health

Proposals for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2012

November 2011

State Government Victoria

Department of Health

Proposals for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED) for 1 July 2012

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Executive Summary

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

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

In order to be accepted into the VAED proposals need to demonstrate clear business justification and be fully costed, meaning funding streams will need to be identified and confirmed. Final acceptance of all proposals is dependent on the Executive Director, Hospital and Health Service Performance (based upon recommendations by the Annual Changes Governance Committee).

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

The proposed revisions for the Victorian Admitted Episodes Dataset (VAED) for 1 July 2012 are summarised below. They include (but are not limited to):

1 Removal of requirement to report both Barthel and FIM™ Scores
Proposal includes:

- Removal of two data elements.
- Amendments to, deletion and addition of edits
- Amendments to business rules

2 ABF Requirements: Addition of *Phase of Care*, *Impairment* to be mandatory
Proposal includes:

- Addition of a new record type in PRS/2 submission file
- Addition of three new data elements (repeating 10 times)
- Addition of edits
- Impairment to be mandatory, Clinical Sub-Program to be removed.
- Option to submit an extract from SNAPshot, the database of the Palliative Care Outcomes Collaboration (PCOC) collecting data on a voluntary basis.

3 Addition of *Care Plan Documented Date*
Proposal includes:

- Addition of one new data element
- Addition of edits

4 Addition of *Advance Care Plan Documented Date*
Proposal includes:

- Addition of one new data element

- Addition of edits

5 Removal of Care Types 7, K, E and F
Proposal includes:

- Removal of four Care Types
- Amendments to business rules and edits
- Removal of edits

6 Addition of Care Types R1 and R2 for Restorative Care
Proposal includes:

- Addition of two new Care Types
- Addition of business rules and edits

7 Addition of Care Type 10 for Organ Procurement – Posthumous episodes
Proposal includes:

- Addition of one new Care Type
- Addition of code values to Admission Source, Admission Type, Criterion for Admission and Separation Mode
- Addition of business rules and edits
- Extension of scope of the VAED to include non-admitted patients

8 Addition of a Separation Referral code for decline of referral to Post-Natal Domiciliary Care.
Proposal includes:

- Addition of code value to Separation Referral

9 Updated Reference Files for Preferred Language and Country of Birth
Proposal includes:

- Updated code lists for Preferred Language and Country of Birth

Introduction

The VAED Proposals Process

The Proposal document is being distributed to all Victorian hospitals, to patient management system suppliers known to have Victorian clients, and to a range of industry bodies. It outlines proposals for changes to PRS/2 and the VAED as at the time of its release in November 2011. This should not be regarded as a complete list of changes to be made for 2012—13. Items in this publication are not guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate it will not change from 1 July 2012. Confirmed changes will be published in the document *Specifications for Revisions to PRS/2 and the VAED for 1 July 2012*, expected to be published in December 2011.

It is expected that release of these proposals will stimulate discussion within the health industry. Prompt feedback is sought on these proposals. Hospitals and software suppliers should review this document and assess the feasibility of the proposals. All are invited to provide written feedback to DH by completing the proforma provided with this document, and forwarding it to HDSS as indicated by **Wednesday 7 December 2011**. Copies of the proforma may also be obtained from the HDSS web site located at http://www.health.vic.gov.au/hdss .

Draft status of document

This document is not a complete specification of proposed changes to the VINAH. Final Specifications will be published at a later date and may contain additions, amendments, and/or removal of information in this document. Although changes to edits, business rules and file structures have been included here, they cannot be considered complete nor final.

Assessment of the impact of proposals

Each proposal is assessed against a set of principles designed to assess the impact that implementation of the proposal is likely to have on services, the Department, software vendors and data users. The principles reflect best practice and standard information management principles.

Each proposal will be assessed using the Measures listed in the table below. The assessment and the feedback from stakeholders will be used to determine whether the proposal is accepted for inclusion in the final specifications for changes for 2012-13.

Category	Measures
Scope	a) The change should be within the scope of the collection.
Collectability	a) The data should already be collected by the service. b) There should be value for the service in collecting the data. c) Collection of the data should be aligned with normal business processes in the service. d) It should be legal for the service to collect the data.
Intended Use	a) Sufficient business justification must be submitted in the proposal. b) The change must be consistent with Departmental policy. c) There should not be a limited time-period for the use of the data. If there is, other avenues of collection should be investigated to ensure this is the most appropriate.
Best Practice	a) The collection of the data should be compliant with relevant standards and policies. If not, specify where non-compliant.
Implementation	a) The proposal must be clearly specified to enable implementation. b) It should be technically possible for services and DH to implement without significant issues.
Data Quality	a) There should be a person, unit or organisation identified to monitor quality. b) There should be minimal transformation of data required by services to meet reporting requirements. c) Reporting of the data should be mandatory for a specified cohort.
Consequential impact	a) The impact on other data already collected, or proposed to collect must be articulated. b) There should not be a negative effect on the reputation or integrity of the collection. c) Identify any dependencies with other projects or plans. d) The impact on time-series data must be quantified. e) The impact on reports, extracts or automated processes must be quantified.
Cost and collection burden	a) The effort required to implement and collect should be commensurate with the frequency of the event triggering collection of reportable data. b) All options for the collection of this data should be assessed and the most appropriate method and

	collection selected.

Orientation to this document

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

- New values and definitions relating to existing items are highlighted in orange.
- Changes to existing items are highlighted in green.
- Redundant values and definitions relating to existing items ~~are struck through.~~
- Comments relating only to the proposal document *[appear in square brackets and italics.]*
- Page numbers representing cross referencing to another section of the VAED Manual are represented by a #.
- Edits that are proposed to change are marked when listed as part of a Data Item or after an Edit Table with a * after the edit number. New proposed edits will be shown with an edit number of ###.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Admitted Episodes Dataset (VAED 17th Edition, 1 July 2011).*

    Specification: details the reporting requirements for the item.

    Administration: provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each proposal is provided.

Abbreviations

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

Symbols

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

Proposed revisions/additions to data items

Proposal 1 – Removal of requirement to report both Barthel and FIM™ Scores

It is proposed to

Remove the requirement to report Barthel Index Score on Admission/Separation when FIM™ Score on Admission/Separation have been reported.

Proposed by

Castlemaine Health

Implementation Date

1 July 2012

Reason for proposal

This change will reduce the workload on health service staff by removing the requirement to report two assessment scores.

Details of change

This proposal incorporates the following changes:

1.1 (p.32)	Remove Barthel Index Score on Admission and Barthel Index Score on Separation
1.2 (p.103)	Amend the S4 record specification to remove Barthel Index scores.
2.8 (p.93)	Amendment of Section 4 Business Rules (Tabular): Care Type: Designated Paediatric Rehabilitation Program (P)
5.7 (p.90)	Amendment of Section 4 Business Rules (tabular): Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K).

Proposal 2 – ABF Requirements: Addition of *Phase of Care*, *Impairment* to be mandatory

It is proposed to	Collect Phase of Care at admission and up to 11 changes of Phase of Care for palliative care patients (Care Type 8). For each phase, the date of the phase change, and the RUG ADL score at the start of the phase will be collected. The first 10 changes of phase will be collected and the last phase before the end of the episode.
Proposed by	Funding Systems Development unit Funding & Information Policy Department of Health
Implementation Date	1 July 2012
Reason for proposal	These changes are required for the implementation of Activity Based Funding (ABF) in order to derive the AN-SNAP (Australian National Sub-Acute and Non-Acute Patient) classification. It is necessary to collect the data prior to the start date of ABF in order to use the data to develop appropriate funding levels and to assess the impact of funding changes to services.
Details of change	This proposal incorporates the following changes:

2.1 (p.37)	Add *Phase of Care at Admission* and at each phase change for Care Type 8 *Palliative Care* episodes.
2.2 (p.36)	Add *Phase Change Date* for each phase change.
2.3 (p.71)	Add *RUG ADL at Phase Start* for each change of phase.
2.4 (p.82)	Re-locate *Source of Referral to Palliative Care* from the S4 Subacute record to the P5 Palliative record.
2.5 (p.84)	Amend Section 4 *Palliative Care Reportin*g to include details about reporting Phase of Care changes. The first ten phase changes and the last phase before separation are collected.
2.6 (p.69)	*Impairment* to become mandatory for Care Types 2 (Rehabilitation Level 1), 6 (Rehabilitation Level 2) and P (Paediatric Rehabilitation).
2.7 (p.32)	*Clinical Sub-Program* to be removed.
2.8 (p.93)	Amendment of Section 4 Business Rules (Tabular): *Care Type: Designated Paediatric Rehabilitation Program (P)*
5.7 (p.90)	Amendment of Section 4 Business Rules (tabular): *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K).*
2.10 (p.124)	Addition of new edits
2.11 (p.109)	Amendments of edits
2.12 (p.103)	Amend the S4 record specification to reflect Palliative Care changes.
2.13 (p.107)	Addition of P5 Palliative Care record specification.
2.14	Addition of data element in Section 3 *PCOC Flag* to indicate

whether separate extracts from the PCOC system are being submitted.

Implementation

Palliative Care information will be removed from the S4 Subacute record in the PRS/2 file structure. A P5 Palliative record will be created.

It is recognised that the required information may currently be reported to the Palliative Care Outcome Collaboration (PCOC), either using an extract from the patient administration system or via SNAPshot. The department will investigate the possibility of processing extracts from both of these sources. Feedback from services reporting to PCOC and interested in the department pursuing these options would be valuable.

Proposal 3 – Addition of *Care Plan Documented Date*

It is proposed to	Add *Care Plan Documented Date* for Care Types 2 (Rehabilitation Level 1), 6 (Rehabilitation Level 2), P (Paediatric Rehabilitation), 8 (Palliative Care), and 9 (GEM).
Proposed by	Continuing Care unit Wellbeing, Integrated Care & Ageing Department of Health
Implementation Date	1 July 2012
Reason for proposal	These changes will enable the Department to fulfil it's obligation to report against the Timeliness of Care Key Performance Indicator required under the National Partnerships Agreement Subacute Care Performance Indicators).
Details of change	This proposal incorporates the following changes:

3.1 (p.35)	Addition of *Care Plan Documented Date*.
3.2 (p.27)	Addition of Concept definition for *Care Plans*.
3.3 (p.99)	Amend the Episode record specification to include *Care Plan* Documented *Date*.
3.4 (p.124)	Addition of edits
5.7 (p.90)	Amendment of Section 4 Business Rules (tabular): *Care Type: Designated and Non*-Designated *Rehabilitation Programs (2, 6, 7 and K).*
2.8 (p.93)	Amendment of Section 4 Business Rules (Tabular): *Care Type: Designated Paediatric Rehabilitation Program (P)*

Proposal 4 – Addition of *Advance Care Plan Documented Date*

It is proposed to	Add Advance Care Plan Documented Date for all episodes in public hospitals.
Proposed by	Continuing Care unit Wellbeing, Integrated Care & Ageing Department of Health
Implementation Date	1 July 2012
Reason for proposal	To measure change in relation to Advance Care Planning activity within the inpatient context. To meet the National Healthcare Agreement / NPA HHWR Schedule C specifications. The key drivers for the addition of the data element are: • The recent endorsement by the Australian Health Ministers' Council of the National Framework for Advance Care Directives (August 2011) • The in principle endorsement by the Minister for the development of a Victorian Advance Care Planning policy.
Details of change	This proposal incorporates the following changes:

3.2 (p.27)	Addition of Concept definition for Care Plans.
4.1 (p.33)	Addition of Advance Care Plan Documented Date.
4.2 (p.99)	Amend the Episode record specification to include *Advance Care Plan Documented Date*.
4.3 (p.124)	Addition of edits

Proposal 5 – Removal of Care Types 7, K, E and F

It is proposed to	Remove Care Types 7 (Designated Rehabilitation Program/Unit: Level 3), K (Non-Designated Rehabilitation Program/Unit), E (Interim Care Program), and F Interim Care Program – Nursing Home Type).
Proposed by	Continuing Care unit Wellbeing, Integrated Care & Ageing Department of Health
Implementation Date	1 July 2012
Reason for proposal	The programs reported under these Care Types are no longer in use.

Details of change

This proposal incorporates the following changes:

5.1 (p.52)	Removal of Care Types 7, K, E and F from Section 3 *Care Type* definition.
5.2 (p.60)	Amendment to Section 3 Contract/Spoke Identifier to remove Interim Care codes.
5.3 (p.30)	Amend Section 2 Concept definition of *Rehabilitation Care*
5.4 (p. 28)	Amend Section 2 Concept definition of *Nursing Home Type/NonAcute Care*
5.5 (p.31)	Remove the Section 2 Concept *Interim Care Program*.
5.6 (p.85)	Amendment of Section 4 Business Rules (tabular): *Account Class, Acc Type, Care Type and Medicare Suffix*.
5.7 (p.90)	Amendment of Section 4 Business Rules (tabular): *Admission Source and Care Type*.
5.8 (p.91)	Amendment of Section 4 Business Rules (tabular): *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K).*
5.9 (p.92)	Removal of Section 4 Business Rules (tabular): *Care Type: Interim Care Program (F and E)*
5.10 (p.96)	Amendment of Section 4 Business Rules (tabular): *Care Type and Separation Mode* for removal of Interim Care
5.11(p. 84)	Removal of Section 4 Business Rules (Non-tabular): *Interim Care Program and Contracting Arrangements*
5.12 (p.109109)	Amendment of edits
5.13 (p.127)	Removal of edits

Note: This change will require a considerable number of minor changes to the VAED manual where references are made to Care Types, most of which will not be reproduced in this document.

Proposal 6 – Addition of Care Types R1 and R2 for Restorative Care

It is proposed to	Add two new Care Types for *Restorative Care: On-site* and *Restorative Care: Off-site*.
Proposed by	Wellbeing, Integrated Care & Ageing Department of Health
Implementation Date	1 July 2012
Reason for proposal	Restorative Care is currently reported under Care Type K (Non-Designated Rehabilitation Program/Unit) with Program Identifier 3 (Restorative Care). Non-Designated Rehabilitation is no longer an active program and Care Type K is to be removed in 2012-13 (See Proposal 5). Restorative Care is provided both at a health service (on-site) and in a residential care setting (off-site) by the health service. Although patients in a residential care setting may not meet admission criteria, the funding for Restorative Care is the same in both settings, and separate Care Types will allow for separation for reporting purposes.

Details of change

The business rules for the new care types have been based on those applicable to Geriatric Evaluation and Management, with some amendments.

This proposal incorporates the following changes:

6.1 (p.52)	Addition of Care Types R1 and R2 to Section 3 *Care Type* definition.
6.2	Add Section 2 Concept definition for *Restorative Care (Will be provided at a later date)*
6.3 (p.90)	Addition of a code value to Section 3: *Accommodation Type* and *Accommodation Type on Separation* for Home-based Restorative Care.
6.4 (p.73)	Removal of code R *Separation and transfer to Restorative Care bed-based program*. Movement to and from Restorative Care will be affected by a Care Type change.
6.5 (p.90)	Amendment of Section 4 Business Rules (tabular): *Admission Source and Care Type* for Restorative Care.
6.6 (p.96)	Amendment of Section 4 Business Rules (tabular): *Care Type and Separation Mode* for Restorative Care.
6.7 (p.97)	Amendment of Section 4 Business Rules (tabular): *Age, Care Type, Carer Availability and Separation Mode* for Restorative Care.
6.8 (p.98)	Amendment of Section 4 Business Rules (tabular): *Intention to Readmit and Separation Mode*, removal of Separation Mode R.
6.9 (p.94)	Addition of Section 4 Business Rules (tabular): *Care Type: Geriatric Evaluation and Management (9) and Restorative Care (R1 and R2)*.
6.10 (p.85)	Amendment of Section 4 Business Rules (tabular): *Account Class, Accommodation Type, Care Type and Medicare Suffix* for Restorative Care.
6.11 (p.124)	Addition of edits

Note: This change will require a considerable number of minor changes to the VAED manual where references are made to Care Types, most of which will not be reproduced in this document.

Proposal 7 – Addition of Care Type 10 for Organ Procurement – Posthumous episodes

It is proposed to	Add a new Care Type 10 for Organ Procurement – Posthumous episodes.
Proposed by	Costing Policy & Analysis Funding and Information Policy Department of Health
Implementation Date	1 July 2012
Reason for proposal	Under the COAG National Health Reform agreement all health services must submit cost data in compliance with the Australian Hospital Patient Costing Standards (AHPCS). These standards include posthumous organ procurement services. The inclusion of organ procurement episodes in the VAED will allow activity to be reconciled against cost data. The data is reportable to the National Hospital Cost Data Collection (NHCDC), which will be reportable to the Independent Hospital Pricing Authority (IPHA) in the future.

