters) may be 2 to 6 characters  Part 4 (optional) Spouse or Dependent Identifier, may be 1 character  **Valid format** (see also above layout and following examples):   * Only alphabetic and numeric characters and spaces are permitted * Alphabetic characters must be in uppercase * A maximum of six numeric characters is permitted * Trailing spaces (to the right) are permitted. * Spaces between characters are not permitted.   Note: VAED does not validate war codes  **Examples** of permitted formats: N123456, VX123456, WXX123A, QXXX1B  If a DVA ID that the hospital believes is correct cannot pass these validations, the hospital should refer the problem to their local DVA office. |
| Validations | 180 DVA ID/TAC Claim Number Blank  181 DVA ID/TAC Claim Number Incorrect |
| Related items | Section 3: Account Class. |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate payment by DVA for DVA patients |
| Principal data users | Department of Veterans’ Affairs |
| Collection start | 1992-93 |
| Definition source | NHDD |
| Code set source | DVA |

## DVA ID / TAC Claim Number (where Account Class is T- *TAC*)

### Specification

|  |  |
| --- | --- |
| Definition | The Transport Accident Commission Claim Number of the person, relating to this hospital admission |
| Field size | 9 |
| Layout | YYXXXXX |
| Location | DVA and TAC Record (Shared field DVA ID/TAC Claim Number) |
| Reported by | Public hospitals |
| Reported for | Episodes with an Account Class of TAC (T-) |
| Reported when | The Episode Record is reported |
| Code set | Obtained from the TAC, allocated to those eligible for TAC benefits  C-U Claim number unavailable should be reported when the person’s TAC claim number is not known by the hospital. |
| Reporting guide | Characters 1-2: Financial year of claim acceptance.  Characters 3‑7: Numeric characters allocated by TAC.  Characters 8-9: Spaces  Examples of permitted formats: 9812345, 5412345 |
| Validations | 180 DVA ID/TAC Claim Number Blank  181 DVA ID/TAC Claim Number Incorrect  446 Dt of Accid Imcompat W TAC Claim Nbr - Warning |
| Related items | Section 3: Account Class, Date of Accident |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate payment by TAC for TAC patients  This data is held separately to other VAED data to ensure that personal information remains confidential. |
| Principal data users | Transport Accident Commission |
| Collection start | 2002—03 |
| Definition source | TAC |
| Code set source | TAC |

## FIM Score on Admission (a)

## FIM Score on Separation (b)

### Specification

|  |  |
| --- | --- |
| Definition | Functional Independence Measure FIMTM Score, as assessed on admission  Functional Independence Measure FIMTM Score, as assessed on separation |
| Field size | 18 |
| Layout | NNNNNNNNNNNNNNNNNN |
| Location | Subacute Record |
| Reported by | Public hospitals |
| Reported for | Care Types 6 and 9  For Care Type P, report spaces. |
| Reported when | A Separation Date is reported in the Episode Record. |
| Code set | Report a score for each item (range 1-7) for 18 items: |

FIM™ is comprised of 18 items, grouped into 2 subscales - motor and cognition

|  |  |
| --- | --- |
| Subscale | Item sequence |
| Motor subscale | 1 Eating  2 Grooming  3 Bathing  4 Dressing Upper Body  5 Dressing Lower Body  6 Toileting  7 Bladder Management  8 Bowel Management  9 Transfers – Bed/Chair/Wheelchair  10 Transfers - Toilet  11 Transfers – Bath/Shower  12 Walk/Wheelchair  13 Stairs |
| Cognitive subscale | 14 Comprehension  15 Expression  16 Social Interaction  17 Problem Solving  18 Memory |
|  |  |
| Reporting guide | Each item is scored on a 7-point scale  1 - Total assistance with helper  2 - Maximal assistance with helper  3 - Moderate assistance with helper  4 - Minimal assistance with helper  5 - Supervision or setup with helper  6 - Modified independence with no helper  7 - Complete independence with no helper  Assessment of FIMTM Scores is required at admission and separation for all S5 Records (excluding Paediatric Rehabilitation Care Type P)  For statistical separations from episodes with Care Types 6 or 9 to episodes with Care Type 6 or 9 the Separation FIMTM of the prior episode may be repeated as the Admission FIMTM of the subsequent episode.  The FIMTM on Admission should be assessed within 72 hours of episode start.  The FIMTM on Separation should be assessed within 72 hours prior to episode end.  **Patients who die in hospital**  The FIMTM on Separation for patients who die in hospital is 18 (i.e. a score of 1 for each item). |
| Validations (a) | 662 Adm FIMTM /Functional Assessment Date/Care Type  645 Invalid Admission FIMTM |
| Validations (b) | 646 Invalid Separation FIMTM  663 Sep FIMTM /Functional Assessment Date/Care Type mismatch  690 Sep FIMTM & Sep Mode Incompat  691 Adm FIMTM > Sep FIMTM |
| Related items | Section 3: Functional Assessment Date on Admission, Functional Assessment Date on Separation  Section 4: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P) |

### Administration

|  |  |
| --- | --- |
| Purpose | To support and further develop casemix classifications for sub-acute episodes of care |
| Principal data users | Department of Health |
| Collection start | 2009-10 |
| Definition source | Department of Health |
| Code set source | FIMTM |

## Functional Assessment Date on Admission (a)

## Functional Assessment Date on Separation (b)

### Specification

|  |  |
| --- | --- |
| Definition | Date of functional assessment for assignment of FIMTM Score on admission  Date of functional assessment for assignment of FIMTM Score on separation |
| Field size | 8 |
| Layout | DDMMYYYY |
| Location | Subacute Record |
| Reported by | Public hospitals |
| Reported for | Admitted episodes with Care Types 6, 9  For Care Types P report spaces |
| Reported when | A Separation Date is reported in the Episode Record. |
| Reporting guide | Reported when a FIMTM Score is reported, for Rehabilitation and GEM (Care Types 6 or 9).  (a) The Functional Assessment must be performed on or after the date of admission but should be within 72 hours of admission.  (b)The Functional Assessment must be performed on or before the date of separation but should be within 72 hours prior to separation.  Where a patient dies in hospital, the Functional Assessment Date on Separation may be reported as spaces.  For statistical separations from episodes with Care Types 6 or 9 to episodes with Care Types 6 or 9, Functional Assessment Date on Separation of the prior episode may be repeated as the Functional Assessment Date on Admission of the subsequent episode.  Validation of data is carried out on the S5 Sub-Acute record. If an E5 Episode record update is submitted with a Care Type change from 6 or 9 to Care Type 1, P, 8, 5x, 0, 4, U or 10 (which does not require Functional Assessment Date on Admission/Separation), the Subacute data will be deleted from the database and a warning edit to this effect will be triggered by the E5 Episode record. |
| Validations (a) | 618 Invalid Adm Functional Assessment Date  622 Functional Assessment Date < 7 days before Adm Date  624 Functional Assessment Date < Adm Date or > 7 days after Adm Date  627 Care Type changed; Sub-Acute data deleted |
| Validations (b) | 619 Invalid Sep Functional Assessment Date  625 Functional Assessment Date > 7 days after Sep Date  626 Functional Assessment Date > Sep Date or < 3 days before Sep Date  627 Care Type changed; Sub-Acute data deleted  662 Adm FIMTM/ Functional Assessment Date/Care Type mismatch  663 Sep FIMTM/ Functional Assessment Date/Care Type mismatch |
| Related items | Section 3: FIMTM Score on Admission, FIMTM Score on Separation  Section 4:Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P), and Care Type: Geriatric Evaluation and Management. |

### Administration

|  |  |
| --- | --- |
| Purpose | To support annual reporting obligation under the Australian Health Care Agreement. |
| Principal data users | Department of Health |
| Collection start | 2006-07 |
| Definition source | Department of Health |

## Funding Arrangement

### Specification

|  |  |
| --- | --- |
| Definition | Identifies the specific funding arrangement, if any, which applies to this episode of care |
| Field size | 1 |
| Layout | N or space |
| Location | Episode Record |
| Reported by | * Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care). * Any Victorian public and private hospital involved in hub and spoke arrangements with another hospital or satellite site. * Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient. * Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS). * Any Victorian private hospital involved in the Public/Private Elective Surgery Initiative (PHESI). * Any Victorian public or private hospital involved in the National Bowel Cancer Screening Program * Any Victorian public hospital managing own waiting list, performing additional elective surgery, under the Elective Surgery Blitz * Any Victorian public hospital approved to report episodes for NHRA-defined and funded highly specialised therapies   All other circumstances, report a space in this field. |
| Reported for | Episodes where an admitted service is provided under contract, hub and spoke, Coordinated Care Trial arrangements, Elective Surgery Access Service (ESAS), Private Hospital Elective Surgery Initiative, Elective Surgery Blitz, NHRA-funded highly specialised therapy, or as directed by the department.  Otherwise, report a space in this field. |
| Reported when | At any time during the episode |
| Code set | Code Descriptor  1 Contract  2 Hub and spoke  4 Coordinated Care Trial  6 Elective Surgery Access Service  7 Private Hospital Elective Surgery Initiative  8 National Bowel Cancer Screening Program  B Elective Surgery Blitz  N NHRA-funded highly specialised therapy  E Emergency use |
| Reporting guide | **1 Contract**  Patient receiving contracted hospital care under an agreement between a purchaser of hospital care (contractor) and a provider of an admitted or non‑admitted service (contracted hospital). |
|  | **2 Hub and Spoke**  Patient receiving a specialist service at another hospital or satellite site (spoke) under a hub and spoke arrangement. This hospital is the hub hospital. (Any service provided at a spoke hospital or satellite site is reported by the hub hospital only.)  **4 Coordinated Care Trial**  Patient identified as a Coordinated Care Trial patient.  **6 Elective Surgery Access Service (ESAS)**  Admission under the Elective Surgery Access Service (ESAS). Use code 6 only if the public hospital has been allocated resources through the Elective Surgery Access Service.  Private hospitals: Do not use code 6.  **7 Private Hospital Elective Surgery Initiative**  Admission under the Public/Private Elective Surgery Initiative. Use code 7 only if approved by DH.  Public hospitals: Do not use code 7.  **8 National Bowel Cancer Screening Program**  Admission under the National Bowel Cancer Screening Program.  **B Elective surgery blitz**  Admission under the elective surgery blitz public hospital managing their own waiting list.  Excludes: Admission under the elective surgery blitz under a contract arrangement with another hospital (report Program Identifier 13)  Private hospitals: Do not use code B  **N NHRA-funded highly specialised therapy**  Admission for NHRA-defined and funded highly specialised therapy  **E Emergency use**  Only to be used under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
| Validations | 410 Illegal Comb Fund Arrang & Contract  416 Invalid Fund Arrangement  423 Invalid Comb Funding/Contract/Transfer  456 Contract Leave, No Contract  478 Funding Arrangement 6, not approved for ESAS  491 Incompat Fields for ESAS  626 Invalid combination for Funding Arrangement PHESI  635 NBCSP but Age < 45 Years  638 Private Hosp, Public Account Without Contract  733 Funding Arrangement B Elective Surgery Blitz, not public  738 Funding Arrangement N NHRA-funded therapy, not approved |
| Related items | Section 3: Contract Role and Contract Type.  Section 4: Contracted Care, Hub and Spoke, Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Private Hospital Elective Surgery Initiative. |

### Administration

|  |  |
| --- | --- |
| Purpose | Identify whether a specific funding arrangement applies to this episode.  Facilitate health services planning and monitoring |
| Principal data users | Multiple internal and external data users |
| Collection start | 1996-97 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Gender

### Specification

|  |  |
| --- | --- |
| **Definition** | How a person describes their gender, as represented by a code |
| **Field size** | 1 |
| **Layout** | N |
| **Location** | Episode Record |
| **Reported by** | All Victorian hospitals (public and private)  Mandatory from 2024-25 |
| **Reported for** | All admitted episodes of care |
| **Code set** | **Code Descriptor**  1 Man, or boy, or male  2 Woman, or girl, or female  3 Non-binary  4 Different term  5 Prefer not to answer  9 Not stated |
| **Reporting guide** | [Gender](https://meteor.aihw.gov.au/content/750032) is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, boy, woman, girl, or non-binary person.  The terms [sex](https://meteor.aihw.gov.au/content/750030) and gender are interrelated, and are often used interchangeably, however they are distinct concepts:   * Sex is understood in relation to sex characteristics. Sex recorded at birth refers to what was determined by sex characteristics observed at birth or in infancy * Gender is about social and cultural differences in identity, expression, and experience.   A person's gender may differ from their sex and may also differ from what is indicated on their legal documents.  A person's gender may stay the same or can change over the course of their lifetime.  **1 Man, or boy, or male**  A person who describes their [gender](https://meteor.aihw.gov.au/content/750032) as man, or boy, or male.  **2 Woman, or girl, or female**  A person who describes their gender as woman, or girl, or female.  **3 Non-binary**  A person who describes their gender as non-binary.  Non-binary is an umbrella term describing gender identities that are not exclusively male or female  **4 Different term**  A person who describes their gender as a term other than man/boy/male, woman/girl/female or non-binary.  **5 Prefer not to answer**  A person who prefers not to respond on how they describe their gender.  **9 Not stated or inadequately described**  Includes:  Question unable to be asked such as when the patient is unconscious or too unwell. |
| **Validations** | 742 Invalid Gender |
|  |  |

### Administration

|  |  |
| --- | --- |
| **Purpose** | To measure usage of services and identify needs and gaps in provision.  To inform development of targeted programs and funding of services. |
| **Principal data users** |  |
| **Collection start** | 2023-24 |
| **Definition source** | Person—gender, code X (METEOR 741842) |
| **Code set source** | Australian Bureau of Statistics Alternative Code system for Gender, Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020. |

## Given Name(s)

### Specification

|  |  |
| --- | --- |
| Definition | The given name/s of the DVA or TAC patient |
| Field size | 15 |
| Layout | AXXXXXXXXXXXXXX |
| Location | DVA and TAC Record |
| Reported by | Public hospitals |
| Reported for | Admitted episodes with an Account Class of V- DVA or T- TAC. |
| Reported when | The Episode Record is reported |
| Reporting guide | The given name/s of the patient.  Permitted characters: A to Z (uppercase), space, apostrophe, and hyphen  The first character must be an alpha character. |
| Validation | 162 Invalid Given Name |
| Related items | Section 3: Account Class, Surname |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate payment by DVA and TAC for relevant episodes of care.  This data is held separately to other VAED data to ensure that personal information remains confidential. |
| Principal data users | Department of Veterans’ Affairs and Transport Accident Commission. |
| Collection start | 1992-93 |
| Definition source | Department of Health |

## Hospital Generated DRG

### Specification

|  |  |
| --- | --- |
| Definition | The DRG generated by the in‑house hospital grouper for this episode of care |
| Field size | 4 |
| Layout | ANNA or NNNA or spaces |
| Location | Diagnosis Record |
| Reported by | Public and private hospitals - optional. Otherwise, report spaces in this field.  Reporting in this field is recommended for hospital quality control, if the hospital has onsite grouping facilities. |
| Reported for | Any/all admitted episodes of care. Otherwise, report spaces in this field. |
| Reported when | The Separation Date is reported in the Episode Record |
| Code set | AR‑DRG used by the hospital |
| Reporting guide | Report the AR‑DRG generated by the hospital for each episode.  This field should be automatically reported for all episodes grouped by the hospital. |
| Validation | 334 Public Hosp DRG ≠ AR-DRG |
| Related items | Section 2: DRG Classification |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable hospitals to detect differences between their grouping processes and those of the department |
| Principal data users | Hospital health information managers |
| Collection Start | 1 July 1998 |
| Definition source | Department of Health |
| Code set source | Commonwealth Department of Health and Aged Care  Department of Health, Victorian health policy and funding guidelines |

## Hospital Insurance Status

### Specification

|  |  |
| --- | --- |
| Definition | The patient’s hospital insurance status, regardless of whether they elect to be a public or private patient or are a compensable or ineligible patient |
| Field size | 1 |
| Layout | N |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Select the first appropriate category:  Code Descriptor  2 Hospital Insurance  4 No Hospital Insurance  9 Hospital Insurance Status Unknown |
| Reporting guide | Persons covered by insurance for benefits for ancillary services only are included in 4 *No Hospital Insurance*.  Do not assume that a mother’s hospital insurance status will apply to her newborn baby. Single insurance cover does not provide for a newborn baby of the policy holder. |
| Validation | 044 Invalid Hospital Insurance Status Code |

### Administration

|  |  |
| --- | --- |
| Purpose | To monitor patterns of hospital insurance usage to inform health policy and planning |
| Principal data users | Department of Health |
| Collection start | 1990-91 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Impairment

### Specification

|  |  |
| --- | --- |
| Definition | The impairment group according to the primary reason for the current episode of rehabilitation care |
| Field size | 6 |
| Layout | NNNNNN or spaces Left justified, trailing spaces |
| Location | Subacute Record |
| Reported by | Public hospitals |
| Reported for | Mandatory if Care type is 6 or P.  For Care Type 9, report spaces |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set  Stroke | Code Descriptor  Stroke – Haemorrhagic  0111 Left Body Involvement (Right Brain)  0112 Right Body Involvement (Left Brain)  0113 Bilateral Involvement  0114 No Paresis  0119 Other stroke  Stroke – Ischaemic  0121 Left Body Involvement (Right Brain)  0122 Right Body Involvement (Left Brain)  0123 Bilateral Involvement  0124 No Paresis  0129 Other stroke |
| Brain dysfunction | Non-traumatic brain dysfunction  0211 Sub-arachnoid haemorrhage  0212 Anoxic brain damage  0213 Other non-traumatic brain dysfunction  Traumatic brain dysfunction  0221 Open injury  0222 Closed injury |
| Neurological | 031 Multiple sclerosis  032 Parkinsonism  033 Polyneuropathy  034 Guillain-Barre Syndrome  035 Cerebral Palsy  038 Neuromuscular disorders (include motor neuron disease)  039 Other neurological disorders |
| Spinal cord | Non-traumatic spinal cord disfunction  04111 Paraplegia, incomplete  04112 Paraplegia complete  041211 Quadriplegia incomplete C1 4  041212 Quadriplegia incomplete C5 8  041221 Quadriplegia complete C1 4  041222 Quadriplegia complete C5 8  0413 Other non-traumatic SCI  Traumatic spinal cord dysfunction  04211 Paraplegia, incomplete  04212 Paraplegia complete  042211 Quadriplegia incomplete C1 4  042212 Quadriplegia incomplete C5 8  042221 Quadriplegia complete C1 4  042222 Quadriplegia complete C5 8  0423 Other traumatic spinal cord dysfunction |
| Amputation | Amputation of limb - not resulting from trauma  0511 Single Upper Amputation Above the Elbow  0512 Single Upper Amputation Below the Elbow  0513 Single Lower Amputation Above the Knee (includes through knee)  0514 Single Lower Amputation Below the Knee  0515 Double Lower Amputation Above the Knee (includes through knee)  0516 Double Lower Amputation Above/below the Knee  0517 Double Lower Amputation Below the Knee  0518 Partial Foot Amputation (includes single/double)  0519 Other Amputation  Amputation of limb – resulting from trauma  0521 Single upper above elbow  0522 Single upper below elbow  0523 Single lower above knee (includes through knee)  0524 Single lower below knee  0525 Double lower above knee (includes through knee)  0526 Double lower above/below knee  0527 Double lower below knee  0528 Partial foot (single or double)  0529 Other amputation from trauma |
| Arthritis | 061 Rheumatoid  062 Osteoarthritis  069 Other Arthritis |
| Pain syndromes | 071 Neck pain  072 Back pain  073 Extremity pain  074 Headache (includes migraine)  075 Multi-site pain  079 Other pain (includes abdominal/chest wall) |
| Fracture | Fracture (includes dislocation)  08111 Fracture of hip, unilateral (includes #NOF)  08112 Fracture of hip, bilateral (includes #NOF)  0812 Fracture of shaft of femur (excludes femur involving knee joint)  0813 Fracture of pelvis  08141 Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)  08142 Fracture of lower leg, ankle, foot  0815 Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)  0816 Fracture of spine (excludes where the major disorder is pain)  0817 Fracture of multiple sites (multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum  Excludes with brain injury or with spinal cord injury)  0819 Other orthopaedic fracture (includes jaw, face, rib, orbit or sites not elsewhere classified) |
| Post orthopaedic surgery | 08211 Unilateral hip replacement  08212 Bilateral hip replacement  08221 Unilateral knee replacement  08222 Bilateral knee replacement  08231 Knee and hip replacement same side  08232 Knee and hip replacement different sides  0824 Shoulder replacement or repair  0825 Post spinal surgery (includes nerve root injury (laminectomy, spinal fusion, discectomy; excludes spinal cord injury or caudaequina)  0826 Other orthopaedic surgery |
| Soft tissue | 083 Soft tissue injury |
| Cardiac | 091 Following recent onset of new cardiac impairment (AMI, cardiac myopathy, cardiac surgery)  092 Chronic cardiac insufficiency  093 Heart and heart/lung transplant |
| Pulmonary | 101 Chronic Obstructive Pulmonary Disease  102 Lung Transplant  109 Other pulmonary |
| Burns | 110 Burns |
| Congenital | 121 Spina Bifida  129 Other congenital deformity |
| Other disabling impairments | 131 Lymphoedema  133 Conversion disorder  139 Other disabling impairments that cannot be classified into a specific group (this group should be rarely used) |
| Major multiple trauma | 141 Brain and spinal cord injury  142 Brain and multiple fracture/amputation  143 Spinal cord and multiple fracture/amputation  149 Other multiple trauma |
| Developmental | 151 Developmental disabilities (excludes cerebral palsy) |
| Restorative | 161 Re-conditioning following surgery  162 Re-conditioning following medical illness  163 Cancer rehabilitation |
| COVID conditions | 181 COVID with pulmonary issues  182 COVID with deconditioning  189 COVID all other |
| Reporting guide | Impairment codes should be assigned by the treating clinician. Code assignment must be supported by the appropriate ICD‑10‑AM codes reported in the X5/Y5 Diagnosis/Extra Diagnosis Records.  The Australian Rehabilitation Outcomes Centre (AROC) provides guidelines for coding Impairments: [AROC](http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow125260.pdf) <http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow125260.pdf > |
| Validations | 253 Rehab Invalid Impairment  258 Sub-Acute: No Sub-Acute Record  293 Impairment Present |
| Related items | Section 2: Rehabilitation Care  Section 4: Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P), and Care Type: Geriatric Evaluation and Management |

### Administration

|  |  |
| --- | --- |
| Purpose | To classify rehabilitation episodes according to impairment group |
| Principal data users | Department of Health |
| Collection start | 2009-10 |
| Definition source | Department of Health |
| Code set source | AROC impairment coding guidelines– 2023 |

## Indigenous Status

### Specification

|  |  |
| --- | --- |
| Definition | Whether a person identifies as being of Aboriginal or Torres Strait Islander origin |
| Field size | 1 |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Code Descriptor  1 Aboriginal but not Torres Strait Islander origin  2 Torres Strait Islander but not Aboriginal origin  3 Both Aboriginal and Torres Strait Islander origin  4 Neither Aboriginal nor Torres Strait Islander origin  8 Question unable to be asked  9 Patient refused to answer |
| Reporting guide | **Code 8 Question unable to be asked** should only be used under the following circumstances:   * When the patient’s medical condition prevents the question of Indigenous Status being asked; or * In the case of an unaccompanied child who is too young to be asked their Indigenous Status.   **Collect for every admitted episode**  This information must be collected for every admitted patient episode and updated each time the patient represents to the hospital for admission.  Systems must not be set up to input a default code |
| Validations | 070 Invalid Indigenous Status  234 Aboriginal/Ts Island but not Aust born  393 Recip HCA Account, Indig Stat A Or TI  495 Incompat Sep Referral and Indigenous Status  513 Indigenous Status/Preferred Language Mismatch  629 Incompatible Adm Source/Indigenous Status |
| Related items | Section 2: Country of Birth, Preferred Language |

### Administration

|  |  |
| --- | --- |
| Purpose | Enable planning and service delivery, monitoring of indigenous health at state / national level, facilitate application of specific funding arrangements |
| Principal data users | Department of Health |
| Collection start | 1987-88 |
| Definition source | NHDD |
| Code set source | NHDD (DH modified) |

## Intended Duration of Stay

### Specification

|  |  |
| --- | --- |
| Definition | The intention of the responsible clinician at the time of the patient’s admission to hospital, to discharge the patient either on the day of admission or a subsequent date |
| Field size | 1 |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Code Descriptor  1 Intended same day  2 Intended overnight (or longer) |
| Reporting guide | The intended duration of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital. This should not be altered after admission, regardless of the actual duration of the episode. |
| Validations | 307 Invalid Intended Duration  308 Adm Crit O But Int’d Same Day  309 Adm Crit B & Int’d Overnight  310 Adm Crit C Int’d Overnight  311 Adm Crit N Int’d Same Day  312 Adm Crit U & Int’d Same Day |

### Administration

|  |  |
| --- | --- |
| Purpose | To provide clinical indicator data. |
| Principal data users | Multiple internal and external data users |
| Collection start | 1996-97 |
| Definition source | NHDD |
| Code set source | NHDD (DH modified) |

## Intention to Re-Admit

### Specification

|  |  |
| --- | --- |
| Definition | The intention of the responsible clinician, at the time of the patient’s separation from hospital, to re-admit the patient within 28 days. |
| Field size | 1 |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private). |
| Reported for | All admitted episodes of care. |
| Reported when | The Separation Date is reported. Otherwise, report spaces. |
| Code set | Code Descriptor  Select the first appropriate category:  0 Not applicable  1 Re admission planned to this hospital within 28 days and booking arranged  2 Re admission planned to this hospital within 28 days but no booking yet arranged  3 Re admission planned to another acute hospital within 28 days and booking arranged  4 Re admission planned to another acute hospital within 28 days but no booking yet arranged  9 No plan to re admit within 28 days |
| Reporting guide | For **statistical separations**, and for patients who have died, or left against medical advice, code 0 (zero) indicates not applicable.  For **formal separations**, this information should be recorded by the patient’s treating medical practitioner at the time of separation to indicate whether there is an intention on the part of the medical practitioner that the patient would be admitted within 28 days either to this hospital or to another acute hospital.  Intention to re‑admit may be for treatment of a condition related to the one for which the patient was originally hospitalised or for another reason.  For Posthumous Organ Procurement episodes (Care Type 10), always assign code 0 Not applicable in this field.  **0 Not applicable**  Includes:   * Patient statistically separated (Separation Mode S). * Died in hospital (Separation Mode D). * Patient who left hospital at own risk against medical advice (Separation Mode Z). * Posthumous Organ Procurement episodes (Separation Mode G)   Excludes:   * Patients who go to a residential aged care facility. * Patients separated to a Transition Care bed-based program   **1, 2, 3 and 4 Re admission planned**  Includes:   * Re admission is planned to this or another acute hospital within 28 days with or without a booking. * Patient transferred (Separation Mode T), and re-admission is planned to this or another acute hospital within 28 days. * Antenatal patient whose dates or medical condition indicate the birth could be within 28 days.   Excludes:  Separation Modes S, D, Z or G (use code 0 Not applicable).  **9 No plan to re admit within 28 days**  Includes:   * Patient whose only plan is for an appointment for a non-admitted (outpatient) occasion of service. * Patient whose medical practitioner has no plan to re admit but expects the patient, of the patient’s own accord, may re-present at this or another hospital within 28 days because of debility, habit or a chronic condition.   Excludes:  Antenatal patient whose dates or medical condition indicate the birth could be within 28 days (classify to appropriate re admission planned code).  Separation Modes S, D, Z or G (use code 0 Not applicable). |
| Validations | 191 Invalid Intention to Readmit  192 Invalid Comb Int. Readmit/Sep Mode  193 Not Separated – Intent Readmit |
| Related items | Section 3: Separation Mode.  Section 4: Intention to Readmit and Separation Mode |