Details of change

This proposal incorporates the following changes:

7.1 (p.52)	Addition of Care Type 10 to Section 3 *Care Type* definition.
7.2 (p.29)	Add Section 2 Concept definition for *Organ Procurement - Posthumous*
7.3 (p.73)	Addition of code G to Section 3 *Separation Mode* for posthumous organ procurement episodes.
7.4 (p.44)	Addition of code G to Section 3 *Admission Source* for posthumous organ procurement episodes.
7.5 (p.48)	Addition of code G to Section 3 *Admission Type* for posthumous organ procurement episodes.
7.6 (p.63)	Addition of code value to Section 3 Criterion for Admission for Organ Procurement episodes.
7.7 (p.95)	Addition of Section 4 Business Rules (tabular): *Care Type: Organ Procurement - Posthumous*.
7.8 (p.90)	Amendment of Section 4 Business Rules (tabular): *Admission Source and Care Type*.
7.9 (p.96)	Amendment of Section 4 Business Rules (tabular): *Care Type and Separation Mode* for Care Type 10.
7.10 (p.98)	Amendment of Section 4 Business Rules (tabular): *Intention to Readmit and Separation Mode* for Separation Mode G.
7.11 (p.124)	Addition of edits

Notes:

This change will require a considerable number of minor changes to the VAED manual where references are made to Care Types, most of which will not be reproduced in this document.

Changes are still to be made to Section 2 *Criterion for Admission* and other parts of the VAED manual.

Changes will be required to the Scope statement for the VAED to allow reporting of organ procurement episodes as they do not meet Criteria for Admission.

Proposal 8 – Addition of a Separation Referral code for decline of referral to Post-Natal Domiciliary Care.

It is proposed to	Add a new Separation Referral code for use when a patient declines a referral to Post-Natal Domiciliary Care.
Proposed by	Performance, Acute Programs and Rural Health Department of Health
Implementation Date	1 July 2012
Reason for proposal	Health services are currently monitored on the percentage of women with pre-arranged Post-natal home care though the suite of health service key performance indicators (KPIs) measured on a monthly basis by the Performance, Acute Programs and Rural Health branch (PAPRH). The statewide target is 100 per cent of women to have postnatal domiciliary care arranged prior to discharge from hospital. At present there is no code to acknowledge instances where a referral has been offered but declined by a woman prior to discharge from hospital. Health services have previously been advised to code this as no referral arranged, impacting on their KPI result.
Details of change	This proposal incorporates the following changes:

8.1(p.77)	Addition of a new Separation Referral code.
8.2 (p.124)	Addition of edits

Proposal 9 – Updated Reference File for Preferred Language and Country of Birth

It is proposed to	Update the reference files for Preferred Language and Country of Birth in accordance with the release of new versions by the Australian Bureau of Statistics.
Proposed by	Admitted, Emergency and Elective Data Funding, Information Policy Department of Health
Implementation Date	1 July 2012
Reason for proposal	The new reference files incorporate amendments which reflect changes to country names and new countries, and corrections to language codes.

Details of change

This proposal incorporates the following changes:

9.1 New reference file for Section 3: Preferred Language – Australian Standard Classification of Languages (ASCL) 2011

The only change to data element definition is an update to the *Code set source*. (Change not shown in this document).

9.2 New reference file for Section 3: Country of Birth – Standard Australian Classification of Countries (SACC) 2011, 2nd Edition, Revision 1

The only change to data element definition is an update to the *Code set source*. (Change not shown in this document).

Updated reference files are available on the HDSS Website. The reference files will detail the changes to each codeset :
www.health.vic.gov.au/hdss/reffiles/index.htm

Further details are available on the ABS website:

Preferred Language:
http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/1267.0main+features82011

Country of Birth:
http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/1269.0main+features1602011

Future developments for feedback: Boarders

It is proposed to	Collect information about hospital boarders to link with costing data.
Proposed by	Costing Policy & Analysis Funding and Information Policy Department of Health
Implementation Date	Unknown
Reason for proposal	Under the COAG National Health Reform agreement all health services must submit cost data in compliance with the Australian Hospital Patient Costing Standards (AHPCS). These standards include Boarders. The inclusion of Boarder episodes in the VAED will allow activity to be reconciled against cost data.
Issues and feedback	This proposal has not been included for 2012-13 as sufficient time is not available to analyse requirements, and develop data definitions and business rules.

Feedback is sought from services commonly accommodating boarders. The department is seeking to understand the practices and processes in services in relation to boarders:

- What constitutes a 'boarder' in your service? For example, length of stay, provision of meals or other service.
- Are boarders recorded on software systems?
- Are boarder episodes linked to a patient episode?
- Can a patient have more than one boarder at one time?
- If boarders are recorded on your software system as an episode, are they placed on leave if they are absent for one night and return the next, or separated and re-admitted?

File Structure Changes

All submission file record types will be changing from ‘4’ to ‘5’. For example, the Episode Record Type will change from E4 to E5.

The following rules will apply for 2012-13:

Record Type	Submission File Header Start Date	Separation Date
E4	30 June 3012 and before	All (including unseparated)
E4	1 July 2012 and after	30 June 2012 or before
E5	1 July 2012 and after	1 July 2012 and after
E5	1 July 2012 and after	Unseparated

For all other record types (Header, Sub-acute, DVA/TAC, Diagnosis, Extra Diagnosis, Trailer 1 and Trailer 2), the Record Type version must be compatible with the Episode Record Type Version. For example, whenever an episode must be submitted as E4, all other associated records must also be version 4. When version 5 is required, all associated record types must be version 5.

Palliative Records can only be version 5 as they are not reportable prior to 2012-13.

Details to the changes to record formats are in this document.

In this document, not all instances of ‘E4’, ‘X4’, ‘Y4’, ‘S4’ and ‘V4’ have be amended, and this document does not reflect all the instances in the VAED manual which will change. The VAED Manual for 2012-13 will be updated at a later time.

Section 2 Concept & Derived Item amendments

Proposal	*Description*
3.2	Addition of Concept definition for Care Plans.

Care Plans

Definition

Care Plans and Advance Care Plans are two distinct concepts and have different reporting requirements in the VAED.

Care Plan

Interdisciplinary care: Assessment and/or treatment services provided jointly by a team that consists of a number of health care professionals who are members of different disciplines dedicated to the ongoing and integrated care of one patient, set of patients or clinical condition. It also requires access to other disciplines for consultation and referral as required and a mechanism for ongoing interdisciplinary review.

Multidisciplinary care: Assessment and/or treatment services provided by a group of health care professionals who are members of different disciplines working together to deliver comprehensive patient care.

The definition of Multi-disciplinary/interdisciplinary care varies according to Care Type:

- Rehabilitation, Geriatric Evaluation and Management and Psychogeriatric care:
  A management plan which includes negotiated goals and indicative time frames which are evaluated by periodic assessment;
- Palliative care:
  A management plan covering the physical, psychological, emotional and spiritual needs of the patient

Advance Care Plan

Advance care planning is a process of planning for future health and personal care whereby the person's values, goals, beliefs and preferences are made known so that they can guide decision making at a future time when the person cannot make or communicate their decisions (referred to here as future wishes).

Advance care planning requires respect for the person and their autonomy. It is often about end-of-life care, but not always. It aims to improve quality of care and is based on human rights principles, including self-determination, dignity and the avoidance of suffering.

An Advance Care Plan comprises any of the following

- a record of a discussion about future wishes
- a discussion with significant family and / or friends that communicates a person's future wishes
- formal written wishes that are witnessed and signed
- informal written wishes that are neither witnessed nor signed
- a completed Enduring Power of Attorney (Medical Treatment)
- the appointment in writing of a Substitute Decision Maker
- a completed Refusal of Treatment Certificate.

In whatever form the documentation takes it must have the potential to assist in some way with future decision making about health and personal care. This is by either appointing a substitute decision maker or recording the person's wishes.

Guide for use Refer to:

Section 3: Care Plan Documented Date, Advance Care Plan Documented Date, Care Type

Proposal	***Description***
5.4	Amend Section 2 Concept definition of *Nursing Home Type/Non-Acute Care.*

Nursing Home Type/Non-Acute Care

(Information not shown is unchanged)

Guide for use Thus, in public hospitals in Victoria, a patient receiving any one of the admitted patient Care Types (not just 4 Other care (Acute) including Qualified newborn) will become a NHT/Non-Acute patient (Care Type ~~F Interim Care Program – Nursing Home Type,~~ 1 NHT/Non-Acute or 5T Mental Health Nursing Home Type) if they receive 35 days of continuous hospitalisation and do not have certification allowing the present type of care to continue.

Proposal	*Description*
7.2	Add Section 2 Concept definition of *Organ Procurement - Posthumous*

Organ Procurement - Posthumous

Definition

Organ procurement - posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.

This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian coding standards.

Declarations of brain death are made in accordance with relevant state/territory legislation.

Donor organs for transplant are procured in two circumstances:

1. From a patient already admitted to the hospital who dies:

- Such a patient's time of separation is the official time of death.
- Therefore, the count of hours in ICU and/or CCU, and the Duration of Mechanical Ventilation and Non-invasive Ventilation, reported to the VAED must cease at official separation, and the ICD-10-AM/ACHI Diagnosis and Procedure Codes for the 'procuring' procedures must not be reported to the VAED.

2. From a person who is declared 'dead on arrival' at the hospital:

- Such a person ~~cannot be~~ is not considered to be 'admitted'.
- ~~Therefore no episode can be reported to the VAED.~~

Under both circumstances, an episode is reported for recording the organ procurement information using Care Type 10 Organ Procurement – Posthumous. For patients who die in the hospital, the admitted episode is closed at the time of death and a new episode created. The two episode are NOT statistically linked. The Admission Source and Separation Mode for all organ procurement episodes are the same for both patients who die in hospital and patients who are dead on arrival.

Refer to:

Section 2: Time of Death

Section 3: Care Type, Duration of Mechanical Ventilation in ICU, Duration of Non-invasive Ventilation (NIV), Duration of Stay in Cardiac/Coronary Care Unit, Duration of Stay in Intensive Care Unit, and Separation Time

Proposal	*Description*
5.3	Amend Section 2 Concept definition of *Rehabilitation Care*

Rehabilitation Care

Definition

Care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by periodic assessment using a recognised functional assessment measure.

The Department of Health Rehabilitation Program excludes Nursing Home Type/Non-Acute patients and Geriatric Evaluation and Management patients.

The department defines ~~three~~ two levels of designated rehabilitation and paediatric rehabilitation programs. ~~In addition to the three levels, rehabilitation may be provided in a non-designated rehabilitation program serving a specified geographical area.~~

Level 1 - Care in a public hospital in a designated Level 1 Rehabilitation Program/Unit.

Level 1 rehabilitation is for use by designated specialty programs providing rehabilitation following spinal cord injury, head injury or amputation and where the rehabilitation episode directly follows the acute care episode in which the injury is the principal diagnosis.

Level 2 - Care in a public or private hospital in a designated Level 2 Rehabilitation Program/Unit.

Level 2 are rehabilitation programs that fully meet the criteria for designation as set out in the document Designation of Rehabilitation Programs, November 1993.

~~Level 3 - Care in a public hospital in a designated Level 3 Rehabilitation Program/Unit.~~

~~Level 3 rehabilitation programs are where interim/transitional designation is provided based on agreed patient days where the minimum rehabilitation designation criteria were not met but geographical or other considerations require the continued provision of interim services pending improved service provision or the development of service capacity in other agencies.~~

~~Non-Designated - Care in a public hospital in a non-designated Rehabilitation Program/ Unit.~~

~~Non-Designated rehabilitation programs are where services are provided on the basis that rehabilitation type care is being delivered in a geographical area requiring the provision of such a service and where the agency is currently not seeking formal designation as a rehabilitation program. This rehabilitation type care is being delivered out of WIES funding.~~

Paediatric - Care in a public hospital in a designated Paediatric Rehabilitation Program/Unit.

Paediatric rehabilitation is for use by designated specialty programs providing rehabilitation to persons generally less than 18 years of age.

Refer to:
Section 2: Episode of Admitted Patient Care, and Sub-Acute Care
Section 3: Care Type and Clinical Sub-Program
Section 5: Sub-Acute Record
Section 9: Supplementary Code Lists Care Types 2, 6, ~~7, K~~ & P:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Proposal	***Description***
5.5	Remove the Section 2 Concept *Interim Care Program*.

~~Interim Care Program~~ (removed)

Section 3 Data Definition amendments

Deleted Data Elements

Proposal	*Description*
1.1	Remove data element from Section 3: *Barthel Index Score on Admission* Remove data element from Section 3: *Barthel Index Score on Separation*
2.7	Remove data element from Section 3: *Clinical Sub-Program*

~~Barthel Index Score on Admission (a)~~

~~Barthel Index Score on Separation (b)~~

~~Clinical Sub-Program~~

New data elements

Proposal	*Description*
4.1	Addition of a new data element in Section 3: *Advance Care Plan Documented Date*.

Advance Care Plan Documented Date

Specification

Definition	The date of documentation that an advance care plan has been initiated updated or reported for the first time.		
Data type	Numeric	***Form***	Date
Field size	8	***Layout***	DDMMYYYY
Location	Episode Record		
Reported by	Public hospitals		
Reported for	All admitted episodes of care		
Reported when	The Episode Record is reported		
Code set	Valid date		

Reporting guide

Report when an Advance Care Plan is initiated, updated or reported for the first time.

If an Advance Care Plan has not yet been documented, do not report this item.

The date of the last update to the Advance Care Plan should be recorded in this item.

If an Advance Care Plan has been documented but the date is unknown then report any date prior to the Admission Date. For episodes which have been initiated by a referral, the referral date could alternatively be reported as the Advance Care Plan Documented Date.

An Advance Care Plan Documented Date should not be recorded if the topic of Advance Care Plan is introduced, but no information to guide future decision-making is gained.

Edits

XXX Invalid Advance Care Plan Documented Date

XXX Advance Care Plan Documented Date is after the Separation Date.

Related items

Section 2: Care Plans

Section 3: Care Type

Administration

Purpose To enable reporting required under the National Partnerships Agreement.

Principal data users Multiple internal and external data users.

Collection start	2012		
Definition source	DH	***Value Domain Source***	DH

Proposal	Description
3.1	Addition of a new data element in Section 3: *Care Plan Documented Date*.

Care Plan Documented Date

Specification

Definition	The date of documentation that either a multidisciplinary care plan or an interdisciplinary care plan was first agreed.		
Data type	Numeric	***Form***	Date
Field size	8	***Layout***	DDMMYYYY
Location	Episode Record		
Reported by	Public hospitals		
Reported for	Care Types 2, 6, P, 8, 9, R1 and R2 AND Episode length of stay is greater than or equal to 7 days		
Reported when	A Separation Date is reported in the Episode Record		
Code set	Valid date		

Reporting guide Care Plan Documented Date should be within 7 days of the start of the sub-acute episode.

Edits

XXX Care Type 2, 6, P, 8, 9 R1 or R2, Separation Date reported, but Care Plan Documented Date is null (W)

XXX Care Plan Documented Date is reported but Care Type is not 2, 6, P, 8, 9, R1 or R2. (R)

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	DH	***Value Domain Source***	DH

Proposal	*Description*
2.2	Add *Phase Change Date* for each phase change.

Phase Change Date

Specification

Definition	The date of a change in the phase of care.		
Data type	Numeric	***Form***	Date
Field size	8	***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		
Code set	A valid date		

Reporting guide

Up to ten changes of Phase of Care can be reported. For each phase change, Phase Change Date, Phase of Care, and RUG ADL on Phase Start must be reported.

The first nine changes of phase are reported. All phase changes after the ninth change are combined and reported in the tenth phase change. In the tenth phase change, the Phase of Care that the patient is in at separation is reported, and the RUG ADL on Phase Change is the score applicable to the last Phase of Care before separation.

Edits

XXX	Phase Change Date is after the Separation Date.
XXX	Phase Change Date is invalid.
XXX	Not sufficient fields: Phase of Care change
XXX	Palliative Care: No Palliative record (W)

Related items Section 3: *Care Type*, *Phase of Care*, *RUG ADL Score*

Administration

Purpose To enable derivation of AN-SNAP classification.

Principal data users Multiple internal and external data users.

Collection start 2012

Definition source	Proposed Pall Care NMDS (DH Modified)	***Value Domain Source***	Proposed Pall Care NMDS (DH Modified)

Proposal	Description
2.1	Add *Phase of Care at Admission* and at each phase change for Care Type 8 *Palliative Care* episodes.

Phase of Care on Admission

Phase of Care on status change

Specification

Definition The phase of care at the start of the palliative care episode, and when a new phase begins.

Data type	Numeric	***Form***	Code
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 is reported at admission and again each time the Phase changes (up to 10 times).

The first nine changes of phase are reported. All phase changes after the ninth change are combined and reported in the tenth phase change. In the tenth phase change, the Phase of Care that the patient is in at separation is reported, and the RUG ADL on Phase Change is the score applicable to the last Phase of Care before separation.

1 - Stable phase

The patient's/client's symptoms are adequately controlled by established management. The situation of the carer(s)/family/friends 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 problem or a rapid increase in the severity of existing problems, either of which requires an urgent change in management or emergency treatment. The carer(s)/family/friends 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. The carer(s)/family/friends

experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the patient.

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 carer(s)/family/friends recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

Edits	XXX	P5 present but Care Type is not 8
	XXX	Phase of Care invalid
	XXX	Not sufficient fields: Phase of Care change

Related items Section 3: Care Type

Administration

Purpose To enable derivation of AN-SNAP classification.

Principal data users Multiple internal and external data users.

Collection start 2012

Definition source	Proposed Pall Care NMDS (DH Modified)	***Value Domain Source***	Proposed Pall Care NMDS (DH Modified)

Amended Data Elements

Proposal	*Description*
6.7	Addition of a code value to Section 3: *Accommodation Type* and *Accommodation Type on Separation* for Home-based Restorative Care.

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 occupied by the patient on their last (counted) patient day.

Data type	Alphanumeric	**Form**	Code
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. Any changes in Accommodation Type are reported in new Status Segments.

(b) Once the Separation Date is reported in the Episode Record.

Code set

For data items (a) and (b), select the first appropriate category:

Code	**Descriptor**
5	Home-based
4	In the Home (Hospital - HITH)
7	Ward Based/Medi-Hotel combination
S	Short Stay Observation Unit
M	Medical Assessment and Planning Unit
6	Emergency Department
C	Nursery accommodation: NICU/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 of Accommodation Type occurs within the same day, do not report the first change; only report the patient's status as of midnight each day.

5 Home-based
Care delivered in a patient's home. This code is only applicable to Care Type R2 (Restorative Care: Off-site)

Excludes:

- Hospital in the Home (HITH) program (use code 4)
- Restorative care provided in a residential facility (use code 1 or 2)

4 In the Home (Hospital - HITH)
Approved care in accommodation outside the hospital.

Includes:

- Under the Hospital in the Home (HITH) program, if the public hospital's Health Service Agreement and/or Statement of Priorities specifies the hospital is participating in this program. HITH services can only be provided to public, private, DVA, TAC and WorkCover patients.

Excludes:

- Accommodation in a Medi-Hotel (use code 7).
- Restorative care provided in a patient's home (use code 5)

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 Short Stay Observation Unit
Accommodation within an approved Short Stay Observation Unit (SOU). The facility may be in, adjacent to, or remote from the Emergency Department.

SOU is a designated unit that is specifically staffed and equipped to provide observation care and treatment for emergency patients who have an expected length of stay between 4 and 24 hours.

Includes:

- General and specific Short Stay Observation Units, for example chest pain units.

Excludes:

- Short stay facilities designated specifically for elective surgical and radiological procedures
- Medical Assessment and Planning Unit admissions (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.

Excludes:

- Short Stay Observation Unit (use code S)

6 Emergency Department
Patient accommodation provided in the emergency department or urgent care centre

C Nursery accommodation: NICU/SCN
Accommodation provided to any infant in a facility approved by the Commonwealth Minister for the purpose of provision of neonatal intensive or special care.

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
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
- Restorative care delivered in a residential care setting

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)

1 Overnight accommodation: shared room

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
- Restorative care delivered in a residential care setting

Edits

	Code	Description
(a)	076	Not Sufficient Fields First Status
	077	Not Sufficient Fields Other Status
	084	Invalid Accom Type
	094	Combination A/C Accom Care Med Suff
	106	Invalid Sep Accomm
	117	Sep Accom Type Not In A Status Seg
	240	Newborn Accom But Over 4 Months
	329	Geri Respite - Invalid Comb
	431	Newborn But Not Newborn Accom
	432	MAPU or SOU >48 Hours
	434	NICU/SCN Accom But Unqual Newborn
	454	Incompat Fields for Interim Care
	463	Accom Type 4, Care Type invalid
	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 SOU
	602	Newborn Accom But Over 12 Months
	XXX	Accom Type 5, Care Type not R2
(b)	106	Invalid Sep Accom
	108	Field(s) Missing From Sep
	117	Sep Accom Type Not In A Status Seg
	401	Accom Type On Sep – Emerg, Not Same Day
	455	Inconsist Newborn Transferred/Unqual Data
	XXX	Accom Type 5, Care Type not R2

Related items

Section 2: Admitted Patient, Hospital in the Home, Intensive Care Unit, and Medi-Hotel.

Section 4:

- Business Rules (non-tabular) Medi-Hotel Reporting and Reporting history of code changes.
- Business Rules (tabular) Account Class, Acc Type, Care Type and Medicare Suffix, and Account Class: Geriatric Respite, ~~and Care Type: Interim Care Program (F and E)~~, and Criterion for Admission: Secondary Family Member.

Section 5: Status Segments.

Section 9: Supplementary Code Lists: Medical Assessment and Planning Units (MAPU); Accommodation Type M: Neonatal Intensive Care Units and Special Care Nurseries; Accommodation Type C: Short Stay Observation Units; Accommodation Type S: and Ward Based/Medi-Hotel Combination; Accommodation Type 7.

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

Proposal	Description
7.4	Addition of code G to Section 3 *Admission Source* for posthumous organ procurement episodes.

Admission Source

Specification

Definition Describes where the patient was residing or living prior to the commencement of an episode of care.

Data type	Alpha	**Form**	Code
Field size	1	**Layout**	A

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Select the first appropriate category:

Code	Descriptor
G	Organ Procurement - Posthumous
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 aged care residential facility
H	Admission from private residence/accommodation

Reporting guide

G Organ Procurement – Posthumous

Assign this code for posthumous organ procurement episodes (Care Type 10) only.

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 G).
- 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: Levels 1, 2, 3 or Paediatric, Care Types (2, 6, ~~7,~~ 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. Requires a Transfer Source code.

Includes:

Public and private acute, extended care and mental health admitted patient units.

Excludes:

- Transition Care bed based program (use code B)
- Aged care residential facilities (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. Does not require a Transfer Source code.

Excludes:

- Home-based Transition Care.

A Transfer from mental health residential facility

Transfer from mental health residential facility (includes Psychogeriatric nursing homes and community care units) (Rehabilitation/Continuing Care/Other Care) funded by Mental Health Services. Only mental health residential facilities listed in Section 9 apply to this code. Does not require a Transfer Source code.

Includes:

- Mental health aged care residential facility.

Excludes:

- Mental health admitted patient units (use code T).

N Transfer from aged care residential facility

Admission to hospital directly from an aged care residential facility (includes nursing home and hostel). Does not require a Transfer Source code.

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, half way houses).

Excludes:

- Transition Care bed based program (use code B).
- Aged care residential facility (use code N).
- Mental health residential facility (use code A).

Edits ***Changes to edits are detailed later in this document***

Related items

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

Section 3: Transfer Source.

Section 4:

- Business Rules (non-tabular) Episode of Care, Newborn and Transfer
- Business Rules (tabular) Account Class: Geriatric Respite, and Admission Source and Admission Type, and Admission Source and Age, and Admission Source and Care Type, and Admission Source and Criterion For Admission,

and Admission Source and Qualification Status, and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6~~, 7 and K~~), and, Care Type P: Designated Paediatric Rehabilitation Program, ~~and Care Type: Interim Care Program (F and E),~~ and Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative and Funding Arrangement: Private Hospital Elective Surgery Initiative.

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

Proposal	*Description*
7.5	Addition of code G to Section 3 *Admission Type* for posthumous organ procurement episodes.

Admission Type

Specification

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

Data type Alpha **Form** Code

Field size 1 **Layout** A

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Select the first appropriate category:

Code	Descriptor
G	Organ Procurement - Posthumous
S	Statistical admission (change in Care Type within this hospital)
Y	Birth episode
M	Maternity
C	Emergency admission through Emergency Department at this hospital (VEMD reporting hospitals only)
L	Admission – from the Waiting List (ESIS reporting hospitals only)
O	Other emergency admission
X	Other admission

Reporting guide

G Organ Procurement – Posthumous

Assign this code for posthumous organ procurement episodes (Care Type 10) only.

S Statistical admission (change in Care Type within this hospital)

Used for statistical admissions.

Excludes:

- Patients who die in hospital and a new episode is created for organ procurement (Use code G).

Y Birth episode

Admission of newborn at or directly after birth.

Excludes second or subsequent admissions in the newborn period:

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

M Maternity

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

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

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

Use of this code is limited to those facilities that report to the Victorian Emergency Minimum Dataset (VEMD).

Includes:
Threatened miscarriage before 20 weeks.

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

L Admission – from the Waiting List (ESIS reporting hospitals only)

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

Use of this code is limited to those facilities that report elective surgery waiting list data to the Elective Surgery Information System (ESIS).

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

O Other emergency admission

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

Includes:

- GP-referred admission or self-referral for acute illness (such as unstable diabetes, CCF, pneumonia, asthma attack) directly for emergency admission.
- Threatened miscarriage before 20 weeks.
- Emergency admission to a hospital without a formal Emergency Department.
- 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 where the hospital reports to the VEMD (use C).

X Other admission

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

Includes:

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

Edits ***Changes to edits are detailed later in this document***

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

Section 4:

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

Arrangement: Rural Patients Initiative and Funding Arrangement: Private Hospital Elective Surgery Initiative.

Administration

Purpose	To: • Distinguish between emergency and non-emergency admissions. • Monitor admissions from the Waiting List. Identify data for maternity and birth episodes.
Principal data users	Funding & Information Policy Branch (Hospital & Health Service Performance, Department of Health).
Collection start	1979-80
Definition source	Department of Health

Code set source	Department of Health

Proposal	*Description*
5.1	Removal of Care Types 7, K, E and F from Section 3 *Care Type* definition.
6.1	Addition of Care Types R1 and R2 to Section 3 *Care Type* definition.
7.1	Addition of Care Type 10 to Section 3 *Care Type* definition.

Care Type

Specification

Definition The nature of the clinical service provided to an admitted patient during an episode of care.

Data type Alphanumeric ***Form*** Code

Field size 2 ***Layout*** AA or NN or 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	Organ Procurement - Posthumous
~~F~~	~~Interim Care Program – Nursing Home Type~~
~~E~~	~~Interim Care Program~~
1	NHT/Non-Acute
P	Designated Paediatric Rehabilitation Program/Unit
2	Designated Rehabilitation Program/Unit: Level 1
6	Designated Rehabilitation Program/Unit: Level 2
~~7~~	~~Designated Rehabilitation Program/Unit: Level 3~~
~~K~~	~~Non-Designated Rehabilitation Program/Unit~~
8	Palliative Care Program
5x	Approved Mental Health Service or Psychogeriatric Program:
	5T – Mental Health Nursing Home Type
	5E – Mental Health Secure Extended Care Unit (SECU)
	5K – Child and Adolescent Mental Health Service (CAMHS)
	5G – Acute, Aged Persons Mental Health Service (APMH)

	5S – Acute, Specialist Mental Health Service
	5A – Acute, Adult Mental Health Service
9	Geriatric Evaluation and Management Program
R1	Restorative Care: On-site
R2	Restorative Care: Off-ste
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 Organ Procurement – Posthumous

Organ procurement - posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

Patients who die in hospital are formally separated at the time of death and a new episode created with Care Type 10 *Organ Procurement – Posthumous*.

~~**F Interim Care Program —Nursing Home Type**~~

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

~~**NHT**~~

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

~~Such a patient will have been assessed by an Aged Care Assessment Service and will hold an Aged Care Client Record (ACCR) (formerly '2624 certificate').~~

~~Private hospitals: Do not use code F.~~

~~*Excludes:*~~

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

~~**E Interim Care Program**~~

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

~~Such a patient will have been assessed by an Aged Care Assessment Service and will hold an Aged Care Client Record (ACCR) (formerly '2624 certificate') before 35 days of continuous hospitalisation.~~

~~Private hospitals: Do not use code E.~~

1 NHT/Non-Acute

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

NHT

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

Non-Acute

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

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

P Designated Paediatric Rehabilitation Program/Unit

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

Private hospitals: Do not use code P.

2 Designated Rehabilitation Program/Unit: Level 1

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

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

Private hospitals: Do not use code 2.

6 Designated Rehabilitation Program/Unit: Level 2

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

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

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

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

~~designated unit.~~

~~Private hospitals: Do not use code 7.~~

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

~~A patient who is admitted to, or transferred to, a non-designated Rehabilitation Program/Unit or admitted to a Restorative Care Program. Use code K only if the public hospital has approval from the Sub-Acute Program to run this program. The combination of Care Type K plus Program Identifier 03 identifies patients admitted to a Restorative Care Program.~~

~~Private hospitals: Do not use code K.~~

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 Approved Mental Health Service or Psychogeriatric Program

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

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

5T Mental Health Nursing Home Type

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

NHT

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

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

Excludes:

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

5E Mental Health Secure Extended Care Unit (SECU)

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

Excludes:

- Mental Health Nursing Home Type (5T)
- Community Care Units (CCU) including Vahland CCU

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

5K Child and Adolescent Mental Health Service (CAMHS)

A patient who is admitted to an approved CAMHS unit.

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

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

Excludes:

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

5S Acute, Specialist Mental Health Service

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

Includes:

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

Excludes:

- Child and Adolescent Mental Health Service (5K)

5A Acute, Adult Mental Health Service

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

Excludes:

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

9 Geriatric Evaluation and Management Program

A patient who is admitted to, or transferred, to a Geriatric Evaluation and Management Program. Use code 9 only if the public hospital's Health Service Agreement and/or Statement of Priorities specify that the hospital has a Geriatric Evaluation and Management Program, or the hospital is approved to provide GEM Level 1. 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.

R1 Restorative Care: On-site

A patient who is admitted to, or transferred to, a Restorative Care Program which is delivered at a campus of a health service. Use only if the public hospital's Health Service Agreement and/or Statement of Priorities specify that the hospitals has a Restorative Care Program.

R1 Restorative Care: Off-site

A patient who is admitted to, or transferred to, a Restorative Care Program which is delivered in a residential care or residential setting. Use only if the

public hospital's Health Service Agreement and/or Statement of Priorities specify that the hospitals has a Restorative Care Program.

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.
- Geriatric respite care.
- Newborn who has been a Qualified newborn for some or all of the duration of this episode.

Excludes:

- Patients admitted to designated units and programs covered by other Care Types.
- Newborn who has been an Unqualified newborn for the entire duration of this stay (U).

U Unqualified newborn

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

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

Additional Notes:

Newborns

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

Refer to Sections 2 and 4: Newborn.

All other episodes

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

For example:

- If the patient is admitted to Acute care (Care Type 4) but later is transferred to an Approved Mental Health Service, the Care Type changes to Care Type 5x, therefore the earlier Episode Record should be completed and a new Episode Record should be started.

- If the patient is admitted to one of the acute Care Types and after 35 days is deemed to require only NHT care (Care Type ~~F,~~ 1 or 5T), the earlier Episode Record should be completed and a new Episode Record should be started.

There are some circumstances when a patient cannot change between Care Types, for example, a patient cannot move between levels of rehabilitation. Further information on changes of Care Type is provided in Sections 2 and 4: Episode of Care.

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

Edits

Changes to edits are detailed later in this document.

Related items

Section 2:

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

Section 4:

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

Section 5: Status Segments.

Section 9:

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

P: Designated Paediatric Rehabilitation.

Administration

Purpose	To distinguish various types of care in order to: • Apply the appropriate funding formula to the episode. • Group episodes to facilitate analysis.
Principal data users	Funding & Information Policy (Hospital & Health Service Performance, DH). Continuing Care and Clinical Service Development (Hospital & Health Service Performance, Department of Health).
Collection start	1995-96

Definition source	Department of Health	**Code set source**	Department of Health

Proposal	*Description*
5.2	Amendment to Section 3 Contract/Spoke Identifier to remove Interim Care codes.

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.
- A non-hospital contracted to provide Interim Care services

Data type	Numeric	**Form**	Code
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 (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 or
2 Hub/Spoke
Otherwise, report a space in this field.

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

Where the Funding Arrangement is 1 Contract, report the relevant Hospital Campus Code (refer to Section 9: Hospital Code Table), which identifies the other party to the contracted service arrangement, with the following exception:

When the Funding Arrangement is 1 Contract and the Contract Type 1 Contract Type B or 7 Contract Type (A), 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 or Campus Code from the list below.