### Administration

|  |  |
| --- | --- |
| Purpose | To:  Calculate rate of unplanned readmissions.  Provide clinical indicator data. |
| Principal data users | Multiple internal and external data users |
| Collection start | 1996-97 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Interpreter Required

### Specification

|  |  |
| --- | --- |
| Definition | The patient’s need for an interpreter, as perceived by the patient or person consenting for the patient |
| Field size | 1 |
| Location | Episode Record |
| Reported by | Public hospitals (voluntary for private hospitals or report space) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Code Descriptor  1 Yes  2 No  9 Not Stated/Inadequately Described |
| Reporting guide | Preferred Language to be asked before Interpreter Required.  If the Preferred language is English, Interpreter Required can be assumed to be 2 No.  This data item must:   * Be checked for every admitted patient episode. * Not be set up to input a default code on computer systems. * Be collected on, or as soon as possible after, admission.   The standard question is:  [Do you] [Does the person] [Does (name)] require an interpreter?  The provision of the question ‘Do you require an interpreter?’ is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.  **1 Yes**  Use code 1 if the patient indicates they need an interpreter  **2 No**  Use code 2 if the patient indicates they do not need an interpreter.  Includes:  Where the Preferred Language is English  **9 Not Stated / Inadequately Described**  Use code 9 if neither Yes nor No can be accurately ascertained.  Includes where Preferred Language is:  0002 Not Stated or  0000 Inadequately described  **Patient is unable to consent (eg baby, child or elderly):**  Where a person is not able to consent for themselves (eg baby, child or elderly) then the need for an interpreter is recorded for the person who is consenting. For example, a guardian or someone with enduring power of attorney. |
| Validations | 517 Invalid Interpreter Required  592 Invalid Comb Int Req/Pref Lang |
| Related items | Section 3: Country of Birth, Indigenous Status, Preferred Language |

### Administration

|  |  |
| --- | --- |
| Purpose | For planning and to form the basis for future funding allocation for Culturally and Linguistically Diverse (CALD) hospital service provision. |
| Principal data users | Multiple internal and external data users |
| Collection start | 2003-04 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Leave days – Phase of Care on Admission (a)

## Leave days – Phase of Care Change (b)

## Leave days – Final Phase of Care (c)

### Specification

|  |  |
| --- | --- |
| Definition | The total number of days during a phase of care that the patient was out of hospital ‘on leave with or without permission’  Leave days – Phase of Care on Admission (a)  Leave days – Phase of Care Change (b)  Leave days – Final Phase of Care (c) |
| Field size | 2 |
| Layout | NN Right justified, zero filled |
| Location | Palliative Record |
| Reported by | Public hospitals |
| Reported for | Care Type 8 episodes where there was leave with or without permission |
| Reported when | A Separation Date is reported in the Episode Record |
| Reporting guide | For each Phase of Care, report number of days the patient was out of hospital on leave with or without permission  **Episodes with more than 10 changes of Phase of Care**  Leave days – Final Phase of Care (c) includes leave days during the Final Phase of Care plus leave days during any Phases of Care omitted from reporting. |
| Validations | 724 Leave days POC on Admission not numeric or blank  726 Leave days POC Change not numeric or blank  727 Leave days Final POC not numeric or blank  740 Pall leave days not equal to Leave Day Total |
| Related items | Section 3: Phase of Care on Admission, Phase of Care Final Phase of Care  Section 4: Palliative care Reporting, Leave |

### Administration

|  |  |
| --- | --- |
| Purpose | Enable calculation of NWAU |
| Principal data users | Department of Health, IHPA, health services |
| Collection start | 2021-22 |
| Definition source | Department of Health |

## Leave with Permission Days Financial Year-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of days during this episode of care that the patient was out of hospital ‘on leave with permission’ in the financial year being reported (includes the month being reported) |
| Field size | 3 |
| Layout | NNN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Episodes where there was a period of leave with permission for the financial year-to-date |
| Reported when | The Episode Record is reported |
| Reporting guide | A valid number complying with the business rules  Leave with Permission Days Financial Year-to-Date must be equal to or greater than Leave with Permission Days Month-to-Date and equal to or less than Leave With Permission Days Total |
| Validations | 047 Leave W Perm Days YTD Not Numeric or Blank  053 Leave W Perm YTD< MTD  055 Leave W Perm Tot<YTD  224 Newborn with Leave |
| Related items | Section 2: Leave with Permission and Leave without Permission.  Section 3: Leave with Permission Days Month-to-Date and Leave with Permission Days Total.  Section 4: Leave |

### Administration

|  |  |
| --- | --- |
| Purpose | Used in calculation of length of stay |
| Principal data users | Automated data processing and validation |
| Collection start | 1990-91 |
| Definition source | Department of Health |

## Leave with Permission Days Month-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of days during this episode of care that the patient was out of hospital ‘on leave with permission’ in the month being reported (month to date) |
| Field size | 2 |
| Layout | NN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Episodes where there was a period of leave with permission for the month |
| Reported when | The Episode Record is reported |
| Reporting guide | A valid number complying with the business rules  Leave with Permission Days Month-to-Date must be equal to or less than Leave with Permission Days Financial Year-to-Date and Leave with Permission Days Total. |
| Validations | 046 Leave W Perm Days MTD Not Numeric or Blank  053 Leave W Perm YTD< MTD  055 Leave W Perm Tot<YTD  224 Newborn with Leave |
| Related items | Section 2: Leave with Permission and Leave Without Permission.  Section 3: Leave with Permission Days Financial Year-to-Date and Leave with Permission Days Total.  Section 4: Leave |

### Administration

|  |  |
| --- | --- |
| Purpose | Used in calculation of length of stay |
| Principal data users | Automated data processing and validation |
| Collection start | 1990-91 |
| Definition source | Department of Health |

## Leave with Permission Days Total

### Specification

|  |  |
| --- | --- |
| Definition | The total number of days during this episode of care that the patient was out of hospital ‘on leave with permission’, including days from the previous financial year/s |
| Field size | 3 |
| Layout | NNN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Episodes where there was a period of leave with permission |
| Reported when | The Episode Record is reported |
| Reporting guide | A valid number complying with the business rules  Leave with Permission Days Total must be equal to or greater than Leave with Permission Days Month-to-Date and Leave with Permission Days Financial Year-to-Date |
| Validations | 049 Leave W Perm Days Tot Not Numeric or Blank  054 Leave W Perm Tot<MTD  055 Leave W Perm Tot< YTD  112 Calc Los + Leave Not = Adm/Sep  224 Newborn with Leave |
| Related items | Section 2: Leave with Permission and Leave without Permission.  Section 3: Leave with Permission Days Financial Year-to-Date, and Leave with Permission Days Month-to-Date.  Section 4: Leave |

### Administration

|  |  |
| --- | --- |
| Purpose | Used in calculation of length of stay |
| Principal data users | Automated data processing and validation |
| Collection start | 1990-91 |
| Definition source | Department of Health |

## Leave without Permission Days Financial Year-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of days during this episode of care that the patient was out of hospital ‘on leave without permission’ in the financial year being reported (includes the month being reported) |
| Field size | 3 |
| Layout | NNN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Episodes where there was a period of leave without permission for the financial year-to-date |
| Reported when | The Episode Record is reported |
| Reporting guide | A valid number complying with the business rules.  Leave without Permission Days Financial Year-to-Date must be equal to or greater than Leave without Permission Days Month-to-Date and equal to or less than Leave without Permission Days Total. |
| Validations | 224 Newborn with Leave  566 Leave W/O Perm Days YTD Not Numeric or Blank  568 Leave W/O Perm YTD< MTD  570 Leave W/O Perm Tot<YTD |
| Related items | Section 2: Leave with Permission and Leave without Permission.  Section 3: Leave without Permission Days Month-to-Date and Leave without Permission Days Total.  Section 4: Leave |

### Administration

|  |  |
| --- | --- |
| Purpose | Used in calculation of length of stay |
| Principal data users | Automated data processing and validation |
| Collection start | 1990-91 |
| Definition source | Department of Health |

## Leave without Permission Days Month-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of days during this episode of care that the patient was out of hospital ‘on leave without permission’ in the month being reported (month to date) |
| Field size | 2 |
| Layout | NN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Episodes where there was a period of leave without permission for the month |
| Reported when | The Episode Record is reported |
| Reporting guide | A valid number complying with the business rules  Leave Without Permission Days Month-to-Date must be equal to or less than Leave Without Permission Days Financial Year-to-Date and Leave Without Permission Days Total. |
| Validations | 224 Newborn with Leave  565 Leave W/O Perm Days MTD not numeric or blank  568 Leave W/O Perm YTD< MTD  569 Leave W/O Perm Tot < MTD |
| Related items | Section 2: Leave with Permission and Leave without Permission.  Section 3: Leave without Permission Days Financial Year-to-Date and Leave without Permission Days Total.  Section 4: Leave |

### Administration

|  |  |
| --- | --- |
| Purpose | Used in calculation of length of stay |
| Principal data users | Automated data processing and validation |
| Collection start | 1990-91 |
| Definition source | Department of Health |

## Leave without Permission Days Total

### Specification

|  |  |
| --- | --- |
| Definition | The total number of days during this episode of care that the patient was out of hospital ‘on leave without permission’, including days from the previous financial year/s |
| Field size | 3 |
| Layout | NNN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Episodes where there was a period of leave without permission |
| Reported when | The Episode Record is reported |
| Reporting guide | A valid number complying with the business rules.  Leave without Permission Days Total must be equal to or greater than Leave without Permission Days Month-to-Date and Leave without Permission Days Financial Year-to-Date. |
| Validations | 112 Calc LOS + Leave Not = Adm/Sep  224 Newborn with Leave  567 Leave W/O Perm Days Tot not numeric or blank  569 Leave W/O Perm Tot<MTD  570 Leave W/O Perm Tot< YTD |
| Related items | Section 2: Leave with Permission and Leave without Permission.  Section 3: Leave without Permission Days Financial Year-to-Date and Leave without Permission Days Month-to-Date  Section 4: Leave |

### Administration

|  |  |
| --- | --- |
| Purpose | Used in calculation of length of stay |
| Principal data users | Automated data processing and validation |
| Collection start | 1990-91 |
| Definition source | Department of Health |

## Locality

### Specification

|  |  |
| --- | --- |
| Definition | Geographic location (suburb/town/locality for Australian residents, country for overseas residents) of usual residence of the person (not postal address) |
| Field size | 22 |
| Layout | AAAAAAAAAAAAAAAAAAAAAA Left justified |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | The Department of Health is only permitted to share this reference file with Victorian health services for non-commercial use, for the purpose of reporting and submitting data to the department.  Victorian health services can request a copy of the postcode-locality reference file for departmental reporting via email to HDSS helpdesk: [hdss.helpdesk@health.vic.gov.au](mailto:hdss.helpdesk@health.vic.gov.au) |
| Reporting guide | The department file excludes non-residential postcodes.  Locality must be blank if the Postcode is 1000 or 9988.  Where the Postcode is 8888 (overseas), report the country the patient lives in, in Locality. The four-digit country code must be one that corresponds with a code listed against 8888 (overseas) in the Postcode/Locality reference file. |
| Validations | 058 Invalid Postcode/Locality  571 Acct Recip, Pcode Oseas, Locality Not RHCA  574 Postcode Overseas, Locality RHCA, Acct Not RHCA |
| Related items | Section 3: Postcode |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable calculation (with Postcode field) of the patient’s appropriate Local Government Area (LGA) which enables:   * Analysis of service utilisation and need for services. * Identification of patients living outside Victoria for purposes of cross-border funding. * Identification of patients living outside Australia for the Reciprocal Health Care Agreement (RHCA). |
| Principal data users | Multiple internal and external users |
| Collection start | 1990-91 |
| Definition source | Department of Health |
| Code set source | ABS National Locality Index (Cat. No. 1252) (DH modified) |

## Marital Status

### Specification

|  |  |
| --- | --- |
| Definition | Current marital status of the person |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Code Descriptor  1 Never married  2 Widowed  3 Divorced  4 Separated  5 Married  6 De facto  9 Not stated / inadequately described |
| Reporting guide | Report the current marital status of the person |
| Validations | 034 Invalid Marital Status |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate social and epidemiological studies |
| Principal data users | Multiple internal and external users |
| Collection start | 1979-80 |
| Definition source | NHDD |
| Code set source | CCDS |

## 

## Medicare Number

### Specification

|  |  |
| --- | --- |
| Definition | Personal identifier allocated by Medicare Australia to eligible persons under the Medicare scheme |
| Field size | 11 |
| Layout | NNNNNNNNNNN or spaces (all zeros are invalid) |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Public hospitals: All patients except in the circumstances covered under Medicare Suffix.  Private hospitals: All contracted patients and for all other patients, where possible. The exceptions are covered under Medicare Suffix. |
| Reported when | The Episode Record is reported |
| Code set | The patient’s Medicare number and individual reference number (IRN), issued by Medicare Australia |
| Reporting guide | Valid:   * First character can only be a: 2, 3, 4, 5, or 6 * Numeric or all blanks * Check digit (ninth character) is the remainder of the following equation: [(1st digit \* 1) + (2nd digit \* 3) + (3rd digit \* 7) + (4th digit \* 9) +(5th digit \* 1) + (6th digit \* 3) + (7th digit \* 7) + (8th digit \* 9)] / 10   Invalid:   * Special characters (for example, $, #) * Alphabetic characters * Zero-filled (if the Medicare number is not available or not applicable, the Medicare number must be left blank)   The Medicare number is printed in the centre on the Medicare card.  The Medicare IRN is also called the ‘eleventh character’ of the number. It is the number printed to the left of the name of the patient.  **Neonates**  For neonates who have not yet been added to the family Medicare card, and therefore have no IRN, there are two reporting options:  Mother's/family's Medicare number in the first ten characters and a zero (0) as the eleventh character  Mother's/family's Medicare number in the first ten characters and the mother's IRN as the eleventh character. |
| Validations | 030 Invalid Medicare number  518 Medicare IRN = 0, Age > 6 Months  519 Medicare IRN = 0, Age > 12 Months |
| Related items | Section 2: Medicare Eligibility Status  Section 3: Medicare Suffix. |