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
~~0050~~	~~Interim Care Program: Residential aged care facility~~
~~0070~~	~~Interim Care Program: Supported accommodation~~
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
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
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
0910	St Vincent's Lithotripsy Service - Bendigo Hospital
0920	St Vincent's Lithotripsy Service - MMC Clayton
0930	St Vincent's Lithotripsy Service - RCH
0940	St Vincent's Lithotripsy Service - MMC Moorabbin
0950	St Vincent's Lithotripsy Service - West Gippsland Healthcare Group
0960	St Vincent's Lithotripsy Service - Ballarat Hospital
0970	St Vincent's Lithotripsy Service - Geelong Hospital
0980	St Vincent's Lithotripsy Service - Frankston Hospital
0990	St Vincent's Lithotripsy Service - Goulburn Valley Health

Reporting guide

~~Codes 0050 and 0070 Interim Care Program shall only be used with Contract Type 7 Contract Type (A).~~

~~0070 Interim Care Program: Supported Accommodation~~

~~Includes:~~

~~Supported Residential Service (SRS)~~

Edits

410	Illegal Comb Fund Arrange & Contract
419	Invalid Contract/Spoke Identifier
420	Contract/Spoke = Campus/Site
456	Contract Leave, No Contract
630	Contract/Spoke Identifier cannot be reported for this campus (Currently inactive)

Related items Section 2: Contracted Care, Leave – Contract, Leave Without Permission and Hub and Spoke.

Section 4:

- Business Rules (non-tabular) Contracted Care and Hub and Spoke
- Business Rules (tabular) Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement and Contract Fields.

Administration

Purpose To enable monitoring of health services provided under contract in Victoria.

Principal data users Funding & Information Policy (Hospital & Health Service Performance, Department of Health).

Collection start 1999-00

Definition source Department of Health **Code set source** Department of Health

Proposal	*Description*
7.6	Addition of code value to Section 3 Criterion for Admission for Organ Procurement episodes.

Criterion for Admission

Specification

Definition The criterion which has been met to justify the patient's admission, or in the case of posthumous organ procurement episodes, allows for the reporting of the episode.

Data type Alpha **Form** Code

Field size 1 **Layout** A

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when The Episode Record is reported.

Code set Criteria for Admission Decision Chart

Code	Descriptor
G	Organ Procurement - Posthumous
N	Qualified newborn
U	Unqualified newborn
O	Patient expected to require hospitalisation for minimum of one night
B	Day-only Automatically Admitted Procedures
E	Day-only Extended Medical Treatment
C	Day-only Not Automatically Qualified Procedures
S	Secondary family member

Reporting guide Refer to Section 1: Publications and Contact Details Relevant to PRS/2 and the VAED for the website link to the Private Health Insurance (Benefits Requirements) Rules 2008.

The original Criterion for Admission must not be changed, even where a patient's condition requires a different course than that planned at admission. For example, a newborn who changes Qualification Status must retain their original Criterion for Admission code (N or U), and Criterion O is not altered if the patient dies, is transferred or is discharged on the same day.

G Organ Procurement – Posthumous

Episodes reported for patients who are deceased but from whom organs are being harvested.

The episodes for this cohort of patients do not meet any criterion for admission but are required to be reported to the VAED.

N Qualified newborn

Any newborn who is:
Admitted within the first nine days of life to facilities approved by the Commonwealth Minister for the provision of special care in designated neonatal intensive care units and designated special care nurseries, or

- Is the second or subsequent live born of a multiple birth, or
- Admitted to or remains in hospital without their mother. That is, the mother must be unable to provide adequate care for the baby before this criterion can be applied. The admitted status of the mother is irrelevant.

U Unqualified newborn

Any newborn who, at time of admission, does not meet any of the criteria for admission as a Qualified newborn (N).

O Patient expected to require hospitalisation for minimum of one night

The patient is expected to require overnight or multi-day hospitalisation. Type O should be used where there is an expectation that the patient will require ongoing admitted care.

Type O includes:

- Patients who present to the Emergency Department, but die within a few hours, despite intensive resuscitative treatment but whose treatment plan initially included an expectation that they would require hospitalisation for a minimum of one night
- Patients who are transferred to another hospital where the intention is that they will require hospitalisation for a minimum of one night, having received active treatment and stabilisation at the original hospital.

Type O excludes:

- Patients whose treatment is expected to be concluded on the same day
- Patients whose care is provided over more than one date (for example, a patient presenting at 11pm and departing at 2am), but for whom the intention is not for ongoing overnight care.

Examples:

- A patient arrives at the hospital with multiple injuries resulting from a car accident and receives emergency stabilisation prior to transfer to another hospital. The first hospital reports an admitted patient, with Criteria for Admission O.
- A patient presents with a headache and baseline observations deteriorate over time. Following diagnosis, the patient is transferred to another facility for treatment. The first hospital reports an admitted patient, with Criteria for Admission O.

B Day-only Automatically Admitted Procedures

In order to meet Criterion for Admission 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.

A patient who is not intended to receive an Automatically Admitted Procedure cannot meet Criterion for Admission Type B.

The Automatically Admitted Procedure List is available at www.health.vic.gov.au/hdss

Where a patient is expected to require treatment on an overnight or multi-day stay basis while receiving an Automatically Admitted Procedure, they should be admitted as Criterion for Admission Type O.

Same day IV therapy is included as a Type B procedure, but non therapeutic IV administration is excluded (for example, administration of contrast for radiological procedures). Placement of an IV cannula alone, or injection via an IV cannula, does not warrant admission.

E Extended Medical Treatment

Criteria for Admission E should be used where patients receive a minimum of four hours of continuous active management consisting of:

- Regular observations (which may include diagnostic or investigative procedures); OR
- Continuous monitoring.

When determining a patient's eligibility for admission as Criteria for Admission E, the following factors could be taken into account:

Regular observations may include:

- Observations of vital or neurological signs provided on a repeated and periodic basis during the patient's treatment
- Provision of repeated and periodic diagnostic or investigative procedures, or provision of treatment.

Hospitals are encouraged to develop local policies or guidelines as to what constitutes regular observations. These guidelines should be consistent with established clinical pathways, protocols or accepted clinical practice.

Continuous monitoring could include:

- Continual monitoring via ECG or similar technologies. (Note: continual blood pressure and/or pulse monitoring is not considered a sufficient level of continual monitoring for these purposes).
- Continuous active supervision or treatment by clinical staff.

Type E excludes:

- Patient has been provided with clinical intervention/s for their condition and requires time to rest prior to discharge home
- Patient has a length of stay of more than four hours, primarily consisting of waiting for results of diagnostic tests
- Patient has been present at the hospital for more than four hours, but has not been engaged in treatment or diagnosis.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode.

When a patient is transferred from the Emergency Department to a ward (including short stay units), the Admission Time is the time treatment was started in the Emergency Department rather than the time it was decided to transfer the patient. Any intervention provided after treatment commences should be recorded and identified as part of the admitted patient's episode of care.

Admission for Day-only Extended Medical Treatment. The patient's medical record must contain clinical documentation that indicates the treatment provided to the patient justified admission, and that continuous active management exceeded four hours.

Includes: Patients undergoing a Type C Professional Attention Procedure where it is intended that they will also receive Extended Medical Treatment.

C Day-only Not Automatically Qualified Procedures

The Not Automatically Qualified for Admission List identifies procedures that would normally be undertaken on a non-admitted basis and therefore not normally accepted as admissions in their own right.

In order to meet Criterion for Admission C, a patient must:

- Receive a procedure on the Not Automatically Qualified for Admission List; and
- Be intended to be treated on a day-only basis; and
- The treating doctor must provide evidence that the patient's special circumstances justify admission for the purpose of having this procedure. This evidence must be documented in the patient's medical record.

Audits of medical records may be conducted for the purpose of ensuring that treatment of such patients in an admitted patient setting is warranted.

A patient who does not undergo a procedure listed on the Not Automatically Qualified for Admission List cannot meet Criterion for Admission C.

The Not Automatically Qualified for Admission List is available at www.health.vic.gov.au/hdss

A patient who is intended to receive a procedure on the Not Automatically Qualified for Admission List as part of an overnight or multi-day stay should be admitted as Criterion for Admission O.

S Secondary Family Member

A person who does not meet any of the Criteria for Admission categories but is accompanying a patient who is admitted. Code S must be used for all such persons.

Only Early Parenting Centres can report this category.

Edits

072	Invalid Criterion for Adm
074	Invalid Age For Criterion
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
328	Early Parenting Centre -Invalid comb
329	Geri Respite - Invalid Comb
336	Invalid Comb For Crit Care Transfer
454	Incompat Fields for Interim Care
455	Inconsist Newborn Transferred/Unqual Data
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
492	Incompat Fields for RPI
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

Related items

Victorian Hospital Admission Policy:
http://www.health.vic.gov.au/hdss/vaed/index.htm

Section 2: Criterion for Admission, Neonate, Newborn, and Overnight or Multi-day Stay.

Section 4:

- Business Rules (non-tabular) Contracted Care
- Business Rules (tabular) Account Class: Geriatric Respite, and Admission Source and Criterion For Admission, and Admission Type and Criterion For Admission, and Age and Criterion For Admission, and Care Type: Designated ~~and Non-Designated~~ Rehabilitation Programs (2, 6~~, 7 and K~~), and Care Type P: Designated Paediatric Rehabilitation Program, ~~and Care Type: Interim Care Program (F and E),~~ and Criterion for Admission and Newborn Qualification Status (1st Status Segment), and Criterion for Admission and Qualification Status, and Criterion for Admission: Secondary Family Member, and Funding Arrangement: Elective Surgery Access Service, and Funding Arrangement: Rural Patients Initiative, and Funding Arrangement: Private Hospital Elective Surgery Initiative, and Newborns: Criteria for Admission, Qualification Status, Care Type.

Administration

Purpose

To prompt the hospital to consider the eligibility of the patient for admission, to identify:

- Any patient admitted for procedures listed on Automatically Admitted Procedure List
- Any patient with special circumstances requiring admission (rather than treatment as an ambulatory patient).
- Any person treated in an Early Parenting Centre not meeting the requirements to be admitted (to omit such episodes from reporting to the Commonwealth).

Principal data users

Funding & Information Policy (Hospital & Health Service Performance, Department of Health).

Collection start

1993-94

Definition source Commonwealth **Code set source** Department Health

Proposal	***Description***
2.6	Impairment to become mandatory for Care Types 2 (Rehabilitation Level 1), 6 (Rehabilitation Level 2) and P (Paediatric Rehabilitation).

Impairment

Specification

Definition The diagnosis, based on the body system manifesting the reason for rehabilitation.

Data type Numeric **Form** Code

Field size 6 **Layout** NNNNNN or spaces

Left justified, trailing spaces

Location Sub-Acute Record

Reported by Public hospitals.

Reported for ~~Optional if Care Type = 2, 6, 7, K, P and Clinical Sub-program present.~~
Mandatory if Care type = 2, 6, ~~7, K,~~ P ~~and Clinical Sub-program NOT present.~~
For Care Types ~~8,~~ 9, R1 and R2 ~~, F and E,~~ report spaces.

Reported when A Separation Date is reported in the Episode Record.

Code set **Code** **Descriptor**

(Information unchanged)

Edits

253 Rehab Invalid ~~Clin Sub-Prog or~~ Impairment
258 Sub-Acute: No Sub-Acute Record
293 ~~Clin Sub-Prog or~~ Impairment Present
405 ~~Inapplic Clin Prog or~~ Impairment For Care Type 2
454 Incompat Fields for Interim Care

Related items Section 2: Rehabilitation Care.

Section 4: Care Type: Designated ~~and Non-Designated~~ Rehabilitation Programs (2, 6~~, 7 and K~~), and Care Type: Designated Paediatric Rehabilitation Program (P)

Administration

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

Principal data users Ambulatory & Co-ordinated Care (Wellbeing, Integrated Care & Aged, DH).

Collection start	2009-10		
Definition source	DH	**Code set source**	DH

Proposal	*Description*
2.3	Add *RUG ADL at Phase Start* for each change of phase.

RUG ADL on Admission (a)

RUG ADL on Separation (b)

RUG ADL at Phase Change (c)

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

Data type Numeric **Form** Score

Field size 2 **Layout** NN or spaces
Right justify, leading zeros.

Location ~~Sub-Acute~~ Palliative
Record

Reported by Public hospitals.

Reported for Episodes with Care Type 8. ~~For Care Types P, 2, 6, 7, K, 9, F and E, report spaces in this field.~~

Reported when A Separation Date is reported in the Episode Record.

Code set Cumulative Score, out of 18. On admission, a minimum score of 04 must be reported. Refer to the RUG ADL Score Table following.

Reporting guide Record what the person actually does, not what they are capable of doing; that is, record the lowest performance of the assessment period.

If the person dies in hospital, record a score of 00 for the Separation RUG ADL.

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.

RUG ADL Score

(Information unchanged)

Edits ***Changes to edits are detailed later in this document.***

Related items	Section 2: Palliative Care. Section 4: Business Rules (tabular) *Care Type: Designated and non-Designated Rehabilitation Programs (2, and 6, 7 and K), and* *Care Type P: Designated Paediatric Rehabilitation Program, and Care Type: Interim Care Program (F and E).*

Administration

Purpose	To support and further develop casemix classifications for sub-acute episodes of care.		
Principal data users	Continuing Care and Clinical Service Development (Hospital & Health Service Performance, DH).		
Collection start	1996-97		
Definition source	DH	**Code set source**	RUG ADL

Proposal	Description
6.4	Removal of code R Separation and transfer to Restorative Care bed-based program. Movement to and from Restorative Care will be effected by a Care Type change.
7.3	Addition of code G for Organ Procurement – Posthumous episodes.

Separation Mode

Specification

Definition Status at separation of the person, and place to which the person is released (where applicable).

Data type	Alpha	**Form**	Code
Field size	1	**Layout**	A

Location Episode Record

Reported by All Victorian hospitals (public and private).

Reported for All admitted episodes of care.

Reported when A Separation Date is reported in the Episode Record.

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

Code	Descriptor
G	Organ procurement - posthumous
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
~~R~~	~~Separation and transfer to Restorative Care bed-based program~~
B	Separation and transfer to Transition Care bed based program
A	Separation and transfer to mental health residential facility
N	Separation and transfer to aged care residential facility
H	Separation to private residence/accommodation

Reporting guide

G Organ Procurement – Posthumous
Assign this code for posthumous organ procurement episodes (Care Type 10) only.

S Statistical Separation (change in Care Type within this hospital)
Assign this code when a new episode of care (change in Care Type) occurs within the same hospital stay.

It is not permissible to:

- Change to Alcohol and Drug Program Care Type following another episode of care (for public hospitals).
- Change between Rehabilitation Program/Units: Levels 1, 2 or 3 Care Types (2, 6 ~~or 7~~).
- 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:
~~Restorative Care bed based program (use code R)~~
Transition Care bed based program (use code B).
Aged care residential facilities (use code N).
Mental health residential units (use code A).

~~R Separation and transfer to Restorative Care bed based program~~
~~Separation and transfer directly to a Restorative Care bed based program. Does not require a Transfer Destination code.~~

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 and community care unit) 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).

N Separation and transfer to aged care residential facility

Separation and transfer to an aged care residential facility (includes nursing home and hostel). Does not require a Transfer Destination code.

Includes:

Patient returning to the aged care residential facility in which they live.

Excludes:

~~Restorative Care bed based program (use code R).~~

Transition Care bed based program (use code B).

Mental health aged care residential facility (use code A).

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 houses.
- Training centres for intellectually disabled persons.
- Prison.
- Forensic hospital (Thomas Embling)
- Juvenile detention centre.
- Armed forces base camp.
- Homeless (shelters, half way 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:

- ~~Restorative Care bed based program (use code R).~~
- Transition Care bed based program (use code B).
- Aged care residential facility (use code N).
- Mental health residential facility (use code A).

Edits ***Changes to edits are detailed later in this document.***

Related items

Section 2: Admission, Admitted Patient, Episode of Admitted Patient Care, Geriatric Evaluation and Management Program, Hospital Stay, Interim Care, Nursing Home Type/Non-Acute care, Palliative Care, Rehabilitation Care and Transfer.

Section 3: Data Definitions, Transfer Source

Section 4: Business Rules (non-tabular) Episode of Care and Transfer Reporting

Section 4: Business Rules (tabular) *Account Class: Geriatric Respite*, *Care Type, Carer Availability and Separation Mode*, *Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode*, *Criterion for Admission: Secondary Family Member* and *Intention to Readmit and Separation Mode*.

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** DH

Mapping between Separation Mode and the Grouper Mode of Separation:

Separation Mode (PRS/2)		Mode of Separation (NHDD and Grouper)	
G	Organ Procurement - Posthumous		No map
D	Death	8	Died
Z	Left against medical advice	6	Left against medical advice
T	Separation and transfer to other acute hospital/ extended care/rehabilitation/geriatric centre	1	Discharge/transfer to an(other) acute hospital
~~R~~	~~Separation and transfer to Restorative Care bed based program~~	~~4~~	~~Discharge/transfer to other health care accommodation~~
B	Separation and transfer to Transition Care bed based program	4	Discharge/transfer to other health care accommodation
N	Separation and transfer to aged care residential facility	2	Discharge/transfer to a Residential Aged Care Service
A	Separation and transfer to mental health residential facility	4	Discharge/transfer to other health care accommodation
H	Separation to private residence/accommodation	9	Other (includes to usual residence)
S	Statistical separation (change in Care Type within this hospital)	5	Statistical discharge-type change

Proposal	*Description*
8.1	Addition of a new Separation Referral code.

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.

Data type Alpha **Form** Code

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 in this field.

Reported for Episodes where the Separation Mode is H *Separation to private residence/accommodation.* For all other Separation Modes, report spaces in this field.

Reported when A Separation Date is reported in the Episode Record.

Code set Select up to four options from list. Do not repeat codes. If more than four referrals have been made, select the first four listed:

Code	Descriptor
F	Domiciliary postnatal care, arranged before discharge
E	Domiciliary postnatal care, referral declined
P	Post Acute Care Program services, arranged before discharge
M	Referral to a community rehabilitation centre 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

In arranging the referral of a patient to these services, the hospital would expect to receive confirmation from the referred provider of their preparedness to accept responsibility for delivering the required services to the patient upon discharge.

Unless a specific service has been arranged, use code X *No referral or support services arranged before discharge*.

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 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 postnatal 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.

P Post Acute Care Program services, arranged before discharge

Discharge, with provision of Post Acute Care Program services arranged before discharge to own home or home of relative or friend or other private accommodation*.
For more information about Post Acute Program Services refer to *Victorian health policy and funding guidelines 2011-2012* available at:
http://www.health.vic.gov.au/pfg/

M Referral to a community rehabilitation centre arranged before discharge

Discharge, with referral to community rehabilitation centre (formerly known as day hospital) arranged before discharge to own home or home of relative or friend or other private accommodation*.
Excludes:
Discharge, with referral to alcohol and drug treatment service (use code L).

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*.

Notes:

*Private accommodation comprises:
Supported residential facilities, special accommodation houses, half-way 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.

Edits ***Changes to edits are detailed later in this document***

Related items Section 3: Separation Mode.
Section 4:
Business Rules (tabular) Account Class: Geriatric Respite and Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type P: Designated Paediatric Rehabilitation Program, and Care Type: Interim Care Program (F and E).

Administration

Purpose To monitor discharge planning processes to inform policy and planning.

Principal data users Continuing Care and Clinical Service Development (Hospital & Health Service

	Performance, DH).		
Collection start	1999-00 (Formerly a sub-set of Separation Mode)		
Definition source	DH	**Code set source**	DH

Proposal	*Description*
2.4	Re-locate Source of Referral to Palliative Care from the S5 Subacute record to the P5 Palliative record.

Source of Referral to Palliative Care

Specification

Definition The source of the person's referral to the DH Palliative Care Program.

Data type Numeric **Form** Code

Field size 2 **Layout** NN
Right justified, leading zero.

Location ~~Sub-Acute~~ Palliative
Record

Reported by Public hospitals.

Reported for Episodes with Care Type 8. ~~For Care Types P, 2, 6, 7, K, 9, F or E, report spaces.~~

Reported when A Separation Date is reported in the Episode Record.

Code set Select the first appropriate category:

Code	Descriptor
01	Community Sector - GP
02	Community Sector - Specialist
03	Community Sector - Self, Carer, Other (eg family member, neighbour)
04	Community Sector - Community Based Agency
05	Hospital - Public - Admitted patient
06	Hospital - Private - Admitted patient
07	Hospital - Outpatient - Non-admitted patient
08	Residential Care - Nursing Home/Hostel
09	Other

Reporting guide -

Edits ***Changes to edits are detailed later in this document***

Related items Section 2: Palliative Care.
Section 4: Business Rules (tabular) Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), and Care Type P: Designated Paediatric Rehabilitation Program, and Care Type: Interim Care Program (F and E).

Administration

Purpose To inform policy and planning decisions.

Principal data users Cancer and Palliative Care Unit (Hospital & Health Service Performance, DH).

Collection start 1998-99

Definition source DH **Code set** DH

source

Section 4 Business Rules amendments

Proposal	Description
5.11	Removal of Section 4 Business Rules (Non-tabular): *Interim Care Program and Contracting Arrangements*

~~Interim Care Program and Contracting Arrangements~~

Proposal	Description
2.5	Amend Section 4 *Palliative Care Reporting* to include details about reporting Phase of Care changes. The first ten phase changes and the last phase before separation are collected.

Palliative Care Reporting

Guide for use

The Palliative Care Type is only reported to the VAED for patients admitted to, or transferred to, a designated Palliative Care program.

The Cancer and Palliative Care Unit, DH, determines which campuses can report Care Type 8. This activity counts towards palliative care targets.

When a patient is deemed to require palliative care during a non-Palliative Care Type episode, a Diagnosis Code of Z51.5 Palliative Care must be included in the Diagnosis Code string to denote the component of palliation.

Phase of Care is reported at admission and each time the Phase changes (up to 10 times).

The first nine changes of phase are reported. All phase changes after the ninth change are combined and reported in the tenth phase change. In the tenth phase change, the Phase of Care that the patient is in at separation is reported, and the RUG ADL on Phase Change is the score applicable to the last Phase of Care before separation.

Refer to:

- Section 2: Episode of Admitted Patient Care.
- Section 3: *Care Type, Phase of Care, RUG ADL, Phase Change Date*
- Section 5: Sub-Acute Record.
- Section 9: Supplementary Code Lists: *Care Type 8*: http://www.health.vic.gov.au/hdss/reffiles/index.htm

Proposal	Description
5.6	Amendment of Section 4 Business Rules (tabular): *Account Class, Acc Type, Care Type and Medicare Suffix*.
6.10	Amendment of Section 4 Business Rules (tabular): *Account Class, Acc Type, Care Type and Medicare Suffix* for Restorative Care. NOTE: Details for Restorative Care and Private, Compensable and other Account Classes are yet to be finalised.

Account Class, Acc Type, Care Type and Medicare Suffix

Listed below are the valid reporting combinations for each Account Class.

Note, Accommodation Type 4 *Hospital in the Home*, can only be used for public, private, DVA, TAC and WorkCover patients, unless the Department has notified hospitals that specific funders accept other types of patients for this program.

Valid reporting combinations of Account Class, Accommodation Type, Care Type and Medicare Suffix

Account Class	Accom Type	Care Type	Medicare Suffix
Newborn (Transferred and Unqualified)			
NT*	B	U	name, C-U
Public			
MP	1 2	R1, R2	name, C-U
MP	1 2 3	~~E,~~ P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U
MP	1 2 3 4 6B M S	4, U	name, C-U
MP	C 7	4	name, C-U
MP	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U
~~MP~~	~~7~~	~~4~~	~~name, C-U~~
MP	5	R2	name, C-U
ME	1 2	R1, R2	name, C-U
ME	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	N-E
ME	1 2 3 4 6 B M S	4, U	N-E
ME	7 C	4	N-E
ME	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	N-E
ME	5	R2	name, C-U
MR	1 2 4	4	name, C-U
MR	1 2	9	name, C-U
MN	1 2 6 M S	1, 5T	name, C-U, N-E
~~MN~~	~~1 2~~	~~F~~	~~name, C-U~~
M5	1 2 6 M S	1, 5T	name, C-U, N-E
~~M5~~	~~1 2~~	~~F~~	~~name, C-U~~
MA	1 2	R1, R2	name, C-U
MA	1 2 3	~~E,~~ P, 2, 6, ~~7, K~~, 8, 9, 5E, 5K, 5G, 5S, 5A	name, C-U
MA	1 2 3 4 6 B M S	4, U	name, C-U

Account Class	Accom Type	Care Type	Medicare Suffix
MA	C 7	4	name, C-U
MA	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 5K, 5G, 5S, 5A	name, C-U
~~MA~~	~~7~~	~~4~~	~~name, C-U~~
MA	5	R2	name, C-U
MF	1 2	R1, R2	name, C-U
MF	1 2 3	~~E,~~ P, 2, 6, ~~7, K,~~ 8, 9, 5E, 5K, 5G, 5S, 5A	N-E
MF	1 2 3 4 6 B M S	4, U	N-E
MF	C 7	4	N-E
MF	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 5K, 5G, 5S, 5A	N-E
~~MF~~	~~7~~	~~4~~	~~N-E~~
MF	5	R2	name, C-U
Private			
PA	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PA	1 2 4 6 B M S	4, U	name, C-U, N-E
PA	C 7	4	name, C-U, N-E
PA	6 M S	5K, 5G, 5S, 5A	name, C-U, N-E
~~PA~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PB	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PB	1 2 4 6 B M S	4, U	name, C-U, N-E
PB	C 7	4	name, C-U, N-E
PB	6 M S	5K, 5G, 5S, 5A	name, C-U, N-E
~~PB~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PC	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PC	1 2 4 6 B M S	4, U	name, C-U, N-E
PC	C 7	4	name, C-U, N-E
PC	6 M S	5K, 5G, 5S, 5A	name, C-U, N-E
~~PC~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PD	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PD	1 2 4 6 B M S	4, U	name, C-U, N-E
PD	C 7	4	name, C-U, N-E
PD	6 M S	5K, 5G, 5S, 5A	name, C-U, N-E
~~PD~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PE	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PE	1 2 3 4 6 B M S	4, U	name, C-U, N-E
PE	C 7	4	name, C-U, N-E
PE	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~PE~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PF	1 2	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PF	1 2 4 6 B M S	4, U	name, C-U, N-E
PF	C 7	4	name, C-U, N-E
PF	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~PF~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PG	1 2 3	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PG	1 2 3 6 B M S	4, U	name, C-U, N-E

Account Class	Accom Type	Care Type	Medicare Suffix
PG	6 M S	5K, 5G, 5S, 5A	name, C-U, N-E
PG	4	4, U	name, C-U, N-E
~~PG~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PG	C 7	4	name, C-U, N-E
PH	1 2	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PH	1 2 6 B M S	4, U	name, C-U, N-E
PH	6 M S	5K, 5G, 5S, 5A	name, C-U, N-E
~~PH~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PH	4	4, U	name, C-U, N-E
PH	C 7	4	name, C-U, N-E
PI	1 2 3 6 M S	P, 2, 6~~, 7, K~~	name, C-U, N-E
PJ	1 2 6 M S	P, 2, 6~~, 7, K~~	name, C-U, N-E
PK	1 2 6 M S	P, 2, 6~~, 7, K~~	name, C-U, N-E
PL	1 2 3 4 6 M S	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PM	1 2 4 6 M S	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PN	1 2 4 6 M S	5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PO	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PO	1 2 3 4 6 B M S C 7	4	name, C-U, N-E
PO	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~PO~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PP	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PP	1 2 3 4 6 B M S C 7	4	name, C-U, N-E
PP	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~PP~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PQ	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PQ	1 2 3 4 6 B M S C 7	4	name, C-U, N-E
PQ	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~PQ~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PR	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
PR	1 2 3 4 6 B M S C 7	4	name, C-U, N-E
PR	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~PR~~	~~7~~	~~4~~	~~name, C-U, N-E~~
PS	1 2 4 6 M S	1, 5T	name, C-U, N-E
PT	1 2 4 6 M S	1, 5T	name, C-U, N-E
PU	1 2 4 6 M S	1, 5T	name, C-U, N-E
PV	1 2 4 6 M S	1, 5T	name, C-U, N-E
DVA			
VX	1 2 3	~~E,~~ P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U
VX	1 2 3 6 B M S	4, U	name, C-U
VX	4 7 C	4	name, C-U
VX	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U
~~VX~~	~~7~~	~~4~~	~~name, C-U~~

Account Class	Accom Type	Care Type	Medicare Suffix
VN	1 2 6 M S	1, 5T	name, C-U
~~VN~~	~~1 2~~	~~F~~	~~name, C-U~~
V5	1 2 6 M S	1, 5T	name, C-U
~~V5~~	~~1 2~~	~~F~~	~~name, C-U~~
Prisoners			
JP	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, P-N
JP	1 2 3 6 B M S	4, U	name, P-N
JP	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, P-N
JP	C	4	name, P-N
JN	1 2 6 M S	1, 5T	name, P-N
Compensable			
WorkCover			
WC	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
WC	1 2 3 6 B M S	4, U	name, C-U, N-E, P-N
WC	4	4	name, C-U, N-E, P-N
WC	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
WC	7	4	name, C-U, N-E
WC	C	4	name, C-U
WN	1 2 6 M S	1, 5T	name, C-U, N-E, P-N
TAC			
TA	1 2 3	~~E,~~ P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
TA	1 2 3 6 B M S	4, U	name, C-U, N-E, P-N
TA	4	4	name, C-U, N-E, P-N
TA	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E, P-N
TA	7	4	name, C-U, N-E
TA	C	4	name, C-U
~~TN~~	~~1 2~~	~~F~~	~~name, C-U~~
TN	1 2 6 M S	1, 5T	name, C-U, N-E, P-N
Services			
AS	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U
AS	1 2 3 6 B M S	4, U	name, C-U
AS	4 7 C	4	name, C-U
AS	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U,
~~AS~~	~~7~~	~~4~~	~~name, C-U~~
AN	1 2 6 M S	1, 5T	name, C-U
Seamen			
SS	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
SS	1 2 3 6 B M S	4, U	name, C-U, N-E
SS	4 7 C	4	name, C-U, N-E
SS	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~SS~~	~~7~~	~~4~~	~~name, C-U, N-E~~
SN	1 2 6 M S	1, 5T	name, C-U, N-E

Account Class	Accom Type	Care Type	Medicare Suffix
Common Law			
CL	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
CL	1 2 3 6 B M S	4, U	name, C-U, N-E
CL	4 7 C	4	name, C-U, N-E
CL	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~CL~~	~~7~~	~~4~~	~~name, C-U, N-E~~
CN	1 2 6 M S	1, 5T	name, C-U, N-E
Other			
OO	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	name, C-U, N-E
OO	1 2 3 6 B M S	4, U	name, C-U, N-E
OO	4 7 C	4	name, C-U, N-E
OO	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	name, C-U, N-E
~~OO~~	~~7~~	~~4~~	~~name, C-U, N-E~~
ON	1 2 6 M S	1, 5T	name, C-U, N-E
Ineligible			
XX	1 2 3	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5E, 5K, 5G, 5S, 5A	N-E
XX	1 2 3 6 B M S	4, U	N-E
XX	4 7 C	4	N-E
XX	6 M S	P, 2, 6, ~~7, K,~~ 8, 9, 0, 5K, 5G, 5S, 5A	N-E
~~XX~~	~~7~~	~~4~~	~~N-E~~
XN	1 2 6 M S	1, 5T	N-E

* Newborns with an Account Class of NT may change to another Account Class in the second or subsequent status segment. The record will then be subject to the validation rules for the subsequent Account Class, but the Care Type can only be U or 4.

Edits		
	094	Combination A/C, Accom Care Med Suff
	329	Geri Respite- Invalid Comb
	454	Incompat Fields for Interim Care

Proposal	Description
5.7	Amendment of Section 4 Business Rules (tabular): *Admission Source and Care Type* for removal of Care Types F, E, 7 and K
6.5	Amendment of Section 4 Business Rules (tabular): *Admission Source and Care Type* for Restorative Care.
7.8	Amendment of Section 4 Business Rules (tabular): *Admission Source and Care Type* to incorporate Organ Procurement Care Type.

Admission Source and Care Type

Valid combinations of Admission Source and Care Type.

Only fields that cannot contain the full code set are listed.