### Administration

|  |  |
| --- | --- |
| Purpose | To assist in monitoring continuity of care across hospitals and ensure eligibility for publicly funded health care. |
| Principal data users | Department of Health |
| Collection start | 1979-80 |
| Definition source | NHDD |
| Code set source | Medicare Australia |

## Medicare Suffix

### Specification

|  |  |
| --- | --- |
| Definition | First three characters of patient’s first given name (as it appears on the person’s Medicare card) |
| Field size | 3 |
| Layout | XXX or A-A |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | The first 3 characters of the patient’s first given name.   * Characters permitted: * Upper case alphas * Space as second and third characters * Space as third character * Hyphen or apostrophe as second character or hyphen or apostrophe as third character.   If Medicare number is unavailable or the patient is not eligible for a Medicare number or the patient is a prisoner, leave the Medicare number blank (not zero-filled) and enter the appropriate suffix:  Code Descriptor  C-U Card unavailable/Not applicable  N-E Not eligible for Medicare  P-N Prisoner |
| Reporting guide | **RCHA**  Report C-U For patients with Account Class MA Reciprocal Health Care Agreement  **Unnamed neonate**  For unnamed neonates where the family has a Medicare number, report a Medicare suffix of 'BAB'. The Medicare number issued to the mother/family must also be reported with   * A Medicare IRN ('eleventh character') of zero (0), OR * The Medicare IRN of the mother. |
| Validations | 031 Blank Medicare Suffix  032 Invalid Medicare Suffix  094 Invalid combination A/C Med Suff |
| Related items | Section 2: Medicare Eligibility Status  Section 3: Medicare number.  Section 4: Account Class and Medicare Suffix |

### Administration

|  |  |
| --- | --- |
| Purpose | To assist in monitoring continuity of care across hospitals and ensure eligibility for publicly funded health care |
| Principal data users | Department of Health |
| Collection start | 1979-80 |
| Definition source | Department of Health |
| Code set source |  |

## Mental Health State Wide Patient Identifier

### Specification

|  |  |
| --- | --- |
| Definition | The client identifier, unique to the client for approved Mental Health Service and Psychogeriatric Programs |
| Field size | 10 |
| Layout | NNNNNNNNNN or spaces Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian public hospitals with an approved Mental Health Service  Private hospitals: Report spaces in this field |
| Reported for | All mental health admitted episodes of care (Care Type 5x) and other episodes in which an ECT has been performed |
| Reported when | The Episode Record is reported |
| Code set | ODS generated |
| Reporting guide | Report the primary Mental Health State-wide Patient Identifier for all mental health episodes of care (Care Types 5x) and episodes reported in which an ECT has been performed. |
| Validations | 575 Care Type 5x, MHSWPI Blank  576 Invalid MHSWPI  577 MHSWPI not on ODS  579 MHSWPI Valid, no Matching DOB  580 MHSWPI Valid, no Matching Sex at birth  581 MHSWPI Valid, Secondary on ODS  660 Care Type ≠ 5x, Procedure Code 14224-xx, MHSWPI mismatch |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable management of clients and their associated data |
| Principal data users | Department of Health |
| Collection start | 2004-05 |
| Definition source | Department of Health |
| Code set source | ODS generated |

## Mother’s UR

### Specification

|  |  |
| --- | --- |
| Definition | The UR Number (Patient Identifier) of the mother of the baby |
| Field size | 10 |
| Layout | XXXXXXXXXX or spaces Right justified, zero filled |
| Location | Episode Record |
| Reported by | Victorian hospitals (public and private) |
| Reported for | Public Hospitals: Newborn episodes where both mother and baby are admitted.  Private hospitals: Newborn episodes where both mother and baby are admitted, and the newborn episode is reported. |
| Reported when | The Episode Record is reported |
| Code set | Valid Patient Identifier |
| Reporting guide | When the baby is born in hospital during this episode of care, report the Patient Identifier of the mother’s episode of care.  If the baby was not born during this episode of care, but both mother and baby are admitted to the hospital, report the Patient Identifier of the mother’s episode of care. |
| Validations | 652 Invalid format Mother’s UR  653 Mother’s UR and Admission Source mismatch  654 Mother’s UR does not exist |
| Related items | Section 3: patient Identifier |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable analysis of the factors affecting the care of both the mother and baby |
| Principal data users | Internal and external data users |
| Collection start | 2009-10 |
| Definition source | Department of Health |
| Code set source | Hospital generated |

## 

## NDIS Participant Flag

### Specification

|  |  |
| --- | --- |
| Definition | National Disability Insurance Scheme (NDIS) participant status of person |
| Field size | 1 |
| Layout | N |
| Location | Episode Record |
| Reported by | Public hospitals |
| Reported for | Episodes with:  Care Types 1, 4, 5x, 6, 8, 9, P, MC |
| Reported when | On admission and updated at any time during the episode |
| Code set | Code Descriptor  1 No  2 Yes – new NDIS participant during this admission  3 Yes – existing NDIS participant prior to admission  4 Not stated |
| Reporting guide | For NDIS participants, also report their NDIS Participant Identifier |
| Validations | 722 Invalid NDIS Participant Flag  743 NDIS Participant Flag / Identifier mismatch  744 Invalid NDIS Participant Identifier |
| Related items | Section 3 NDIS Participant Identifier |

### Administration

|  |  |
| --- | --- |
| Purpose | * To compare cohorts with NDIS dependence to those without to determine impacts on LOS * Analyse long term outcomes of timeliness and availability of NDIS supports on patient cohorts |
| Principal data users | Multiple internal and external data users |
| Collection start | July 2021 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## NDIS Participant Identifier

### Specification

|  |  |
| --- | --- |
| **Definition** | National Disability Insurance Scheme (NDIS) participant number of person who is a registered NDIS participant |
| **Field size** | 9 |
| **Layout** | NNNNNNNNN or spaces |
| **Location** | Episode Record |
| **Reported by** | Public hospitals |
| **Reported for** | Registered NDIS participants |
| **Reported when** | On admission and updated at any time during the episode |
| **Code set** | Allocated by the National Disability Insurance Agency |
| **Reporting guide** | The NDIS participant number is the unique reference number allocated to the individual by the NDIS as a form of identification once the agency has approved the provision of NDIS services for that person.  For new NDIS participants, report the NDIS participant number as soon as this becomes available.  Valid:   * All numeric or all spaces * For NDIS participants who are unable to provide their number report 999999999 * For non-NDIS participants, report spaces in this field |
| **Validations** | 743 NDIS Participant Flag / Identifier mismatch  744 Invalid NDIS Participant identifier |
| **Related items** | Section 3 NDIS Participant Flag |

### Administration

|  |  |
| --- | --- |
| **Purpose** | To identify NDIS participants within health data collections, and the primary identifier for data linkage between health data collections and the NDIA |
| **Principal data users** | Health Services and Aged Care Policy, Department of Health |
| **Collection start** | July 2023 |
| **Definition source** | Department of Health |
| **Code set source** | National Disability Insurance Agency |

## Onset Date

### Specification

|  |  |
| --- | --- |
| Definition | Date of admission for the acute episode for care, relating to an injury or disease condition, for which the person has now been admitted for a subsequent rehabilitation episode of care |
| Field size | 8 |
| Layout | DDMMYYYY |
| Location | Subacute Record |
| Reported by | Public hospitals |
| Reported for | Episodes with Care Type P or 6  For Care Types 9, report spaces in this field |
| Reported when | A Separation Date is reported in the Episode Record. |
| Reporting guide | Onset Date must be equal to or earlier than the Admission Date, and after the Date of Birth.  The Admission Date of the acute episode should be obtained from the acute hospital where the acute episode occurred.  If the patient is admitted to rehabilitation directly from the community, this field should match the date of admission in the Episode Record. |
| Validations | 255 Rehab: Invalid Onset Date  258 Sub-Acute: No Sub-Acute Record  289 Adm Sc is T’fer & Onset = Adm Date  290 Stat Adm Sc & Onset = Adm Date  294 Onset Date Present |
| Related items | Section 2: Rehabilitation Care.  Section 4: Care Type: Designated Rehabilitation Program (6) and Designated Paediatric Rehabilitation Program (P) |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable measurement of the time elapsed since the initial acute episode, to support and further develop casemix classifications for sub-acute episodes |
| Principal data users | Department of Health |
| Collection start | 1995-96 |
| Definition source | Department of Health |

## Patient Days Financial Year-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of patient days the person has accrued during the current financial year-to-date excluding leave with and without permission days (includes the month being reported). (Total of patient days recorded in each of the status segments) |
| Field size | 3 |
| Layout | NNN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Reporting guide | A number in the range 00 to 366  Patient Days includes Contracted Leave Days.  Patient Days Financial Year-to-Date must be equal to or greater than Patient Days Month-to-Date and equal to or less than Patient Days Total. |
| Validations | 076 Not Sufficient Fields First Status  077 Not Sufficient Fields Other Status  087 Pt Days YTD Not Numeric or blank  091 Pt Days YTD < MTD  093 Pt Days Total < YTD |
| Related items | Section 4: Length of Stay, Reporting history of code changes – status segments |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable hospitals to reconcile YTD days reported each month |
| Principal data users | Department of Health |
| Collection start | 1983-84 |
| Definition source | Department of Health |

## Patient Days Month-to-Date

### Specification

|  |  |
| --- | --- |
| Definition | The number of patient days the person has accrued during the current month excluding leave with and without permission days, where current month refers to the month nominated by the Header start and end dates. (Total of patient days recorded in each of the status segments) |
| Field size | 2 |
| Layout | NN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Reporting guide | A number in the range 00 to 31  Patient Days includes Contracted Leave Days.  Patient Days Month-to-Date must be equal to or less than Patient Days Financial Year to-Date and Patient Days total. |
| Validations | 076 Not Sufficient Fields First Status  077 Not Sufficient Fields Other Status  086 Pt Days MTD not numeric or blank  091 Pt Days YTD<MTD  092 Pt Days Total<MTD |
| Related items | Section 4: Length of Stay, Reporting history of code changes – status segments |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable hospitals to reconcile MTD days reported each month |
| Principal data users | Department of Health |
| Collection start | 1983-84 |
| Definition source | Department of Health |

## Patient Days Total

### Specification

|  |  |
| --- | --- |
| Definition | The total number of patient days the person has accrued during the whole episode of care to date excluding leave with and without permission days (includes the month being reported). (Total of patient days recorded in each of the status segments) |
| Field size | 4 |
| Layout | NNNN Right justified, zero filled |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Reporting guide | A number in the range 0001 to 9999  Patient Days includes Contracted Leave Days.  Patient Days Total must be equal to or greater than Patient Days Month to-Date and Patient Days Financial Year to Date. |
| Validations | 076 Not Sufficient Fields First Status  077 Not Sufficient Fields Other Status  089 Pt Days Tot Not Numeric or blank  092 Pt Days Total < MTD  093 Pt Days Total < YTD  096 Total Days Can’t Be Zero  112 Calc LOS + Leave Not = Adm /Sep  113 Same Day Status: Total Pt Days Not 1  243 Unqual Newborn but Total Days > 9  432 MAPU or SOU > 48 Hours |
| Related items | Section 4: Length of Stay, Reporting history of code changes – status segments |

### Administration

|  |  |
| --- | --- |
| Purpose | Major measure of resource use. Also identifies whether episode is:  An inlier or outlier for the appropriate DRG.  Same day or one day or multi day. |
| Principal data users | Multiple internal and external users |
| Collection start | 1979-80 |
| Definition source | Department of Health |

## Patient Identifier

### Specification

|  |  |
| --- | --- |
| Definition | An identifier, unique to a patient within this hospital or campus (patient’s record number/unit record number) |
| Field size | 10 |
| Layout | XXXXXXXXXX Right justified, zero filled |
| Location | Episode Record  Sub-Acute Record  Palliative Record  DVA and TAC Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record, Sub-Acute Record, Palliative Record or DVA and TAC Record are reported |
| Code set | Hospital generated |
| Reporting guide | If multiple campuses submit to the VAED in a single submission file, the Patient Identifier must be unique to the service. If the campuses submit data separately, the Patient Identifier must be unique to each campus.  All newborns must have their own Patient Identifier. This cannot be the newborn’s mother’s Patient Identifier but could be the mother’s Patient Identifier with a prefix or suffix. |
| Validations | 026 Zero Sep; Existing Not Discharged  027 Adm Record; Overlaps Existing  028 Prior Adm; No Sep Date  029 Invalid Pt ID  062 Duplicate Pt ID, Adm Date Time, Diff Unique  063 Prior Not Discharged  064 Duplicate Pt ID, Date Time  248 Tran Pt ID not same as Episode or Sub Ac  499 Stat Admission: No Prev Episode  531 Same UK, diff Pt ID  686 Tran Pt ID not same as Episode or Pall |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable relevant episodes to be updated and provide the potential for episodes to be linked across patient settings |
| Principal data users | Automated processing and validation |
| Collection start | 1979-80 |
| Definition source | Department of Health |

## Phase of Care Change Date (a)

## Final Phase of Care Start Date (b)

### Specification

|  |  |
| --- | --- |
| Definition | (a) The date of a change in the Phase of Care  (b) The date the final Phase of Care begins (where more than 10 changes of Phase of Care occur) |
| Layout | DDMMYYYY |
| Location | Palliative Record |
| Reported by | Public hospitals |
| Reported for | Care Type 8 |
| Reported when | A Separation Date is reported in the Episode Record |
| Reporting guide | After admission, when a change of Phase of Care occurs, a set of three data items must be reported:   * Phase of Care Change Date (a), * Phase of Care on Phase Change, and * RUG ADL on Phase Change.   Up to ten changes of Phase of Care can be reported: each time the Phase of Care changes, a new set of these three data items must be reported.  Phase changes are reported in sequence.  Note: Where more than ten changes of Phase of Care occur, all Phase changes after the tenth change are omitted and only details of the final Phase of Care are reported in the following fields:   * Final Phase of Care, * Final Phase of Care Start Date (b) and * RUG ADL on Start Final Phase of Care.   A Phase of Care must have a minimum of one patient day.  Phase of Care Change Date or Final Phase of Care Start Date must not be reported on Admission Date or Separation Date. |
| Validations | 674 Phase of Care Change Date ≤ Adm Date or ≥ Sep Date  676 Phase of Care Change Dates not in sequence/repeated  679 Invalid Phase of Care Change Date  684 Not sufficient fields: Phase of Care change  698 Invalid Final Phase of Care  702 Not sufficient fields: Final Phase of Care  703 Final Phase of Care present but < 10 Change |
| Related items | Section 4: Palliative Care reporting |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable derivation of AN-SNAP classification |
| Principal data users | Multiple internal and external data users |
| Collection start | 2012-13 |
| Definition source | Proposed Palliative Care NMDS (DH modified) PCOC v3 (draft) |

## Phase of Care on Admission (a)

## Final Phase of Care (b)

## Phase of Care on Phase Change (c)

### Specification

|  |  |
| --- | --- |
| Definition | (a) The Phase of Care at the start of the Palliative Care episode  (b) The last Phase of Care within the Palliative Care episode (where more than 10 changes of Phase of Care occur)  (c) The new Phase of Care when a phase change occurs |
| Field size | 1 |
| Layout | N |
| Location | Palliative Record |
| Reported by | Public hospitals |
| Reported for | Care Type 8 |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Code Descriptor  1 Stable phase  2 Unstable phase  3 Deteriorating phase  4 Terminal phase |
| Reporting guide | Phase of Care on Admission (a) is reported as the Phase at the time of admission.  After admission, when a change of Phase of Care occurs, a set of three data items must be reported:   * Phase of Care Change Date * Phase of Care on Phase Change (c); and * RUG ADL on Phase Change.   Up to ten changes of Phase of Care can be reported: each time the Phase of Care changes, a new set of these three data items must be reported.  Phase changes must be reported in sequence. |
|  | Note: Where more than ten changes of Phase of Care occur, all Phase changes after the tenth change are omitted and details of only the final Phase of Care are reported in the following fields:   * Final Phase of Care (b), * Final Phase of Care Start Date, and * RUG ADL on Start Final Phase of Care. |
| Guide to phases | **1 - Stable phase**  All patients not classified as unstable, deteriorating or terminal.  The patient’s/client’s symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.  The situation of the family/carers is relatively stable, and no new issues are apparent. Any needs are met by the established plan of care.  **2 - Unstable phase**  The patient/client experiences the development of a new unexpected problem or a rapid increase in the severity of existing problems, either of which requires an urgent change in management or emergency treatment.  The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.  **3 - Deteriorating phase**  The patient/client experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.  The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the patient. This requires a planned support program and counselling as necessary.  **4 - Terminal phase**  Death of patient/client with life-limiting illness is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:   * Profoundly weak * Essentially bed bound * Drowsy for extended periods * Disoriented for time and has a severely limited attention span * Increasingly disinterested in food and drink * Finding it difficult to swallow medication   This requires the use of frequent, usually daily, interventions aimed at physical, emotional, and spiritual issues.  The family/carers recognise that death is imminent, and care is focussed on emotional and spiritual issues as a prelude to bereavement. |
| Validations | 677 Invalid Phase of Care on Admission  678 Phase of Care on Phase Change same as previous  684 Not sufficient fields: Phase of Care change  687 Palliative Care: No Palliative  698 Invalid Final Phase of Care  699 Invalid Phase of Care on Phase Change  700 Palliative Record: Phase of Care on Adm Blank  702 Not sufficient fields: Final Phase of Care  703 Final Phase of Care present but < 10 Changes |
| Related items | Section 4: Palliative Care reporting |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable derivation of AN-SNAP classification |
| Principal data users | Multiple internal and external data users |
| Collection start | 2012-13 |
| Definition source | Proposed Palliative Care NMDS (DH modified) PCOC v3 (modified) |
| Code set source | Proposed Palliative Care NMDS (DH modified) PCOC v3 (modified) |

## Postcode

### Specification

|  |  |
| --- | --- |
| Definition | Postcode or locality in which the person usually resides (not postal address) |
| Field size | 4 |
| Layout | NNNN |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | The Department of Health is only permitted to share this reference file with Victorian health services for non-commercial use, for the purpose of reporting and submitting data to the department.  Victorian health services can request a copy of the postcode-locality reference file for departmental reporting via email to HDSS helpdesk: [hdss.helpdesk@health.vic.gov.au](mailto:hdss.helpdesk@health.vic.gov.au)  Other codes  Code Descriptor  1000 No fixed abode  8888 Overseas (Report the four-digit country code in the Locality field.)  9988 Unknown |
| Reporting guide | Non-residential postcodes are excluded from DHHS’s postcode locality file.  For newborns, use the postcode of mother’s residential address. |
| Validations | 058 Invalid Postcode/Locality  391 Recip HCA Account, Not O/Seas P/Code  571 Acct Recip, Pcode Oseas, Locality Not RHCA  572 Postcode Overseas, Account Not Recip, or Inelig  573 Postcode Overseas, Account Public  574 Postcode Overseas, Locality RHCA, Acct Not RHCA |
| Related items | Section 3: Locality |

### Administration

|  |  |
| --- | --- |
| Purpose | Used for calculation (with Locality field) of the patient’s appropriate Local Government Area (LGA) to:   * Analyse service utilisation and need for services. * Identify patients living outside Victoria for purposes of cross border funding. * Identify patients living outside Australia for the Reciprocal Health Care Agreement (RHCA). |
| Principal data users | Multiple internal and external users |
| Collection start | 1979-80 |
| Definition source | Department of Health |
| Code set source | Australia Post (DH modified) |

## Preferred Death Place

### Specification

|  |  |
| --- | --- |
| Definition | The place identified by the patient within four days of admission as their preferred place to die |
| Field size | 2 |
| Layout | NN or spaces |
| Location | Palliative Record |
| Reported by | Public hospitals |
| Reported for | Care Type 8 |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Report the first appropriate category  Code Descriptor  10 Private residence  21 Residential – aged care setting  22 Residential – other setting  30 Non-residential setting  41 Inpatient setting – designated palliative care unit  42 Inpatient setting – other than designated palliative care unit  97 Unknown, not stated or not asked  99 Other location |
| Reporting guide | This topic needs to be addressed sensitively by clinicians and forms part of the client’s discharge planning process.  It is expected this will be discussed within 4 days of admission.  **97 Unknown, not stated or question not asked**  Includes:   * Where it was inappropriate to ask the question * Where the patient did not know or was not able to answer the question * Where the answer is otherwise unknown |
| Validations | 711 Palliative Record: Preferred Death Place invalid |

### Administration

|  |  |
| --- | --- |
| Purpose | To assist with outcome analyses and service planning, and meeting state government reporting requirements |
| Principal data users | Department of Health |
| Collection start | 2017-18 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Preferred Language

### Specification

|  |  |
| --- | --- |
| Definition | The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English |
| Field size | 4 |
| Layout | NNNN or spaces |
| Location | Episode Record |
| Reported by | Public hospitals (optional for private hospitals) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Refer to Preferred Language reference file available at [HDSS reference files](https://www.health.vic.gov.au/data-reporting/vemd-vaed-vinah-esis-reference-files)  <https://www.health.vic.gov.au/data-reporting/vemd-vaed-vinah-esis-reference-files> |
| Reporting guide | This information must:   * Be checked for every admitted patient episode. * Not be set up to a default code on computer systems. * Be collected on, or as soon as possible after, admission.   The standard question is:  What is [your] [the person’s] preferred language?  Patient is unable to consent (for example baby, child, or elderly):  Where a person is not able to consent for themselves (for example baby, child, or elderly) then the language of the person who is consenting will be recorded. For example, a guardian or someone with enduring power of attorney.  **8000 Australian Indigenous languages, NEC**  Includes:  All Australian Indigenous languages not shown separately on the code list  **0002 Not Stated**  Includes:   * Patients who are not able to respond to this question at any time during their hospital stay. * Child unaccompanied by an adult, who is too young to identify preferred language in relation to the ability to consent.   This question on the form was not filled in or filled in correctly and cannot be verified throughout the admission. |
| Validations | 511 Invalid Preferred Language  513 Indigenous Status/Preferred Language Mismatch  514 Language is Unspecified  592 Invalid Comb Int Req/Pref Lang |
| Related items | Section 3: Country of Birth, Indigenous Status, and Interpreter Required. |

### Administration

|  |  |
| --- | --- |
| Purpose | For planning and to form the basis for future funding allocation for Culturally and Linguistically Diverse (CALD) hospital service provision |
| Principal data users | Department of Health |
| Collection start | 2003-04 |
| Definition source | NHDD |
| Code set source | ABS Australian Standard Classification of Languages (ASCL), 2016 version |

## Proceduralist ID

### Specification

|  |  |
| --- | --- |
| Definition | The Australian Health Practitioner Regulation Agency (AHPRA) number of the health practitioner performing the procedure |
| Field size | 13 |
| Layout | XXXXXXXXXXXXX |
| Location | Diagnosis Record | |
| Reported by | All Victorian hospitals (public and private)  Mandatory from 1 July 2023  Optional for episode records reporting Contract Role A (purchasing hospital). |
| Reported for | All admitted episodes of care where the first coded procedure is one identified in the ICD-10-AM/ACHI Library file as requiring the procedure start date time [ICD Library file: column L coding practices, code 4 and 6], and episodes where Procedure Start Date Time is reported |
| Reported when | The Diagnosis Record is reported |
| Code set | AHPRA number |
| Reporting guide |  |
| Validations | 714 Proceduralist ID / Procedure Start Date Time mismatch  741 Proceduralist ID invalid |
| Related items | Procedure Start Date |

### Administration

|  |  |
| --- | --- |
| Purpose | To monitor quality and safety |
| Principal data users | Department of Health |
| Collection start | 2018-19 |
| Definition source | VAHI |
| Code set source | Australian Health Practitioner Regulation Agency |

## Procedure Codes

### Specification

|  |  |
| --- | --- |
| Definition | Up to 40 ACHI codes reflecting the interventions used for the diagnosis and/or treatment of ill health during this episode of care |
| Field size | 8 (x 40) |
| Layout | NNNNNNN 8th character - A or space  Left justified, trailing spaces |
| Location | Diagnosis Record (12)  Extra Diagnosis Record (28) |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | VAED ICD-10-AM/ACHI Library File is available from HDSS help desk |
| Reporting guide | Where no procedures were performed, report spaces  Character 1 7 must contain a numeric code of seven characters  Character 8 must be F, N or space  Report procedures undertaken during this episode of care in accordance with the Australian Coding Standards and the Victorian Additions to Australian Coding Standards. The Victorian Additions to Australian Coding Standards are available at [Vic additions ACS](https://www.safercare.vic.gov.au/data-reports/clinical-coding-and-classifications/victorian-additions-to-australian-coding-standards) < https://www.safercare.vic.gov.au/data-reports/clinical-coding-and-classifications/victorian-additions-to-australian-coding-standards>  Omit punctuation as shown in ACHI books (no dash in codes); for example, ACHI procedure code 40903-00 Neuro-endoscopy must be entered 4090300.  **Procedures performed under contract at another agency**  Procedures performed at another hospital under contract to this hospital are recorded by both hospitals (where the episode is admitted by both hospitals), but flagged in the contracting hospital only, by use of a flag in the eighth character allocated for each procedure code.  ‘F’ indicating the procedure was performed on an admitted basis.  ‘N’ indicating the procedure was performed on a non-admitted basis. |
| Validations | 127 Nil Value DRG  160 AR-DRG Grouper GST Code>Zero  195 Blank X5  197 Embedded Blank Diag Oper  320 MV Duration but no procedure code  334 Hosp Generated DRG not = PRS/2 DRG  351 Illegal Code Format |
|  | 352 Code Not found On Code File  353 Code & Age Incompatible  354 Code & Sex at birth Incompatible  358 Rare diagnosis or procedure code  408 Contract Role ‘A’ W/Out Proc Flag  409 Proc Flag W/out Contract Role ’A’  428 X5 Upd not Accompanied by Y5 Upd  596 Same Day ECT: Not in Care Type 4  600 Invalid Code  641 MV Hours with Incorrect Procedure Code  644 NIV Hours with Incorrect Procedure Code |
| Related items | Section 2: DRG classification  Section 3: Hospital Generated DRG  Section 4: Contracted Care |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate:  Epidemiological studies and other research.  Grouping for casemix purposes. |
| Principal data users | Multiple internal and external users |
| Collection start | 1979-80 |
| Definition source | Department of Health |
| Code set source | ACHI |