If Admission Source is	then Care Type must be
G Organ Procurement - Posthumous	10
S Statistical Admission (change in Care Type within this hospital)	~~F, E,~~ R1, R2, 1, P, 2, 6, ~~7, K,~~ 8, 5x, 9, 4
Y Birth Episode	4, U
B Transfer from Transition Care bed based program	~~F, E,~~ R1, R2, 1, P, 2, 6, ~~7, K,~~ 8, 5x, 9, 0, 4
N Transfer from Aged Care Residential Facility	~~F, E,~~ R1, R2, 1, P, 2, 6, ~~7, K,~~ 8, 5x, 9, 0, 4
A Transfer from Mental Health Residential Facility	~~F, E,~~ R1, R2, 1, P, 2, 6, ~~7, K,~~ 8, 5x, 9, 0, 4
If Care Type is	**then Admission Source must be**
~~F Interim Care Program – Nursing Home Type~~	~~S, T, B, N, A, H~~
~~E Interim Care Program~~	~~S, T, B, N, A, H~~
10 Organ Procurement - Posthumous	G
R1 Restorative Care: On-site	S, T, B, N, A, H
R2 Restorative Care: Off-site	S, T, B, N, A, H
1 NHT/Non-Acute	S, T, B, N, A, H
P Designated Paediatric Rehabilitation	S, T, B, N, A, H
2 Designated Rehab – Level 1	S, T, B, N, A, H
6 Designated Rehab – Level 2	S, T, B, N, A, H
~~7 Designated Rehab – Level 3~~	~~S, T, B, N, A, H~~
~~K Non-Designated Rehab Program/Unit~~	~~S, T, B, N, A, H~~
8 Palliative Care Program	S, T, B, N, A, H
5x Approved Mental Health/Psychogeriatric	S, T, B, N, A, H
9 Geriatric Evaluation and Management Program	S, T, B, N, A, H
0 Alcohol and Drug Program	T, B, N, A, H
U Unqualified Newborn	Y, T, H

Edits 488 Incompat Care Type/Adm Source Statistical

Proposal	*Description*
5.8	Amendment of Section 4 Business Rules (tabular): *Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K).*

Care Type: Designated ~~and Non-Designated~~ Rehabilitation Programs (2, and 6~~, 7 and K~~)

If Care Type is 2 Designated Rehabilitation Program/Unit: Level 1, 6 Designated Rehabilitation Program/Unit: Level 2~~, 7 Designated Rehabilitation Program/Unit: Level 3 or K Non-Designated Rehabilitation Program/Unit~~ then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Note that the only difference between the four Care Types is ~~Clinical Sub-program.~~ Impairment

Field	Valid codes
E4 5 Episode Record	
Admission Source	S, T, B, N, A, H
Admission Type	S, C, L, O, X
Qualification Status	X
Separation Referral	P, M, L, B, U, C, S, D, G, A, K, T, R, X or spaces
Criterion for Admission	B, C, E, O
Mental Health Legal Status	9
Funding Arrangement	1 or space
Care Plan Documented Date	DDMMCCYY or spaces
X4 Diagnosis Record	
Admission weight	Spaces
Duration of MV	Spaces
Duration of NIV	Spaces
S4 Sub-Acute Record	
~~Barthel Index Score on Admission~~	~~Range 000 to 100~~
~~Barthel Index Score on Separation~~	~~Range 000 to 100~~
FIM^{TM} Score on Admission	Range 111111111111111111 to 777777777777777777, or spaces
FIM^{TM} Score on Separation	Range 111111111111111111 to 777777777777777777, or spaces
Functional Assessment Date on Admission	DDMMCCYY
Functional Assessment Date on Separation	DDMMCCYY or spaces
~~Clinical Sub-program~~	

Field	Valid codes
~~If Care Type 2~~	~~020, 04x, 05x (if Impairment is reported, may be spaces)~~
~~If Care Type 6, 7, K~~	~~Any code from list see section 3 (if Impairment is reported, may be spaces)~~
Impairment	
If Care Type 2	02x, 04x, 05x ~~(if Clinical Sub-Program is reported, may be spaces)~~
If Care Type 6~~, 7, K~~	Any code from list see section 3 ~~(if Clinical Sub-Program is reported, may be spaces)~~
Onset Date	DDMMCCYY
Admission/Re-admission to Rehabilitation	0, 1
~~RUG ADL on Admission~~	~~Spaces~~
~~RUG ADL on Separation~~	~~Spaces~~
~~Source of Referral to Palliative Care~~	~~Spaces~~

Edits

253*	Rehab: Invalid Clin Sub-Prog
254	Rehab: Invalid Adm/Re-Adm to Rehab
255	Rehab Invalid Onset Date
258*	Sub-Acute: No Sub-Acute Record
260	Invalid Care for Qual
291	Adm Barthel > Sep Barthel
305	Adm Rug ADL Present
306	Sep Rug ADL Present
341	Source Of Refer To Pal Care Present
620	Adm Barthel/Functional Assessment Date / Care Type mismatch
621	Sep Barthel/Functional Assessment Date / Care Type mismatch
627	Care Type changed, Sub-Acute data deleted
662	Adm FIM™/Functional Assessment Date / Care Type mismatch
663	Sep FIM™ /Functional Assessment Date / Care Type mismatch

Proposal	***Description***
5.9	Removal of Section 4 Business Rules (tabular): *Care Type: Interim Care Program (F and E)*

~~Care Type: Interim Care Program (F and E)~~

Proposal	Description
2.8	Amendment of Section 4 Business Rules (Tabular): *Care Type: Designated Paediatric Rehabilitation Program (P)*

Care Type: Designated Paediatric Rehabilitation Program (P)

If Care Type is P *Designated Paediatric Rehabilitation Program/Unit* then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Note that the only difference between the four Care Types is Clinical Sub-program.

Field	Valid codes
E4 5 Episode Record	
Admission Source	S, T, B, N, A, H
Admission Type	S, C, L, O, X
Qualification Status	X
Separation Referral	P, M, L, B, U, C, S, D, G, A, K, T, R, X or spaces
Criterion for Admission	B, C, E, O
Mental Health Legal Status	9
Funding Arrangement	1 or space
Care Plan Documented Date	DDMMCCYY or spaces
X4 Diagnosis Record	
Admission weight	Spaces
Duration of MV	Spaces
Duration of NIV	Spaces
S4 Sub-Acute Record	
~~Barthel Index Score on Admission~~	~~Spaces~~
~~Barthel Index Score on Separation~~	~~Spaces~~
FIM™ Score on Admission	Range 111111111111111111 to 777777777777777777, or spaces
FIM™ Score on Separation	Range 111111111111111111 to 777777777777777777, or spaces
Functional Assessment Date on Admission	Spaces
Functional Assessment Date on Separation	Spaces
~~Clinical Sub-program~~	~~Any code from list see section 3 (if Impairment is reported, may be spaces)~~
Impairment	Any code from list see section 3 ~~(if Impairment is reported, may be spaces)~~
Onset Date	DDMMCCYY
Admission/Re-admission to Rehabilitation	0, 1
~~RUG ADL on Admission~~	~~Spaces~~
~~RUG ADL on Separation~~	~~Spaces~~
~~Source of Referral to Palliative Care~~	~~Spaces~~

Proposal	*Description*
6.9	Addition of Section 4 Business Rules (tabular): *Care Type: Geriatric Evaluation and Management (9) and Restorative Care (R1 and R2).*

Care Type: Geriatric Evaluation and Management (9) and Restorative Care (R1 & R2)

If Care Type is 9 *Geriatric Evaluation and Management Program* or R1/R2 *Restorative Care* then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Field	Valid codes
E5 Episode Record	
Admission Source	S, T, B, N, A, H
Admission Type	S, C, L, O, X
Qualification Status	X
Separation Referral	P, M, L, B, U, C, S, D, G, A, K, T, R, X or spaces
Criterion for Admission	B, C, E, O
Mental Health Legal Status	9
Funding Arrangement	1 or space
Care Plan Documented Date	DDMMCCYY or spaces
X5 Diagnosis Record	
Admission weight	Spaces
Duration of MV	Spaces
Duration of NIV	Spaces
S5 Sub-Acute Record	
FIM™ Score on Admission	Range 111111111111111111 to 777777777777777777
FIM™ Score on Separation	Range 111111111111111111 to 777777777777777777
Functional Assessment Date on Admission	Valid date
Functional Assessment Date on Separation	Valid date
Impairment	Spaces
Onset Date	Spaces
Admission/Re-admission to Rehabilitation	Space

Edits		
	258	Sub-Acute: No Sub-Acute Record
	260	Invalid Care for Qual
	293	Impairment Present
	294	Onset Date Present
	295	Admission/Readmission to Rehab Present
	620	Admission FIM™/Functional Assessment Date/Care Type mismatch
	621	Separation FIM™/Functional Assessment Date/Care Type mismatch
	627	Care Type changed, Sub-Acute data deleted

Proposal	***Description***
7.7	Addition of Section 4 Business Rules (tabular): *Care Type: Organ Procurement - Posthumous*.

Care Type: Organ Procurement - Posthumous (10)

If Care Type is 10 *Organ Procurement – Posthumous* then the following fields must contain the codes shown below. Only fields that cannot contain the full code set are listed.

Field	Valid codes
E5 Episode Record	
Admission Source	G
Admission Type	G
Qualification Status	X
Separation Mode	G
Separation Referral	Spaces
Criterion for Admission	G
Mental Health Legal Status	9
Funding Arrangement	Space
Intention to Re-admit	0
X5 Diagnosis Record	
Admission weight	Spaces
Duration of MV	Spaces
Duration of NIV	Spaces

Proposal	Description
5.10	Amendment of Section 4 Business Rules (Tabular): *Care Type and Separation Mode* for removal of Interim Care
6.6	Amendment of Section 4 Business Rules (Tabular): *Care Type and Separation Mode* for Restorative Care
7.9	Amendment of Section 4 Business Rules (tabular): *Care Type and Separation Mode* for Care Type 10

Care Type and Separation Mode

Valid combinations. Only fields that cannot contain the full code set are listed.

If Care Type is		then Separation Mode must be
5K	Approved Mental Health Service or Psychogeriatric Program – Child and Adolescent Mental Health Service (CAMHS)	S, D, Z, T, A, H
0	Alcohol and Drug Program	D, Z, T, R, B, N, A, H, S
U	Unqualified Newborn	D, Z, T, H
10	Organ Procurement - Posthumous	G
If Separation Mode is		**then Care Type must be**
S	Statistical Separation (change in Care Type within this hospital)	~~F, E,~~ 1, P, 2, 6, ~~7, K,~~ 8, 5x, 9, R1, R2, 4, 0
~~R~~	~~Separation/Transfer Restorative Care bed based program~~	~~F, E, 1, P, 2, 6, 7, K, 8, 5E, 5T, 5G, 5S, 5A, 9, 0, 4~~
B	Separation/Transfer Transition Care bed based program	~~F, E,~~ 1, P, 2, 6,~~7, K,~~ 8, 5E, 5T, 5G, 5S, 5A, 9, R1, R2, 0, 4
N	Separation/Transfer Aged Care Residential Facility	~~F, E,~~ 1, P, 2, 6,~~7, K,~~ 8, 5E, 5T, 5G, 5S, 5A, 9, R1, R2, 0, 4
A	Separation/Transfer Mental Health Residential Facility	~~F, E,~~ 1, P, 2, 6, ~~7, K,~~ 8, 5x, 9, R1, R2, 0, 4
G	Organ procurement - posthumous	10

Edits 489 Incompat Care Type/Sep Mode Statistical

Proposal	*Description*
6.7	Amendment of Section 4 Business Rules (tabular): *Age, Care Type, Carer Availability and Separation Mode* for Restorative Care

Age, Care Type, Carer Availability and Separation Mode

The edit table applies to Public Hospital episodes only. Private hospitals should report Carer Availability as a space only.

For Care Types 1, P, 2, 6,~~ 7, K,~~ 8, 9, R1 and R2 ~~F and E~~, if an episode has the combination of Separation Mode and Age, then Carer Availability must have one of the codes in the third column:

Separation Mode	Age	Carer Availability
S, D, Z, ~~R,~~ T, B, N, A	any age	1
H	<8 years	4, 5, 6
H	>7 years	1, 2, 3, 4, 5, 6, 7, 8

Edits 390 Incompat Care Type, Carer Avail, Age and Sep Mode

Proposal	*Description*
6.8	Amendment of Section 4 Business Rules (tabular): *Intention to Readmit and Separation Mode*, removal of Separation Mode R.
7.10	Amendment of Section 4 Business Rules (tabular): *Intention to Readmit and Separation Mode* for Separation Mode G.

Intention to Readmit and Separation Mode

Valid combinations. Only fields that cannot contain the full code set are listed.

If Intention to Readmit is		**then Separation Mode must be**
0	Not applicable	G, S, D, Z, T
1	Re-admission planned this hospital within 28 days, booking arranged	~~R,~~ B, N, A, H
2	Re-admission planned this hospital within 28 days, no booking arranged	~~R,~~ B, N, A, H
3	Re-admission planned other hospital within 28 days, booking arranged	~~R,~~ B, N, A, H
4	Re-admission planned other hospital within 28 days, no booking arranged	~~R,~~ B, N, A, H
9	No plan to re-admit within 28 days	~~R,~~ B, N, A, H
If Separation Mode is		**then Intention to Readmit must be**
G	Organ procurement - posthumous	0
S	Statistical Separation (change in Care Type within this hospital)	0
D	Death	0
Z	Left against medical advice	0
T	Separation and Transfer to other Acute Hospital/ Extended Care/Rehabilitation/Geriatric Centre	0
~~R~~	~~Separation and Transfer to Restorative Care bed based program~~	~~1, 2, 3, 4, 9~~
B	Separation and Transfer to Transition Care bed based program	1, 2, 3, 4, 9
N	Separation and Transfer to Aged Care Residential Facility	1, 2, 3, 4, 9
A	Separation and Transfer to Mental Health Residential Facility	1, 2, 3, 4, 9
H	Separation to Private Residence/Accommodation	1, 2, 3, 4, 9

Edit 192 Invalid Comb Int./Readmit/Sep Mode

Section 5 Compilation and Submission amendments

Episode Record

Proposal	*Description*
3.3	Amend the Episode record specification to include *Care Plan Documented Date.*
4.2	Amend the Episode record specification to include *Advance Care Plan Documented Date*.

Episode Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	E4 5
M	Unique Key	9	3	Hospital-generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
M	Campus Code	4	22	Refer to Section 9
M	Medicare Number	11	26	NNNNNNNNNNN or spaces
M	Medicare Suffix	3	37	AAA or A-A
M	Sex	1	40	1, 2, 3, 4
M	Marital Status	1	41	1, 2, 3, 4, 5, 6, 9
M	Date of Birth	8	42	DDMMCCYY
M	Postcode	4	50	NNNN Refer to Section 3
M	Locality	22	54	Refer to Section 3
M	Admission Date	8	76	DDMMCCYY
M	Admission Time	4	84	HHMM
M	Admission Type	1	88	G, S, Y, M, C, L, O, X
M	Admission Source	1	89	G, S, Y, T, B, N, A, H
1	Transfer Source	4	90	NNNN or spaces Refer to Section 3
	Leave With Permission Days MTD	2	94	NN or spaces
	Leave With Permission Days Financial YTD	3	96	NNN or spaces
	Leave With Permission Days Total	3	99	NNN or spaces
	Status Segment Occurs 7 times			
2	Account Class	2	102, 115, 128, 141, 154, 167, 180	AA or AN Refer to Field specification in Section 3
2	Accommodation Type	1	104, 117, 130, 143,	1, 2, 3, 4, 5, 6, 7, B, C, M, S

Note	Data Item	Field Size	Record Position	Layout/Code Set
			156, 169, 182	
2	Qualification Status	1	105, 118, 131, 144, 157, 170, 183	N, U, X
2	Patient Days MTD	2	106, 119, 132, 145, 158, 171, 184	Must be present if other Status details are present
2	Patient Days Financial YTD	3	108, 121, 134, 147, 160, 173, 186	Must be present if other Status details are present
2	Patient Days Total	4	111, 124, 137, 150, 163, 176, 189	Must be present if other Status details are present
3	Separation Date	8	193	DDMMCCYY
3	Separation Time	4	201	HHMM
3	Separation Mode	1	205	G, S, D, Z, T, B, N, A, H
1	Transfer Destination	4	206	NNNN or spaces Refer to Section 3
4	Separation Referral	4	210	F, E, P, M, L, B, U, C, S, D, G, A, K, T, R, X or spaces Left justified, trailing spaces
5	Carer Availability	1	214	1, 2, 3, 4, 5, 6, 7, 8 or space
3	Account Class on Separation	2	215	AA or AN Refer to Field specification in Section 3
3	Accommodation Type on Separation	1	217	1, 2, 3, 4, 6, 7, B, C, M, S
M	Care Type	2	218	10, ~~F, E,~~ 1, P, 2, 6, ~~7, K~~, 8, 5x, 9, R1, R2, 0, 4, U Refer to Section 3
M	Country of Birth	4	220	NNNN Refer to Section 3
M	Indigenous Status	1	224	1, 2, 3, 4, 8, 9
M 6	Criterion for Admission	1	225	G, B, C, N, U, E, O, S
M	Intended Duration of Stay	1	226	1, 2
M	Hospital Insurance Fund	3	227	Refer to Section 3
M	Hospital Insurance Status	1	230	2, 4, 9
3	Mental Health Legal Status	1	231	1, 2, 9
7	Funding Arrangement	1	232	1, 2, 4, 5, 6, 7, 8 or space
8	Contract Type	1	233	1, 2, 3, 4, 5, 6, 7 or space
8	Contract Role	1	234	A, B or space
9	Contract/Spoke Identifier	4	235	NNNN or spaces Refer to Section 3
10	Contract Leave Days - MTD	2	239	NN or spaces

Note	Data Item	Field Size	Record Position	Layout/Code Set
10	Contract Leave Days - Financial YTD	2	241	NN or spaces
10	Contract Leave Days - Total	2	243	NN or spaces
	User Flag	1	245	Optional field, free text
12	Preferred Language	4	246	NNNN Refer to Section 3
12	Interpreter Required	1	250	1, 2, 9 or space Refer to Section 3
13	ACAS Status	1	251	1, 2, 3, 4, 5 or space Refer to Section 3
15	Mental Health Statewide Patient Identifier	10	252	ODS generated 10 digit number (NNNNNNNNNN), right justified, zero filled or spaces Refer to Section 3
	Leave Without Permission Days MTD	2	262	NN or spaces
	Leave Without Permission Days Financial YTD	3	264	NNN or spaces
	Leave Without Permission Days Total	3	267	NNN or spaces
~~17~~	~~Palliative Care Patient Days~~	~~3~~	~~270~~	~~Spaces (item no longer reported)~~
3	Intention to Readmit	1	270	0, 1, 2, 3, 4, 9
M	Date of Birth Accuracy Flag	3	271	AAA Refer to Section 3
7, 14	Program Identifier	2	274	NN or spaces Refer to Section 3
16, 14	Mother's UR	10	276	NNNNNNNNNN or spaces
17	Advance Care Plan Documented Date	8	286	DDMMCCYY or spaces
18	Care Plan Documented Date	8	294	DDMMCCYY or spaces
Total		**~~288~~ 301**		

All alpha characters uppercase. All numeric fields are right justified and zero filled.

M Mandatory

1 Transfer Source: Mandatory if Admission Source = T, else spaces. Transfer Destination: Mandatory if Separation Mode = T, else spaces.

2 Mandatory in first Status Segment. In any subsequent Status Segment, if any field is present, then all fields for that segment must be present.

3 Mandatory but transmit only when Separation Date is transmitted.

4 Mandatory for public hospital if Separation Mode = H but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.

5 Carer Availability: Mandatory for public hospitals when Care Type is 1, P, 2, 6, ~~7, K,~~ 8, 9, R1, or R2 ~~F or E~~ but transmit only when Separation Date is transmitted, else spaces. Private hospitals report a space.

6 Criterion for Admission: Code S only for use by Early Parenting Centres.

7 Mandatory for all hospitals involved in contracted care, hub and spoke arrangements, or the specified funding arrangements, programs or initiatives,, else space.

8 Mandatory for all hospitals involved in contracted care arrangements, else space.

9 Mandatory for all hospitals involved in contracted care or Hub and Spoke (only Hub reports) arrangements, else spaces.

10 Mandatory for contracting hospitals, in specific instances. Refer to Section 3.

12 Mandatory for all public hospitals. Private hospitals report codes or spaces.

13 Mandatory for public hospitals when Care Type is 1, 2, 4, 6, ~~7, K,~~ 8, 9, R1, or R2 ~~F or E~~, and patient age is greater than or equal to 50, and where the episode is not a same day episode, but transmit only when Separation Date is transmitted, else spaces. Private hospitals report codes or spaces.

14 Where a field at the end of a record has a value of space, the record can be ended at the last field where a value is not space(s).

15 Mandatory for all public hospitals with an approved Mental Health Service when Care Type is 5x or Care Type 4 and an ECT has been performed. Private hospitals report spaces.

16 Mandatory for newborn episodes where the baby is born in the hospital.

17 Mandatory when documented as per Reporting Guide for data element

18 Mandatory for public hospitals when Care Type is 2, 6, P, 8, 9, R1 or R2, and the length of stay is greater than or equal to 7 days.

Sub-Acute Record

Proposal	*Description*
1.2	Amend the S4 record specification to remove Barthel Index scores.
2.12	Amend the S4 record specification to reflect Palliative Care changes

Sub-Acute Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	S4
M	Unique Key	9	3	Hospital generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
~~1, 2, 4~~	~~Barthel Index Score on Admission~~	~~3~~	~~22~~	~~NNN (range 000 to 100) or spaces~~ ~~Right justified, zero filled~~
~~1, 2, 4~~	~~Barthel Index Score on Separation~~	~~3~~	~~25~~	~~NNN (range 000 to 100) or spaces~~ ~~Right justified, zero filled~~
~~9~~	~~Clinical Sub-program~~	~~3~~	~~28~~	~~NNN or spaces~~ ~~Refer to code list in Section 3~~ ~~Right justified, zero filled~~
1~~, 6~~	Onset Date	8	~~31~~ 22	DDMMCCYY or spaces
1~~, 6~~	Admission/Re-admission to Rehabilitation	1	~~39~~ 30	0, 1 or space
~~5~~ O	User Flag	1	~~40~~ 31	Optional field, free text
~~3~~ ~~5~~	~~RUG ADL on Admission~~	~~2~~	~~41~~	~~NN (range 00 to 18) or spaces~~ ~~Right justified, zero filled~~
~~3~~ ~~5~~	~~RUG ADL on Separation~~	~~2~~	~~43~~	~~NN (range 00 to 18) or spaces~~ ~~Right justified, zero filled~~
~~3~~ ~~5~~	~~Source of Referral to Palliative Care~~	~~2~~	~~45~~	~~NN (range 01 to 09) or spaces~~
~~1,~~ 2~~, 4~~	Functional Assessment Date on Admission	8	~~47~~ 32	DDMMCCYY or spaces
~~1,~~ 2~~, 4~~	Functional Assessment Date on Separation	8	~~55~~ 40	DDMMCCYY or spaces
~~7~~ 1	Impairment	6	~~63~~ 48	From code list or spaces
~~8~~ 2	FIM™ Score on Admission	18	~~69~~ 54	NNNNNNNNNNNNNNNNNN or spaces Right justified, zero filled
~~8~~ 2	FIM™ Score on Separation	18	~~87~~ 72	NNNNNNNNNNNNNNNNNN or spaces Right justified, zero filled
		Total ~~104~~ 89		

All alpha characters uppercase. All numeric fields right justified and zero filled.

M Mandatory

1 Mandatory if Care Type = 2, 6, or P

2	Mandatory if Care Type = 2, 6, 9, R1 or R2
O	Optional

~~1~~	~~Mandatory if Care Type = 2, or 6, 7 or K *Rehabilitation Program Unit*~~
~~2~~	~~Mandatory if Care Type = 9 *Geriatric Evaluation and Management Program*~~
~~3~~	~~Mandatory if Care Type = 8 *Palliative Care Program*~~
~~4~~	~~Mandatory if Care Type = F or E *Interim Care Program*~~
~~5~~	~~Where a field at the end of a record has a value of space(s), the record can be ended at the last field where a value is not space(s).~~
~~6~~	~~Mandatory if Care Type = P *Designated Paediatric Rehabilitation Program/Unit*~~
~~7~~	~~Optional if Care Type = 2, 6, 7, K, P and Clinical Sub-program present.~~
	~~Mandatory if Care type = 2, 6, 7, K, P and Clinical Sub-program NOT present.~~
~~8~~	~~Mandatory if Care Type = 2, 6, 7, E, F, 9~~
	~~Optional if Care Type K~~
~~9~~	~~Optional if Care Type = 2, 6, 7, K, P and Impairment present.~~
	~~Mandatory if Care Type = 2, 6, K, P and Impairment NOT present.~~

Reported by Public hospitals.

[Private hospitals: Do not report S4s.]

Reported for Care Types ~~F, E,~~ P, 2, 6, ~~7, K, 8, and~~ 9, R1 and R2 only.

Reported when A Separation Date is reported in the Episode Record.

Refer to: 'Data Transmission Scheduling', page 5-**Error! Bookmark not defined.**.

Reporting guide

General

The data items collected in the Sub-Acute Record (marked with an * in the table below) are needed for the support and further development of casemix classifications for sub-acute episodes.

Sub-Acute Record field	Rehab Care Type 2, 6~~, 7 or K~~	~~Palliative Care Type 8~~	GEM Care Type 9 Restorative Care Types R1 and R2	~~Interim Care Type F, E~~	Paed Rehab Care Type P
Transaction Type	S4	~~S4~~	S4	~~S4~~	S4
Unique Key	*	~~*~~	*	~~*~~	*
Patient Identifier	*	~~*~~	*	~~*~~	*
~~Barthel Index Score on Admission~~	~~*~~	~~Spaces~~	~~*~~	~~*~~	~~Spaces~~
~~Barthel Index Score on Separation~~	~~*~~	~~Spaces~~	~~*~~	~~*~~	~~Spaces~~
Functional Assessment Date on Admission	*	~~Spaces~~	*	~~*~~	Spaces
Functional Assessment Date on Separation	*	~~Spaces~~	*	~~*~~	Spaces
~~Clinical Sub-Program~~	~~*~~	~~Spaces~~	~~Spaces~~	~~Spaces~~	~~*~~
Onset Date	*	~~Spaces~~	Spaces	~~Spaces~~	*
Admission / Re-admission	*	~~Spaces~~	Spaces	~~Spaces~~	*
~~RUG ADL on Admission~~	~~Spaces~~	~~*~~	~~Spaces~~	~~Spaces~~	~~Spaces~~
~~RUG ADL on Separation~~	~~Spaces~~	~~*~~	~~Spaces~~	~~Spaces~~	~~Spaces~~
~~Source of Referral to Palliative Care~~	~~Spaces~~	~~*~~	~~Spaces~~	~~Spaces~~	~~Spaces~~
Impairment	*	~~Spaces~~	Spaces	~~Spaces~~	*
FIM™ Score on Admission	*	~~Spaces~~	*	~~*~~	Spaces
FIM™ Score on Separation	*	~~Spaces~~	*	*	Spaces

Correction

To correct a Sub-Acute Record, re-transmit the entire Sub-Acute Record, including the corrections. This will overwrite the existing record held by PRS/2.

Re-transmitting the Sub-Acute Record causes the Episode Record to be re-edited.

Deletion

To delete a Sub-Acute Record, re-transmit a Sub-Acute Record with the same Unique Key, and enter all 9s in the ~~Clinical Sub-Program or~~ *Impairment*.

If an Episode Record is deleted, the Sub-Acute Record will automatically be deleted. Re-transmitting the Episode Record alone will not re-generate the Sub-Acute Record; the Sub-Acute Record must also be re-transmitted.

A record can be deleted and re-transmitted in the same transmission as long as the hospital sequences the deletion first.

If an episode that was previously reported with a Sub-Acute Care Type is amended to report a non-Sub-Acute Care Type, the Sub-Acute data will be deleted from the database and a Warning edit will be printed on the Control Report.

Data Items

Transaction Type

The value identifying the Sub-Acute Record is ‘S4’.

The content of this field will be printed in PRS/2 Control Reports, when and where the Sub-Acute Record is printed.

User Flag

This field has been added at the suggestion of a software supplier. Hospitals can use the field for data management purposes, perhaps to flag certain types of records, such as corrections.

Palliative Record

Proposal	*Description*
2.13	Addition of P5 Palliative Care record specification

Palliative Record File Structure

Note	Data Item	Field Size	Record Position	Layout/Code Set
M	Transaction Type	2	1	P5
M	Unique Key	9	3	Hospital generated Right justified, zero filled
M	Patient Identifier	10	12	Hospital generated Right justified, zero filled
2	PCOC Flag	1	22	Y/N
M	RUG ADL on Admission	2	23	NN (range 00 to 18) Right justified, zero filled
M	RUG ADL on Separation	2	25	NN (range 00 to 18) Right justified, zero filled
M	Source of Referral to Palliative Care	2	27	NN (range 01 to 09)
M	Phase of Care on Admission	1	29	N
	Phase Status Change *Occurs 10 times*			
1	Phase Change Date	8	30, 41, 52, 63, 74, 85, 96, 107, 118, 129	DDMMYYYY or spaces
1	Phase of Care on Status Change	1	38, 49, 60, 71, 82, 93, 104, 115, 126, 137	N or spaces
1	RUG ADL on Phase Change	2	40, 51, 62, 73, 84, 95, 106, 117, 128, 139	NN or spaces
O	User Flag	1	141	Optional field, free text
		Total 141		

All alpha characters uppercase. All numeric fields right justified and zero filled.

M Mandatory
1 In each segment if any field is present, then all fields for that segment must be present.
2 Mandatory.
{Further details about this flag and the possibility of obtaining data from PCOC will be available when developed.}
O Optional

Reported by Public hospitals.

[Private hospitals: Do not report P5s.]

Reported for Care Type~~s F, E, P, 2, 6, 7, K,~~ 8~~, and 9~~ only.

Reported when A Separation Date is reported in the Episode Record.

Refer to: 'Data Transmission Scheduling', page 5-x

Reporting guide

Correction
To correct a Palliative Record, re-transmit the entire Palliative Record, including the corrections. This will overwrite the existing record held by PRS/2.

Re-transmitting the Palliative Record causes the Episode Record to be re-edited.

Deletion
To delete a Palliative Record, re-transmit a Palliative Record with the same Unique Key, and enter all 9s in the RUG ADL on Admission.

If an Episode Record is deleted, the Palliative Record will automatically be deleted. Re-transmitting the Episode Record alone will not re-generate the Palliative Record; the Palliative Record must also be re-transmitted.

A record can be deleted and re-transmitted in the same transmission as long as the hospital sequences the deletion first.

If an episode that was previously reported with a Palliative Care Type is amended to report a non- Palliative Care Type, the Palliative data will be deleted from the database and a Warning edit will be printed on the Control Report.

Data Items

Transaction Type
The value identifying the Palliative Record is 'P5'.

The content of this field will be printed in PRS/2 Control Reports, when and where the Palliative Record is printed.

User Flag
Hospitals can use the field for data management purposes, perhaps to flag certain types of records, such as corrections.

Edits

Modified edits:

004 Unknown Record Type

Effect REJECTION

Problem The Transaction Type (first two characters of this record) is not valid.

Valid: H4, E4, X4, Y4, P5, S4, V4, T4, U4

Remedy If this is a valid record, correct the Transaction Type and re-transmit the record.

065 Original Deleted Upd Sep < Cutoff

Effect Warning

Problem This update transaction has been accepted but the effect (deletion of an E4 Episode Record) may not be what was intended: you are warned that something has been deleted.

The current E4 has updated an existing episode including adding a Separation Date or changing an existing Separation Date but the new Separation Date has put the episode into a financial year for which the VAED file has been closed. [On 10 September each year, the file for the previous financial year is closed.]

The effect of this current transaction has been to delete the original E4 and any associated Records (X4/Y4 Diagnosis Record, V4 DVA and TAC Record, P5 Palliative Record, and/or S4 Sub-Acute Record) from the current file, as the patient appears to have been separated before that period started. This update transaction is not retained on the current PRS/2 file. The effect is that the episode no longer appears in PRS/2.

Remedy Check Separation Date.

- If the Separation Date in this update transaction is correct then no further action is required: the VAED file for that period has been closed so no more data can be accepted.
- If the Separation Date in this update transaction is incorrect and the correct date would place the separation in the period currently being collected, amend the Separation Date and re-transmit the E4 and associated X4/Y4, V4, P5 and S4, if applicable.

123 Episode Deleted

Effect Warning

Problem This is a successful E4 Episode Record deletion; if an X4/Y4, V4, P5 or S4 was also recorded in PRS/2, these have also been deleted.

Remedy If there was no such episode then no replacement E4 needs to be re-transmitted to PRS/2 and no further action is necessary.

If another E4 is to be transmitted for this episode, the X4/Y4, V4, P5 and S4, if applicable, must also be re-transmitted.

169 No Corresponding Episode

Effect REJECTION

Problem This X4/Y4 Diagnosis Record, S4 Sub-Acute Record, P5 Palliative Record, or V4 DVA and TAC Record has a Unique Key for which there is no E4 Episode Record on file.

Remedy This problem would be because the E4 was:

- never submitted, or
- deleted, or
- rejected when first submitted because of an error and not corrected and re-transmitted, or
- submitted with a different Unique Key.

Check Unique Key:

If Unique Key is wrong, amend and re-transmit this X4/Y4/S4/V4/P5.

If Unique Key is the same as the original E4, check which of the first three explanations above is applicable; if necessary, amend the E4 and re-transmit together with this X4/Y4/S4/V4/P5.

250 Deleted – Episode is Sub-Acute

Effect Warning

Problem An E4 Episode Record has been successfully deleted; if an S4 Sub-Acute Record was also recorded in PRS/2, the S4 has also been deleted.

Remedy If there was no such episode no further action is necessary.

If another E4 is to be re-transmitted for this episode and the Care Type is ~~F, E,~~ P, 2, 6, ~~7, K, 8~~ R1, R2, or 9, the S4 must also be re-transmitted.

253 Rehab: Invalid ~~Clin Sub-Prog or~~ Impairment

Effect REJECTION

Problem The E4 Episode Record's Care Type is P, 2, or 6~~, 7 or K~~ *Rehabilitation* but the S4 Sub-Acute Record's Clinical Sub-Program or Impairment code is invalid.

Remedy Check Care Type (E4), Clinical Sub-Program (S4) and Impairment (S4), 293 amend as appropriate and re-transmit the E4 and/or S4.

Refer to:

Section 4: Business Rules (tabular) Care Type: Designated ~~and Non-Designated~~ Rehabilitation Programs (2 and 6~~, 7 and K~~), Care Type P: Designated Paediatric Rehabilitation Program/Unit.

254 Rehab: Invalid Adm/Re-Adm to Rehab

Effect REJECTION

Problem The E4 Episode Record's Care Type is P, 2, or 6~~, 7 or K~~ *Rehabilitation* but the S4 Sub-Acute Record's Admission/Re-admission to Rehabilitation is invalid.

Remedy Check Care Type (E4) and Admission/Re-admission to Rehabilitation (S4), amend as appropriate and re-transmit the X4 and/or S4.