## Procedure Start Date Time

### Specification

|  |  |
| --- | --- |
| Definition | Date and Time at which a procedure commenced for an admitted patient |
| Field size | 12 |
| Layout | DDMMYYYYHHMM or spaces |
| Location | Diagnosis Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | * Episodes in which an ECT has been performed (private hospitals only) * All admitted episodes of care where the first coded procedure is one identified in the ICD-10-AM/ACHI Library file as requiring the procedure start date time [ICD Library file: column L coding practices, code 4 and 6]   The library file is available from HDSS help desk  Time of procedure is required if:   * Campus reports to VEMD and * Admission Type is C or O (emergency admissions)   For all other episodes, time of procedure is optional and may be reported as spaces, eg ‘01082019 ‘  If not required, report spaces. |
| Reported when | The Diagnosis Record is reported |
| Reporting guide | Valid date / time (24-hour time 0000 to 2359)  **ECT in private hospitals**  Report the date ECT is first administered  **Procedure identified in Library file**  The procedure is deemed to have commenced when:   * The first incision is made for a surgical procedure. * The instrument is inserted for procedures in a cardiac catheter laboratory or those involving the use of a scope. |
| Validations | 655 Invalid Procedure Start DateTime  656 Proc Start DateTime < Adm Date or > Sep Date  657 Proc Start DateTime and Valid Proc Mismatch  714 Proceduralist ID / Procedure Start Date Time mismatch  723 Private ECT, Procedure Start Date Time blank or invalid |
| Related items | Section 3: Procedure Codes, Proceduralist ID |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable analysis of wait times for surgical and significant procedures |
| Principal data users | Department of Health |
| Collection start | 2009-10 |
| Definition source | Department of Health |

## Program Identifier

### Specification

|  |  |
| --- | --- |
| Definition | Identifies the specified program, if any, which applies to this episode of care |
| Field size | 2 |
| Layout | NN or spaces |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Episodes for patients admitted under a specified department program  Otherwise, report spaces in this field |
| Reported when | The Episode Record is reported |
| Code set | Code Descriptor  05 Home Birthing Program  09 Specialist ABI Rehabilitation Service  10 Specialist Spinal Rehabilitation Service  08 COVID-19 surge response  11 Emergency use  12 Emergency use  13 Elective Surgery Blitz |
| Reporting guide | Report the corresponding code for the program when advised to do so by the department.  If more than one code applies, report the first listed  **05 Home Birthing Program**  Patient identified as a Home Birthing Program patient as approved by the department. Use code 05 for both mother and baby episodes.  **09 Specialist ABI Rehabilitation Service**  Patient admitted to centre providing statewide specialist Acquired Brain Injury (ABI) rehabilitation for Victorians with severe/catastrophic ABI.  **10 Specialist Spinal Rehabilitation Service**  Patient admitted to centre providing statewide specialist spinal rehabilitation services  **08 COVID-19 surge response**  Patient admitted to private hospital under contract arrangement due to COVID-19 pandemic  **Emergency use codes**  Only to be used under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
|  | **13 Elective Surgery Blitz**  Additional elective surgery performed under this initiative as a contract arrangement with another hospital. Contract details must be reported. |
| Validations | 648 Invalid Program Identifier  649 Program Identifier Care Type Mismatch  651 Program Identifier, campus not approved for program 733 Program Identifier 13 Elective Surgery Blitz, no contract |

### Administration

|  |  |
| --- | --- |
| Purpose | Identify whether a specified program applies to this episode  Facilitate health services planning and monitoring  Identify patients admitted to private hospitals due to COVID-19 pandemic |
| Principal data users | Multiple internal and external data users |
| Collection start | 2009-10 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Qualification Status

### Specification

|  |  |
| --- | --- |
| Definition | Qualification status indicates whether each patient day within a newborn episode of care is either qualified or unqualified |
| Field size | 1 |
| Layout | A |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The Episode Record is reported |
| Code set | Code Descriptor  N Qualified newborn  U Unqualified newborn  X Not applicable |
| Reporting guide | Status Segments are used to record changes between Qualified and Unqualified status for newborns and the duration of these periods (patient days).  The patient’s Qualification Status ‘as of midnight’ should be reported to VAED. If the Qualification Status changes more than once during the day, report the last Qualification Status before midnight.  Note: In order to meet criteria to be a ‘Qualified Newborn’ during a period of accommodation in HITH, a newborn must be ‘the second or subsequent live born of a multiple birth’.  For all other admitted patients, a single Qualification Status code (X) is recorded; indicating newborn qualification status is not relevant to this patient.  Qualification Status is not relevant in episodes for posthumous organ procurement (Care Type 10), including where the donor is under 10 days of age: report code X Not applicable. |
| Guide by code | **N Qualified newborn**  A newborn who, for the patient days being recorded in this Status Segment, meets at least one of the following criteria:   * Admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the provision of special care in designated Neonatal Intensive Care Units (NICUs) and designated Special Care Nurseries (SCNs), or * Is the second or subsequent live born of a multiple birth, or * Remains in hospital after their mother is separated from hospital or is admitted to hospital without their mother.   **U Unqualified newborn**  A newborn who, for the patient days being recorded in this Status Segment, does not meet any of the criteria for ‘Qualified Newborn’.  **X Not applicable**  An admitted patient other than a newborn |
| Validations | 076 Not Sufficient Fields First Status  077 Not Sufficient Other Status  098 Invalid Qual Type  224 Newborn With Leave  241 Illegal Qual Stat Combination N &X  242 Illegal Qual Stat Combination U &X  243 Unqual Newborn But Total Days > 9  260 Invalid Care For Qual  403 Qual Newborn W/Out Justificat  434 NICU or SCN Accom But Unqual Newborn  483 Incompat Adm Source/Qual Stat  485 Incompat Adm Type/Qual Stat  487 Incompat Age/Qual Stat/Care Type  490 Incompat Crit For Adm/Qual Stat  491 Incompat Fields for ESAS  626 Invalid Combination for Funding Arrangement PHESI  642 Unqualified Newborn but Separation Mode D |
|  | Section 4: Newborn Reporting |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable removal of unqualified newborn days, and episodes where the newborn is unqualified for the entire length of stay, to satisfy reporting requirements under the AHCA |
| Principal data users | Australian Institute of Health and Welfare |
| Collection start | 1995-96 |
| Definition source | NHDD |
| Code set source | Department of Health |

# Reason for Discharge Delay

Specification

|  |  |
| --- | --- |
| **Definition** | The main reason that a health service is unable to discharge a patient that has a reported Clinically Ready for Discharge Date. |
| **Field size** | 1 |
| **Layout** | N or space |
| **Location** | Extra Episode Record |
| **Reported by** | Public hospitals |
| **Reported for** | Episodes where a patient has a reported Clinically Ready for Discharge Date |
| **Reported when** | The Clinically Ready for Discharge Date is prior to the Separation Date. |
| **Code set** | Code Descriptor  1 Awaiting Commonwealth Aged Care Service – Residential Aged Care  2 Awaiting Commonwealth Aged Care Service – Community Aged Care  3 Awaiting National Disability Insurance Scheme (NDIS processing and planning outcomes)  4 Inability to access accommodation or housing (other than Aged Care)  5 Administrative or legal decision-making  6 Complex medical, mental and cognitive care needs (limited options available to meet ongoing care in the community)  7 Awaiting Transitional Care Program  8 Other |
| **Reporting guide** | Select the main reason that a health service is unable to discharge a patient that has a reported Clinically Ready for Discharge Date.  For instance, if a patient requires a guardian appointed to consent for a patient to transition to residential aged care, then administrative or legal decision-making should be selected.  Examples of administrative or legal decision-making arrangements delaying discharge could include:   * Guardianship determination (VCAT/OPA) or substitute decision making * State Trustee or Centre Link * NDIS eligibility determination, plan approval, implementation of supports (including equipment/home modifications) and other disability services/accommodation * Equipment/home modifications (non-NDIS) * ACAS |
| **Validations** | 746 Reason for Discharge Delay and Clinically Ready for Discharge Date mismatch  747 Reason for Discharge Delay invalid |
| **Related items** | Clinically Ready for Discharge Date  NDIS Participant Flag  NDIS Participant Identifier |

### Administration

|  |  |
| --- | --- |
| **Purpose** | To complement Clinically Ready for Discharge Date and provide more granular details as to why a patient may remain in hospital when clinically able to be discharged, with the aim of establishing consistent hospital discharge protocols and responses. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2024 |
| **Definition source** | Department of Health |

## RUG ADL on Admission (a)

## RUG ADL on Separation (b)

## RUG ADL on Phase Change (c)

## RUG ADL on start Final Phase of Care (d)

### Specification

|  |  |
| --- | --- |
| Definition | RUG ADL (Resource Utilisation Group Activities of Daily Living):  (a) As assessed on admission.  (b) As assessed on separation.  (c) As assessed at the start of a new Phase of Care (up to 10 changes)  (d) As assessed at the start of the Final Phase of Care (where more than 10 changes of Phase of Care occur) |
| Field size | 2 |
| Layout | NN or spaces Right justified, leading zeros |
| Location | Palliative Record |
| Reported by | Public hospitals |
| Reported for | Episodes with Care Type 8 Palliative Care and MC Maintenance Care  RUG ADL on Admission (a) – Care Types 8, MC  RUG ADL on Separation (b) – Care Types 8, MC  RUG ADL on Phase Change (c) – Care Type 8  RUG ADL on start Final Phase of Care (d) – Care Type 8 |
| Reported when | A Separation Date is reported in the Episode Record  Note: RUG ADL on start Final Phase of Care (d) – field is only reported when more than 10 changes of Phase of Care occur. |
| Code set | (a), (c), (d) 04 to18 (RUG ADL score from assessment)  (b) 04 to 18 (RUG ADL score from assessment)  (b) 00 No assessment - person died |
| Reporting guide | Record what the person does, not what they are capable of doing; that is, record the lowest performance of the assessment period.  On the score sheet, do not leave any spaces blank. It is essential that each data collector knows what behaviours and/or tasks are contained within each item and have a ‘working knowledge’ of the scale.  RUG ADL must be reported each time a patient enters a new Phase of Care in their palliative care episode.  If the person dies in hospital, report a score of 00 for the RUG ADL on Separation. |
|  | **RUG-ADL is a four-item scale measuring patient motor function for activities of daily living including:**   * Bed mobility * Toileting * Transfers * Eating   **The scoring scale for bed mobility, toileting and transfers is:**  1 - Independent or supervision only  3 - Limited physical assistance  4 - Other than two person physical assist  5 - Two or more person physical assist  **The scoring scale for eating is:**  1 - Independent or supervision only  2 - Limited assistance  3 - Extensive assistance/total dependence/tube fed |
| Validations | (a) 680 Palliative Record: Adm RUG ADL Blank or Invalid Range  (b) 297 Sep RUG ADL & Sep Mode Incompatible  681 Palliative Record: Sep RUG ADL Blank or Invalid Range  (c) 682 Palliative Record: Invalid RUG ADL on Phase Change  (d) 682 Palliative Record: Invalid RUG ADL on Phase Change |
| Related items | Section 2: Palliative Care, Maintenance Care  Section 4: Palliative Care Reporting |

### Administration

|  |  |
| --- | --- |
| Purpose | To support and further develop casemix classifications for sub-acute episodes of care |
| Principal data users | Department of Health |
| Collection start | 1996-97 |
| Definition source | Department of Health |
| Code set source | RUG ADL |

## Separation Date

### Specification

|  |  |
| --- | --- |
| Definition | Date on which an admitted patient completes an episode of care |
| Field size | 8 |
| Layout | DDMMYYYY |
| Location | Episode Record  DVA and TAC Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | The episode of care is complete |
| Reporting guide | The Separation Date must be on or after the Admission Date.  If no other separation details are submitted (patient not yet separated), zero filled Separation Date is accepted.  The Separation Date may relate to a formal or statistical separation.  **Statistical Separations**  Statistical Separation must have a Separation Date equalling the next episode’s Admission Date. Statistical separations and admissions cannot occur over midnight. |
| Validations | 026 Zero Sep; Existing not Discharged  027 Adm Record; Overlaps Existing  028 Prior Adm; No Sep Date  063 Prior Not Discharged  065 Original Deleted Upd Sep < Cutoff  066 Sep Date Prior to Cutoff Date  101 Invalid Sep Date  102 Sep Date < Adm Date  108 Field(s) are missing From Sep  112 Calc Los +Leave Not = Adm/Sep  115 Adm Time Not < Sep Time  119 Sep Time - No Sep Date  122 Sameday Adm Source/ Sep Mode Mismatch  127 Nil Value DRG  160 AR-DRG Grouper GST Code > Code  179 Trans Sep Not Same As Episode  193 Not Separated – Intent Readmit  196 X5 Record Epis. Not Separated |
| Validations cont. | 258 Sub – Acute: No Sub Acute Record  259 Invalid Rehab/Subac – Episode Sep Date  322 ICU/CCU Stay > Total Stay  323 MV Duration > Total Stay  352 Code Not Found On Code File  388 Sep Referral - Episode Not Separated  438 NIV Duration >Total Stay  461 ACAS Status not Required  465 Adm Duration < 15 Mins  467 Adm Wt <1000g, LOS <28 Days, Sep Mode  T or D  468 Care Type  1 or F, LOS >365 Days  505 Stat Episode: Previous Episode > 1 Minute Apart  533 ACAS Status Code Required  593 Invalid Sep Date; > Header  596 Same Day ECT: Not in Care Type 4  598 Same Day Rehabilitation: Not in Scope |
| Related items | Section 4: Episode of care, Length of Stay |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable validation of patient days and to enable an episode of care to be placed into month and year of separation:  For counting purposes  To check codes in the record against the valid codes for that year. |
| Principal data users | Multiple internal and external data users |
| Collection start | 1979-80 |
| Definition source | NHDD |

## Separation Mode

### Specification

|  |  |
| --- | --- |
| Definition | Status at separation of the person, and place to which the person is released (where applicable) |
| Field size | 1 |
| Layout | A |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Select the first appropriate category  Code Descriptor  G Posthumous Organ Procurement  S Statistical Separation (change in Care Type within this hospital)  D Death  Z Left against medical advice  T Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre  B Separation and transfer to Transition Care bed-based program  A Separation and transfer to mental health residential facility  J Separation and transfer to a residential aged care facility, which is not the usual place of residence  L Separation and transfer to residential aged care facility, which is the usual place of residence  H Separation to private residence/accommodation  C Emergency use |
| Reporting guide | **G Posthumous Organ Procurement**  Assign this code for posthumous organ procurement episodes (Care Type 10)  Excludes:  A patient who has died in hospital (use code D)  **S Statistical Separation** (change in Care Type within this hospital campus)  Assign this code when a new episode of care (change in Care Type) occurs within the same hospital stay.  Excludes:   * Change to Alcohol and Drug Program Care Type following another episode of care (for public hospitals). * Change from or to Unqualified newborn (Care Type U) as a Statistical Separation or a Statistical Admission. Changes between Qualified and Unqualified status of newborns are recorded in Status Segments using the Qualification Status field. Refer to Section 2: Newborns |
|  | **D Death**  Died in hospital  **Z Left against medical advice**  Patient absconds or leaves against medical advice, at own risk. This Separation Mode is significant in the allocation of some DRGs.  Includes:  Newborns taken from the hospital against medical advice.  **T Separation and transfer to other acute hospital / extended care / rehabilitation / geriatric centre**  Separation and transfer to another hospital, regardless of whether the patient is to be admitted at the receiving hospital. Requires a Transfer Destination code.  Includes:   * Unqualified newborn being transferred to another hospital. * Public and private acute, extended care and mental health admitted patient units.   Excludes:   * Transition Care bed-based program (use code B). * Residential aged care facility, not usual residence (use code J) * Residential aged care facility, usual residence (use code L) * Mental health residential units (use code A).   **B Separation and transfer to Transition Care bed-based program**  Separation and transfer directly to a Transition Care bed-based program. Does not require a Transfer Destination code.  Excludes:  Home-based Transition Care (use code H and Separation Referral Code T).  **A Separation and transfer to mental health residential facility**  Separation and transfer to mental health residential facility (includes psychogeriatric nursing home, community care unit and prevention and recovery care (PARC) units) funded by Mental Health Services. Does not require a Transfer Destination code.  Includes:   * Patient returning to the mental health residential facility in which they live. * Mental health aged care residential facility.   Excludes:  Mental health admitted patient units (use code T).  **J Separation and transfer to residential aged care facility, which is not the usual place of residence**  Includes:  Any of the following terms: nursing home, hostel, high care, and low care  Only those facilities that are in receipt of subsidies from the Commonwealth Government under the Aged Care Act 1997 and provide accommodation and supported care (ranging from help with daily tasks and personal care to 24-hour nursing care) to eligible people.  Does not require a Transfer Destination code.  Excludes:   * Transition Care bed-based program (use code B). * Mental health aged care residential facility (use code A) * Patient returning to residential aged care facility in which they live (use L)   **L Separation and transfer to residential aged care facility, which is the usual place of residence**  Includes:  Any of the following terms: nursing home, hostel, high care, and low care  Only those facilities that are in receipt of subsidies from the Commonwealth Government under the Aged Care Act 1997 and provide accommodation and supported care (ranging from help with daily tasks and personal care to 24-hour nursing care) to eligible people.  Does not require a Transfer Destination code.  Excludes:   * Transition Care bed-based program (use code B). * Mental health aged care residential facility (use code A) * Residential aged care facility, which is not usual place of residence (use J)   **H Separation to private residence/accommodation**  Place of residence immediately following separation. Requires a Separation Referral code.  Includes:   * Home or home of relative or friend * Supported residential facilities * Special accommodation house * Training centres for intellectually disabled persons * Prison * Forensic hospital (Thomas Embling) * Juvenile detention centre * Armed forces base camp * Homeless (shelters, halfway houses) * A patient in Accommodation Type 4 in the Home (Hospital – HITH) in private accommodation or residential facility who, on separation, remains in the same private accommodation * Home-based Transition Care   Excludes:   * Transition Care bed-based program (use code B) * Residential aged care facility, not usual residence (use code J) * Residential aged care facility, usual residence (use code L) * Mental health residential facility (use code A)   **C Emergency use**  Only to be used under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
| Validations | 103 Invalid Sep Mode  108 Fields(s) Missing from Sep  109 Trans Dest Not Blank  110 Invalid Transfer Type  122 Sameday Adm Source/ Sep Mode Mismatch  127 Nil Value DRG  160 AR-DRG Grouper GST Code Zero  192 Invalid Comb Int. Readmit Sep Mode  297 Sep Rug ADL & Sep Mode Incompatible  328 Early Parenting Centre – Invalid Comb  334 Hosp Generated DRG Not = PRS/2 DRG  390 Incompat Care Type, Carer Avail, Age and Sep Mode  394 Sep Mode Home, No Sep Referral  395 Sep Mode Not Home, Sep Referral Present  397 Sep Referral Postnatal, Incompat Age/Sex at birth  423 Invalid Comb Fund/ Contract /Transfer  467 Adm Wt <1000g, LOS < 28 Days, Sep Mode ≠ T or D  471 Care Type 5x, not usual Sep Referral  489 Incompat Care Type/Sep Mode Statistical  493 Incompat Sep Mode/Age <15  494 Incompat Sep Mode/Age <55  501 Stat Episode: Adm Source ≠ Sep Mode Prev Episode  597 Mental Health Episode: Sep Mode = S  642 Unqualified Newborn but Separation Mode D  643 Maternity Episode but Separation Mode D  690 Sep FIMTM & Sep Mode Incompatible  696 Posthumous Organ Proc: Care Type/Sep Mode mismatch |

### Administration

|  |  |
| --- | --- |
| Purpose | To:  Distinguish between formal and statistical separations.  Study service patterns - Care Type changes, transfers.  Assist in the allocation of DRGs. |
| Principal data users | Multiple internal and external data users |
| Collection start | 1979-80 |
| Definition source | NHDD |
| Code set source | Department of Health |

## Separation Referral

### Specification

|  |  |
| --- | --- |
| Definition | Clinical care and support services arranged by the hospital to meet the person’s recuperative needs when discharged to private accommodation or home. |
| Field size | 4 |
| Layout | AAAA or spaces Left justified, trailing spaces |
| Location | Episode Record |
| Reported by | Public hospitals  Private hospitals – Optional. If the private hospital chooses not to report these data, report spaces |
| Reported for | Episodes where the Separation Mode is H Separation to private residence/accommodation  For all other Separation Modes, report spaces |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Code Descriptor  F Domiciliary postnatal care, arranged before discharge  E Domiciliary postnatal care, referral declined  H Health Independence Program services, arranged before discharge  L Alcohol and drug treatment service, arranged before discharge  B Community palliative care support, arranged before discharge  U Home nursing support, arranged before discharge  C Mental health community services, arranged before discharge  S Referral to private psychiatrist, arranged before discharge  D Psychiatric disability support services, arranged before discharge  G Referral to general practitioner, arranged before discharge  A Referral to Aged Care Assessment Service (ACAS), arranged before discharge  K Referral to Aboriginal and Torres Strait Islander (ATSI) service, arranged before discharge  T Referral to Transition Care home-based program, arranged before discharge  R Other clinical care and/or support services, arranged before discharge  X No referral or support services arranged before discharge |
| Reporting guide | Select up to four options from list. Do not repeat codes. If more than four referrals have been made, select the first four listed  In arranging the referral of a patient to these services, the hospital would expect to receive confirmation from the service provider of their preparedness to accept responsibility for delivering the required services to the patient upon discharge.  Unless a specific service has been arranged, or referral to domiciliary postnatal care specifically declined, use code X No referral or support services arranged before discharge. |
| Guide by code | **F Domiciliary postnatal care, arranged before discharge**  Mother discharged, with domiciliary postnatal care arranged before discharge to her own home or home of relative or friend or other private accommodation\*. Domiciliary care includes that provided by the hospital and by home nursing services.  Code not for use for the baby’s Separation Mode: unless a specific service (with another code) has been arranged for the baby, baby’s code would be X No referral or support services arranged before discharge.  Excludes:  Referral to domiciliary postnatal care offered, but declined by patient (use code E)  **E Domiciliary postnatal care, referral declined**  Mother discharged. Mother offered referral to domiciliary postnatal care before discharge but declined referral. Domiciliary care includes that provided by the hospital, by home nursing services and by community services.  Code not for use for the baby’s Separation Mode.  **H Health Independence Program services, arranged before discharge**  Referral to a health independence program (HIP), arranged before discharge  Includes:  Programs previously known as Post Acute Care, Hospital Admission Risk Program, Subacute Ambulatory Care Services and Residential In Reach  **L Referral to alcohol and drug treatment service, arranged before discharge**  Discharge, with referral to alcohol and drug treatment service, arranged before discharge to own home or home of relative or friend or other private accommodation\*.  **B Community palliative care support, arranged before discharge**  Discharge, with community palliative care service support arranged before discharge to own home or home of relative or friend or other private accommodation\*.  **U Home nursing support, arranged before discharge**  Discharge, with home nursing support arranged before discharge to own home or home of relative or friend or other private accommodation\*. Home nursing support includes that provided by the hospital and by district nursing services.  **C Mental health community services, arranged before discharge**  Discharge, with mental health community services arranged before discharge to own home or home of relative or friend or other private accommodation\*.  **S Referral to private psychiatrist, arranged before discharge**  Discharge, with referral to a private psychiatrist arranged before discharge to own home or home of relative or friend or other private accommodation\*.  **D Psychiatric disability support services, arranged before discharge**  Discharge, with referral to psychiatric disability support services arranged before discharge to own home or home of relative or friend or other private accommodation\*.  **G Referral to general practitioner, arranged before discharge**  Discharge, with referral to general practitioner arranged before discharge to own home or home of relative or friend or other private accommodation\*.  **A Referral to Aged Care Assessment Service (ACAS), arranged before discharge**  Discharge, with referral to Aged Care Assessment Service (ACAS) arranged before discharge to own home or home of a relative or friend or other private accommodation.  **K Referral to Aboriginal and Torres Strait Islander (ATSI) service, arranged before discharge**  Discharge, with referral to an Aboriginal and Torres Strait Islander (ATSI) service arranged before discharge to own home or home of a relative or friend or other private accommodation\*.  Includes:   * Services provided by the local Aboriginal co-operative * Designated Koori HACC services * Designated Koori Alcohol and Drug Services   **T Referral to Transition Care home-based program, arranged before discharge**  Discharge, with referral to a Transition Care home-based program arranged before discharge to own home or home of a relative or friend or other private accommodation\*.  Excludes:  Bed-based Transition Care (use Separation Mode code B).  **R Other clinical care and/or support services, arranged before discharge**  Discharge, with other clinical care and support service arranged before discharge to own home or home of relative or friend or other private accommodation\*.  Includes:   * Discharge to residential care facility if patient was admitted from a less supportive form of accommodation, such as a private home. * Discharge of newborn to foster care. * Any service not under the other values for this field (for example, outpatient appointment, specialist appointment, meals on wheels, home maintenance services, private community care and services, community health services, private allied health services, maternal and child health services).   **X No referral or support services arranged before discharge**  No referral or support services arranged before discharge to own home or home of relative or friend or other private accommodation\*.  Note:  \*Private accommodation comprises:  Supported residential facilities, special accommodation houses, halfway houses, training centres for intellectually disabled persons, prisons, and armed forces hospitals.  Includes:   * A patient treated under the HITH program in private accommodation or residential facility who, on separation, remains in the same private accommodation. * A newborn discharged with his/her mother. |
| ****Validations**** | 388 Sep Referral - Episode Not Separated  389 Invalid Sep Referral  394 Sep Mode Home, No Sep Referral  395 Sep Mode not Home, Sep Referral Present  396 Sep Referral, No Refer Plus Other Ref  397 Sep Referral Postnatal, Incompatible Age/ Sex at birth  398 Sep Referral, Duplicates  462 Incompat ACAS Status and Sep Referral  471 Care Type 5x, not usual Sep Referral  495 Incompat Sep Referral and Indigenous Status  718 Delivery episode, Sep Referral is not E or F |
| ****Related items**** | Section 3: Separation Mode |

### Administration

|  |  |
| --- | --- |
| Purpose | To monitor discharge planning processes to inform policy and planning |
| Principal data users | Department of Health |
| Collection start | 1999-00 (formerly a subset of Separation Mode) |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Separation Time

### Specification

|  |  |
| --- | --- |
| Definition | The time at which a patient completes an episode of care |
| Field size | 4 |
| Layout | HHMM |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | A Separation Date is reported in the Episode Record |
| Reporting guide | Valid 24-hour time (0000 to 2359)  **Formal separation** - the time at which patient presents at the discharge office/desk. For patients who leave against medical advice, Separation Time is the time of last patient contact. For patients who die in hospital, Separation Time is the time of death (that is, brain death).  **Statistical separation** (Care Type change) – a dummy Separation Time can be reported to enable the times to be automatically recorded. Care Type changes could be recorded as occurring at midday. The Separation Time must be one minute earlier than the Admission Time of the following episode (for example, if Separation Time of the earlier episode was made to be 1200, Admission Time of the new episode would be 1201).  Note: For episodes for posthumous organ procurement (Care Type 10), report Separation Time after all activity related to the organ procurement has ceased. |
| Validations | 027 Adm Record; Overlap Existing  108 Fields(s) Missing from Sep  114 Invalid Sep Time  115 Adm Time Not < Sep Time  119 Sep Time - No Sep Date  322 ICU/CCU Stay > Total Stay  323 MV Duration > Total Stay  438 NIV Duration > Total Stay  465 Adm Duration < 15 Mins  505 Stat Episode: Previous Episode > 1 Minute Apart  551 Type C Crit for Adm, LOS >4 hrs  553 Type E Crit for Adm, LOS <4 hrs |
| Related items | Section 2: Time of death |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable the exact length of stay to be determined |
| Principal data users | Multiple internal and external data users |
| Collection start | 1993-94 |
| Definition source | Department of Health |

## Sex at birth

**Specification**

|  |  |
| --- | --- |
| **Definition** | The sex of the person as recorded at birth or infancy.  The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code. |
| **Field size** | 1 |
| **Layout** | N |
| **Location** | Episode Record |
| **Reported by** | All Victorian hospitals (public and private) |
| **Reported for** | All admitted episodes of care |
| **Reported when** | The Episode Record is reported |
| **Code set** | Code Descriptor  1 Male  2 Female  5 Another term |
| **Reporting guide** | The term 'sex' refers to a person's biological characteristics. A person's sex is usually described as being either male or female; some people may have both male and female characteristics, or neither male nor female characteristics, or other sexual characteristics.  Sex recorded at birth refers to what was determined by sex characteristics observed at birth or infancy.  Hospitals should refrain from making assumptions about a person's sex based on indicators such as their name, voice or appearance.  1 Male  Persons whose sex at birth or infancy was recorded as male.  2 Female  Persons whose sex at birth or infancy was recorded as female.  5 Another term  Persons whose sex at birth or infancy was recorded as another term (not male or female). |
|  |  |
| **Validations** | 033 Invalid Sex at birth  059 Maternity - Not Female  127 Nil Value DRG |
|  | 160 AR-DRG Grouper GST Code>Zero  354 Code & Sex at birth Incompatible  397 Sep Referral Postnatal, Incompat Age/Sex at birth  580 MHSWPI Valid, no Matching Sex at birth |
| **Related items** | Section 2: Age, DRG Classification |

**Administration**

|  |  |
| --- | --- |
| **Purpose** | To enable:   * Analyses of service utilisation and epidemiological studies * Verification of other fields (such as diagnosis and procedure codes) for consistency. * To assist in the allocation of DRGs |
| **Principal data users** | Multiple internal and external data users |
| **Collection start** | 1979-80  Version 2 effective 1 July 2024 (updated from Sex to Sex at birth) |
| **Definition source** | Person—sex, code X (METEOR 741686) |
| **Code set source** | Person—sex, code X (METEOR 741686) |

## 

## Source of Referral to Palliative Care

### Specification

|  |  |
| --- | --- |
| Definition | The source of the person’s referral to the DH Palliative Care Program |
| Layout / Location | NN / Palliative Record |
| Reported by | Public hospitals |
| Reported for | Care Type 8 |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Code Descriptor  10 Public hospital – not further defined  11 Public hospital – palliative care unit/team  12 Public hospital – oncology unit/team  13 Public hospital – medical unit/team  14 Public hospital – surgical unit/team  15 Public hospital – emergency department  20 Private hospital – not further defined  21 Private hospital – palliative care unit/team  22 Private hospital – oncology unit/team  23 Private hospital – medical unit/team  24 Private hospital – surgical unit/team  25 Private hospital – emergency department  30 Outpatient clinic  40 General Practitioner  50 Specialist Practitioner  60 Community Palliative Care Service  61 Community Generalist Service  70 Residential Aged Care Facility  80 Self, carer(s), family, friends  90 Other  99 Unknown/inadequately described |
| Reporting guide | Select the first appropriate category |
| Validations | 683 Invalid Source of Refer to Pal Care  687 Pall Care: No Palliative Record |
| Related items | Section 2: Palliative Care, Section 4: Palliative Care Reporting |

### Administration

|  |  |
| --- | --- |
| Purpose | To inform policy and planning decisions. |
| Principal data users | Department of Health |
| Collection start | 1998-99 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Surname

### Specification

|  |  |
| --- | --- |
| Definition | The surname of the DVA or TAC patient |
| Field size | 25 |
| Layout | AXXXXXXXXXXXXXXXXXXXXXXXX |
| Location | DVA and TAC Record |
| Reported by | Public hospitals |
| Reported for | Admitted episodes with an Account Class of V- *DVA* or T- *TAC* |
| Reported when | The Episode Record is reported |
| Reporting guide | Surname of the person  Permitted characters: A to Z (uppercase), space, apostrophe, and hyphen.  The first character must be an alpha character |
| Validation | 161 Invalid Surname |
| Related items | Section 3: Account Class and Given Name(s) |

### Administration

|  |  |
| --- | --- |
| Purpose | To facilitate payment by DVA and TAC for relevant episodes of care.  This data is held separately to other VAED data to ensure that personal information remains confidential. |
| Principal data users | Department of Veteran’s Affairs and Transport Accident Commission. |
| Collection start | 1992-93 |
| Definition source | Department of Health |

## Transfer Destination

### Specification

|  |  |
| --- | --- |
| Definition | Identification of the hospital campus to which a person is transferred, following separation from this hospital campus |
| Field size | 4 |
| Layout | NNNN or spaces |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Admitted episodes where the Separation Mode is T Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centres.  Otherwise, report spaces |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Refer to Campus code table available: [HDSS reference files](https://www.health.vic.gov.au/data-reporting/reference-files)  < https://www.health.vic.gov.au/data-reporting/reference-files >  **Hospital identifier for interstate and overseas hospitals**  Compile a code according to the following convention:  **First character:**  9 for all interstate and overseas hospitals  **Second character: state/overseas identifier**  0 Queensland  1 New South Wales  2 Tasmania  3 South Australia  4 Western Australia  5 ACT  6 Northern Territory  7 New Zealand  8 Other overseas  **Third character: hospital type**  0 Major specialist/teaching  1 Other public acute  2 Extended care  3 Private  5 Psychiatric (public only)  6 Rehabilitation (public only)  9 Other healthcare accommodation (eg early parenting centres)  **Fourth character:**  7 for all interstate and overseas hospitals  For example, an extended care hospital in New South Wales would be coded 9127.  Unknown Transfer Destination code is 9999 |
| Reporting guide | **Forensic Hospitals and Armed Forces Hospitals**  These are not generally recognised as hospitals by the Australian Government Department of Health and Ageing, and therefore separation to such facilities is not an inter-hospital transfer (report Separation Mode H Separation to private accommodation or home). |
| Validations | 078 T- Srce T- Dest Code Matches Hosp  109 Transfer Dest Not Blank  110 Invalid Transfer Type |
| Related items | Section 2: Transfer  Section 4: Transfer Reporting |

### Administration

|  |  |
| --- | --- |
| Purpose | Study of transfer patterns. |
| Principal data users | Department of Health |
| Collection start | 1999-00 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Transfer Source

### Specification

|  |  |
| --- | --- |
| Definition | Identification of the hospital campus the person has been transferred from, following separation from that hospital |
| Field size | 4 |
| Layout | NNNN or spaces |
| Location | Episode Record |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | Admitted episodes where the Admission Source is T Transfer from acute hospital/extended care/rehabilitation/geriatric centres  Otherwise, report spaces |
| Reported when | The Episode Record is reported |
| Code set | Refer to Campus code table 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 >  **Hospital identifier for interstate and overseas hospitals**  Compile a code according to the following convention:  **First character:**  9 for all interstate and overseas hospitals  **Second character: state/overseas identifier**  0 Queensland  1 New South Wales  2 Tasmania  3 South Australia  4 Western Australia  5 ACT  6 Northern Territory  7 New Zealand  8 Other overseas  **Third character: hospital type**  0 Major specialist/teaching  1 Other public acute  2 Extended care  3 Private  5 Psychiatric (public only)  6 Rehabilitation (public only)  9 Other healthcare accommodation (eg early parenting centres)  **Fourth character**:  7 for all interstate and overseas hospitals  Thus, an extended care hospital in New South Wales would be coded 9127.  Unknown Transfer Source code is 9999 |
| Reporting guide | **Forensic Hospitals and Armed Forces Hospitals**  These are not generally recognised as hospitals by the Australian Government Department of Health and Ageing, and therefore admission from such facilities is not an inter-hospital transfer (report Admission Source H Private Residence/Accommodation). |
| Validations | 042 Invalid Transfer Source  051 Transfer Source Not Blank  078 T- Srce/ T- Dest Code Matches Hosp |
| Related items | Section 2: Transfer  Section 4: Transfer Reporting |

### Administration

|  |  |
| --- | --- |
| Purpose | Study of transfer patterns |
| Principal data users | Department of Health |
| Collection start | 1979-80 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Triage Score on Admission

### Specification

|  |  |
| --- | --- |
| Definition | The score derived from use of the evidence-based palliative care triage tool that considers the clinical status and the person and family/carer situation |
| Field size | 3 |
| Layout | NNN or spaces  Right justified, zero filled |
| Location | Palliative Record |
| Reported by | Public hospitals |
| Reported for | Episodes with Care Type 8 Palliative Care  Mandatory from 1 July 2025 |
| Reported when | A Separation Date is reported in the Episode Record |
| Code set | Code Descriptor  000 to 100 Valid score  999 Not stated or unknown  Any values outside this range are invalid. |
| Reporting guide | This is the Triage Score determined before admission or transfer to the unit. The triage score is calculated based on a validated tool with seven items across physical, psychosocial and caregiver domains, and provides a score from 0 to 100 points.  Triage is to be completed by a clinician or triage officer who has an appropriate level of training and clinical experience in palliative care to ascertain accurate assessments of the triage factors from the referrer.  Code 999 or ‘not stated or unknown’ should only be reported when the evidence-based triage tool was not used to determine clinical urgency. |
| Validations | 725 Invalid Triage Score on Admission |
| Related items | Section 5 Palliative Record |

### Administration

|  |  |
| --- | --- |
| Purpose | To improve equity of access for people referred to specialist palliative care |
| Principal data users | Multiple internal and external data users |
| Collection start | July 2021 |
| Definition source | Department of Health |
| Code set source | Department of Health |

## Unique Key

### Specification

|  |  |
| --- | --- |
| Definition | A unique identifier specific to an individual admitted patient episode of care |
| Field size | 9 |
| Layout | XXXXXXXXX Right justified, zero filled | |
| Location | Episode Record  Extra Episode Record  Diagnosis Record  Extra Diagnosis Record  Sub-Acute Record  Palliative Record  DVA and TAC Record | |
| Reported by | All Victorian hospitals (public and private) |
| Reported for | All admitted episodes of care |
| Reported when | Any of the above record types is reported |
| Code set | Hospital-generated |
| Reporting guide | The Unique Key can be computer-generated or have specific relevance at the hospital.  A Unique Key should not be changed. If in exceptional circumstances, there is a need to alter the number (eg data entry error) the original episode would have to be deleted and re‑submitted with a new Unique Key.  Do not re‑use a Unique Key; a Unique Key must not be re‑assigned to another episode for the same patient or to another patient.  When changing software supplier, care must be taken to ensure Unique Keys remain unique, i.e. new episodes should be allocated a number higher than the last number reported. |
| Validations | 005 Deletion Record - No Match Found  026 Zero Sep; Existing Not Discharged  027 Adm Record; Overlaps Existing  028 Prior Adm; No Sep Date  060 Unique Key Blank  062 Duplicate Pt ID, Adm Date Time, Diff Unique  063 Prior Not Discharged  064 Duplicate Pt ID, Date Time  169 No Corresponding Episode  192 Diagnoses Delete: No Record on File  248 Tran Pt ID Not Same as Episode or Subac  249 No Sub-Acute to Delete  259 Invalid Rehab/Subac- Episode Sep Date  371 Episode Deletion: DVA/TAC Trans Present  372 Episode Deletion: Multiple Epis Trans  374 Episode DVA/TAC V5 Transaction  375 Episode DVA/TAC: V5 Trans Rejected  377 Episode DVA/TAC: Multiple E5 Trans  378 Episode DVA/TAC: Multiple V5 Trans  379 Epis Not DVA/TAC: V5 Trans Present  380 Epis Not DVA/TAC: V5 Trans: Multiple E5s  382 Epis Not DVA/TAC: Multiple V5 Trans  383 V5 Trans: No Episode Trans  384 V5 Trans: Multiple Episode Trans  531 Same UK, diff Pt ID |

### Administration

|  |  |
| --- | --- |
| Purpose | To enable data records (E5, J5, X5, Y5, S5, P5 and V5) to be amalgamated into a single record for each episode of care, for validation and reporting purposes. |
| Principal data users | Department of Health |
| Collection start | 1990-91 |
| Definition source | Department of Health |
| Code set source | Hospital-generated |

## Unplanned return to theatre

### Specification

|  |  |
| --- | --- |
| Definition | An indicator of whether a patient had a surgical procedure/operation and required an unplanned return to the operating theatre during the same episode of admitted care |
| Field size | 1 |
| Layout | N or space |
| Location | Diagnosis Record |
| Reported by | Public and private hospitals |
| Reported for | All episodes where the patient had a surgical procedure/operation identified in the ICD-10-AM/ACHI Library file as requiring the unplanned return to theatre data element to be reported [ICD Library file: column L code practices, code 6] |
| Reported when | At any time during the episode |
| Code set | 1 Yes  2 No  9 Not stated/inadequately described |
| Reporting guide | The return to the operating theatre should be for a surgical procedure related to the initial procedure but may be performed by the same surgeon or a different surgeon.  The reported value is a clinically determined value and will be documented in the patient’s medical record either at the time of the return to theatre or upon the clinician’s review of the medical notes.  Hospitals are encouraged to set up processes to support clinicians to review returns to theatre to enable the reporting of the appropriate value.  For contracted care episodes, when the patient has a return to theatre in Hospital A, the value will be reported by Hospital A (the contracting hospital) as hospital A reports the initial surgical procedure undertaken at Hospital B (with suffix F) as part of the reported episode.  **1** **Yes**  The patient had one or more unplanned returns to the operating theatre during an episode of admitted patient care.  Excludes:   * Return to the operating theatre where the subsequent procedure was planned and documented prospectively at the time of the original procedure (for example, staged procedures). * Patient who was separated and readmitted for an unplanned return to theatre in a subsequent episode   **2** **No**  The patient did not have one or more unplanned returns to the operating theatre during an episode of admitted patient care.  **9** **Not stated/inadequately described**  It is uncertain or inadequately documented in the primary data collection to know whether the patient did or did not have one or more unplanned returns to the operating theatre during an episode of admitted patient care. |
| Validations | 737 Unplanned return to theatre invalid  739 Unplanned return to Theatre and valid Proc mismatch |

### Administration

|  |  |
| --- | --- |
| Purpose | To identify true unplanned returns to theatre HAC4 (surgical complications requiring unplanned return to theatre) |
| Principal data users | Victorian Agency for Health Information |
| Collection start | 1 July 2022 |
| Definition source | METeOR Identifier 578317 |
| Code set source | METeOR Identifier 578317 |