Refer to:

Section 4: Business Rules (tabular) Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), Care Type P: Designated Paediatric Rehabilitation Program/Unit.

255 Rehab: Invalid Onset Date

Effect REJECTION

Problem The E4 Episode Record's Care Type is P, 2, or 6~~, 7 or K~~ but the S4 Sub-Acute Record's Onset Date is either:

- In an incorrect format, or
- Later than the Admission Date, or
- Earlier than the Date of Birth.

Remedy Check Admission Date, Care Type, Date of Birth (E4) and Onset Date (S4), amend as appropriate and re-transmit the E4 and/or S4.

Refer to:

Section 4: Business Rules (tabular) Care Type: Designated and Non-Designated Rehabilitation Programs (2, 6, 7 and K), Care Type P: Designated Paediatric Rehabilitation Program/Unit.

258 Sub-Acute: No Sub-Acute Record

Effect Warning

Problem The Public Hospital E4 Episode Record's Care Type is P, 2, or 6~~, 7 or K~~ *Rehabilitation*, ~~8 Palliative Care,~~ 9 *Geriatric Evaluation and Management Program* o~~r F or E Interim Care~~, R1 or R2 *Restorative Care*, and a Separation Date is present, however there has been no S4 Sub-Acute Record accepted for this patient.

Triggers for this edit are:

- If Care Type = P, 2, or 6~~, 7 or K, Clinical Sub-Program AND~~ Impairment is not present.
- If Care Type = 9, R1 or R2 ~~, E or F, Barthel Index~~ FIM™ Score on Admission is not present.

~~If Care Type = 8, RUG ADL on Admission is not present.~~

Remedy Check Care Type, Separation Date (E4) and all S4 data items (Admission/Readmission to Rehabilitation, ~~Barthel Index Score~~ FIM™ Score on Admission and Separation, ~~Clinical Sub-Program,~~ Impairment, Onset Date, ~~RUG ADL on Admission and Separation~~ and Source of Referral to Palliative Care), amend as appropriate, and re-transmit the E4 and/or S4.

If Care Type is correct, investigate why no S4 is recorded: if it has been submitted but rejected, amend and re-transmit; if the information is not yet available, ensure the S4 is submitted as soon as possible.

If the patient is not yet separated, delete the Separation Date.

285 Sub-Acute Record not Required

Effect REJECTION

Problem An S4 Sub-Acute Record has been transmitted, however in an E4 Episode Record with the same Unique Key, the Care Type is not reported as one of P, 2, or 6, 7 or K *Rehabilitation*, 8 Palliative Care, or 9 *Geriatric Evaluation and Management Program*. or F or E Interim Care.

Remedy Check Care Type (E4), amend as appropriate and re-transmit the E4 and/or S4.

288 Sep Barthel FIM™ & Sep Mode Incompatible

Effect REJECTION

Problem The E4 Episode Record's Care Type is 2, or 6, 7 or K *Rehabilitation*, 9 *Geriatric Evaluation and Management*, or R1 or R2 *Restorative Care*, or F or E Interim Care, and the Separation Mode is D *Death*, but the S4 Sub-Acute Record's Barthel Index FIM™ Score on Separation is reported as greater than 000 not 1(x18).

Remedy Check Separation Mode (E4) and Barthel Index FIM™ Score on Separation (S4), amend as appropriate and re-transmit the E4 and/or S4.

Barthel Index FIM™ Score on Separation for patients who die in hospital is 000 1(x18).

289 Adm Sc T'fer & Onset = Adm Date

Effect NOTIFIABLE

Problem The E4 Episode Record's Care Type is P, 2, or 6~~, 7 or K~~ and the Admission Source is T *Transfer from acute hospital/extended care/rehabilitation/geriatric centre*, but the S4 Sub-Acute Record's Onset Date is the same date as the Admission Date in the E4.

Remedy AEED acknowledges that for a small number of episodes this combination of data items is correct. Check Admission Date, Admission Source, Care Type (E4) and Onset Date (with source hospital if necessary) (S4). Where incorrect, amend as appropriate and re-transmit the E4 and/or S4. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. Where the data has not been corrected or confirmed AEED will periodically notify each hospital and ask them to do so.

A patient transferred to this hospital to commence an episode of rehabilitation is expected to have an onset date for that condition before the start of this rehabilitation episode.

Refer to:

Section 4: Business Rules (tabular) Care Type: Designated ~~and Non-Designated~~ Rehabilitation Program (2, or 6~~, 7 or K~~), Care Type P: Designated Paediatric Rehabilitation Program/Unit.

290 Stat Adm Sc & Onset = Adm Date

Effect NOTIFIABLE

Problem The E4 Episode Record's Care Type is P, 2, or 6~~, 7 or K~~ *Rehabilitation* and the Admission Source is S *Statistical admission (change in Care Type within this hospital)*, but the S4 Sub-Acute Record's Onset Date is the same date as the Admission Date in the E4.

Remedy AEED acknowledges that for a small number of episodes this combination of data items is correct. Check Admission Date, Admission Source, Care Type (E4) and Onset Date (S4). Where incorrect, amend as appropriate and re-transmit the E4 and/or S4. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. Where the data has not been corrected or confirmed AEED will periodically notify each hospital and ask them to do so.

Where there is a change of Care Type it is expected that the onset date would be before the start of this rehabilitation episode.

Refer to:

Section 4: Business Rules (tabular) Care Type Designated ~~and Non-Designated~~ Rehabilitation Program (2, or 6~~, 7 or K~~), Care Type P: Designated Paediatric Rehabilitation Program/Unit.

291 Adm ~~Barthel~~ FIM™ > Sep ~~Barthel~~ FIM™

Effect Warning

Problem The E4 Episode Record's Care Type is 2, or 6~~, 7 or K~~ Rehabilitation, 9 Geriatric Evaluation and Management Program, or R1 or R2 *Restorative Care*, ~~or F or E Interim Care,~~, and the Separation Mode is not D Death, or S Statistical Separation (change in Care Type within this hospital); however, the S4 Sub-Acute Record's ~~Barthel Index~~ FIM™ Score on Admission is higher than the ~~Barthel Index~~ FIM™ Score on Separation.

Remedy Check Care Type, Separation Mode (E4) and ~~Barthel Index~~ FIM™ Scores on Admission and Separation (S4), amend as appropriate, and re-transmit the E4 and/or S4.

This may be correct, but for most patients an increase in ~~Barthel Index~~ FIM™ Score would be expected over the course of an episode.

294 Onset Date Present

Effect REJECTION

Problem The E4 Episode Record's Care Type is ~~8 Palliative Care,~~ 9 *Geriatric Evaluation and Management Program,* or R1 or R2 *Restorative Care* ~~or F or E Interim Care Program~~ but the S4 Sub-Acute Record has an Onset Date.

Remedy Check Care Type (E4) and Onset Date (S4), amend as appropriate and re-transmit the E4.

295 Adm/Readmit To Rehab Present

Effect REJECTION

Problem The E4 Episode Record's Care Type is ~~8 Palliative Care,~~ 9 *Geriatric Evaluation and Management Program,* or R1 or R2 *Restorative Care* ~~or F or E Interim Care Program~~ but the S4 Sub-Acute Record has an Admission/Readmission to Rehabilitation.

Remedy Check Care Type (E4) and Admission/Readmission to Rehabilitation (S4), amend as appropriate and re-transmit the E4 and/or S4.

297 Sep RUG ADL & Sep Mode Incompatible

Effect REJECTION

Problem The E4 Episode Record's Care Type is 8 *Palliative Care* and Separation Mode is D *Death*, but the ~~S4 Sub-Acute~~ P5 Palliative Record's RUG ADL on Separation is greater than 00.

Remedy Check Care Type, Separation Mode (E4), and RUG ADL on Separation (~~S4~~ P5), amend as appropriate and re-transmit the E4 and/or ~~S4~~ P5.

303 Pall Care but Invalid Adm Rug ADL

Effect REJECTION

Problem The E4 Episode Record's Care Type is 8 *Palliative Care Program* but the ~~S4 Sub-Acute~~ P5 Palliative Record's RUG ADL on Admission is invalid.

Remedy Check Care Type (E4) and RUG ADL on Admission (~~S4~~ P5), amend as appropriate and re-transmit the E4 and/or ~~S4~~ P5.

304 Pall Care but Invalid Sep Rug ADL

Effect REJECTION

Problem The E4 Episode Record’s Care Type is 8 *Palliative Care Program* but the ~~S4 Sub-Acute~~ P5 Palliative Record’s RUG ADL on Separation is invalid.

Remedy Check Care Type (E4) and RUG ADL on Separation (~~S4~~ P5), amend as appropriate and re-transmit the E4 and/or ~~S4~~ P5.

340 Invalid Source of Refer to Pal Care

Effect REJECTION

Problem The E4 Episode Record’s Care Type is 8 *Palliative Care* but the Source of Referral to Palliative Care in the ~~S4 Sub-Acute~~ P5 Palliative Record is invalid.

Remedy Check Care Type (E4) and Source of Referral to Palliative Care (~~S4~~ P5), amend as appropriate and re-transmit the E4 and/or ~~S4~~ P5.

397 Sep Referral Postnatal, Incompat Age/Sex

Effect REJECTION

Problem The E4 Episode Record’s Separation Referral is F *Domiciliary postnatal care* or E *Domiciliary postnatal care, referral declined, arranged before discharge* but the patient's age and/or sex are incompatible.

Remedy Check Admission Date, Date of Birth, Separation Referral and Sex, amend as appropriate and re-transmit the E4.

Only the mother is referred for postnatal care, therefore the patient must be female and of childbearing age (between 11 and 54 years).

405 Inapplic ~~Clin Prog or~~ Impairment for Care Type 2

Effect REJECTION

Problem The E4 Episode Record's Care Type is 2 *Rehabilitation–Level 1* but the S4 Sub-Acute Record's ~~Clinical Sub-Program or~~ Impairment code does not justify Level 1 Rehabilitation (and then only for the rehabilitation episode following acute treatment). The categories justifying Level 1 are represented by ~~Clinical Sub-Programs /~~ Impairment:

- 02x Head injury
- 04x Spinal cord or
- 05x Amputation of limb

Remedy Check Care Type (E4), ~~Clinical Sub-Program (S4),~~ and Impairment (S4), amend as appropriate and re-transmit the E4 and/or S4.

If this is *not* the rehabilitation episode following acute treatment for head injury, spinal cord injury or amputation of limb, amend the Care Type to 6~~, 7 or K.~~

If this *is* a rehabilitation episode following acute treatment for the relevant conditions, amend the ~~Clinical Sub-Program or~~ Impairment code.

Refer to:
Section 4: Business Rules (tabular) Care Type: Designated ~~and Non-Designated~~ Rehabilitation Program (2, or 6~~, 7 or K~~).

406 Rehab Care Type W/Out Rehab PDx

Effect NOTIFIABLE

Problem The E4 Episode Record's Care Type is P, 2 or 6~~, 7 or K~~ *Rehabilitation* but the Principal Diagnosis Code is not Z50.- *Care involving use of rehabilitation procedures*.

Remedy AEED acknowledges that for a small number of episodes this combination of data items is correct. Check Care Type (E4) and Principal Diagnosis Code (X4). Where incorrect, amend as appropriate and re-transmit the E4 and/or X4. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. Where the data has not been corrected or confirmed AEED will periodically notify each hospital and ask them to do so.

If this is *not* a Rehabilitation episode, amend the Care Type.

If this *is* a Rehabilitation episode, check Principal Diagnosis code for a miss-code or miss-punch, or for a sequencing error; the Principal Diagnosis Code for a Rehabilitation episode should be Z50.-.

407 Rehab Level 2~~, or 3 or 4~~ W Low Adm ~~Barth~~ FIM

Effect Warning

Problem The E4 Episode Record's Care Type is 6~~, 7 or K~~ *Rehabilitation – Level 2*~~, Level 3, or Non-Designated Program/Unit~~ but the S4 Sub-acute Record's Admission ~~Barthel~~ FIM™ is less than 002.

Remedy Check Care Type (E4) and Admission ~~Barthel~~ FIM™ (S4), amend as appropriate, and re-transmit the E4 and/or S4.

It is unlikely that a patient with such a low ~~Barthel~~ FIM™ would be receiving Level 2~~, 3, Non-Designated Program/Unit rehabilitation~~.

If this was *not* Level 2~~, Level 3, or Non-Designated Program/Unit rehabilitatio~~n, amend the Care Type.

If this was Level 2~~, Level 3 or Non-Designated Program/Unit rehabilitation~~, check Admission ~~Barthel~~ FIM™.

If the ~~Barthel~~ FIM™ was not assessed for this episode, enter the ~~Barthel~~ FIM™ for the initial rehabilitation episode, not 000.

An exception would be a quadriplegic patient after the Level 1 rehabilitation episode.

427 Trans Type Invalid Comb W Sep Date

Effect REJECTION

Problem The Transaction Type is invalid for the Separation Date reported for this episode. For episodes valid Transactions Types are E4, X4, Y4, S4, P5, and V4. For Header and Trailer records the valid Transaction Types are H4, T4, and U4.

Remedy Check Transaction Type, amend as appropriate and re-transmit data.

468 Not NHT, LOS > 365 Days

Effect NOTIFIABLE

Problem The E4 Episode Record's Care Type is not 1 NHT/Non-Acute ~~or F Interim Care Program – Nursing Home Type~~ or 5T Approved Mental Health Service or Psychogeriatric Program, Mental Health Nursing Home Type, or 5E Mental Health Secure Extended Care Unit (SECU), and the calculated Length of Stay is > 365 days.

Remedy AEED acknowledges that for a small number of episodes this combination of data items is correct. Check Admission Date, Care Type and Separation Date. Where incorrect, amend as appropriate and re-transmit the E4. Alternatively, contact the HDSS Helpdesk to confirm that information is correct. Where the data has not been corrected or confirmed AEED will periodically notify each hospital and ask them to do so.

498 Pall Care without Pall Care Diag

Effect REJECTION

Problem This is a Palliative Care episode (represented by Care Type 8 ~~and/or the presence of Palliative Care Patient Days in the E4 Episode Record~~) yet the X4 or Y4 Diagnosis Record does not contain a Diagnosis Code of Z51.5 *Palliative Care*.

Remedy Check Care Type~~, Palliative Care Patient Days~~ (E4) and Diagnosis Codes (X4/Y4), amend as appropriate and re-transmit the E4 and/or X4/Y4.

506 Stat Episode: Rehab also in Next Episode

Effect FATAL (DH only, not on PRS/2 reports)

Problem The E4 Episode Record's Separation Mode is S *Statistical Separation (change in Care Type within this hospital)* and Care Type is either 2, or 6 ~~or 7~~ *Designated Rehabilitation,* however the following episode's Care Type is also either 2, or 6 ~~or 7~~ *Designated Rehabilitation*, indicating a statistical separation to a different level of rehabilitation~~, excluding Care Type K Non-Designated Rehabilitation Program/Unit~~.

Remedy Check the episode's Separation Mode and Care Type and the subsequent episode's Care Type, amend as appropriate and re-transmit the E4.

This combination of data items is incorrect, but is fatal to accommodate the PRS/2 logic in the update process. AEED will notify each hospital periodically of their episodes that trigger fatal edits. This combination of data items must be amended, or episodes will be removed from the end of year VAED consolidated file.

507 Stat Episode: Rehab also in Prior Episode

Effect REJECTION

Problem The E4 Episode Record's Admission Source is S *Statistical Admission (change in Care Type within this hospital)* and Care Type is either 2, or 6 ~~or 7~~ *Designated Rehabilitation,* however the previous episode's Care Type is also either 2, or 6 ~~or 7~~ *Designated Rehabilitation*, indicating a statistical admission to a different level of rehabilitation~~, excluding Care Type K Non-Designated Rehabilitation Program/Unit~~.

Remedy Check the episode's Admission Source and Care Type and the previous episode's Care Type, amend as appropriate and re-transmit the E4.

598 Same Day Rehabilitation: not in Scope

Effect REJECTION

Problem The E4 Episode Record's Care Type is P, 2 or 6~~, 7 or K~~ *Rehabilitation Unit/Program*, and the Admission Date and Separation Date are the same, and the Separation Mode is not T *Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre,* D *Death* or Z *Left against medical advice*.

Remedy Check Admission Date, Care Type and Separation Date, amend as appropriate and re-transmit the E4.

Same day rehabilitation does not meet Criterion for Admission, and therefore should not be reported on the VAED.

622 Adm Functional Assessment Date > 7 days before Adm Date

Effect REJECTION

Problem The S4 Sub-Acute record has a Functional Assessment Date on Admission which is more than 7 days before the Admission Date, and the episode is not a statistical change from Care Type ~~F, E,~~ 2, 6, ~~7,~~ R1, R2, or 9 ~~or K~~.

Remedy Check Admission Date (E4) and Functional Assessment Date on Admission (S4), amend as appropriate and re-transmit the E4 and/or S4.

623 Adm Funct Assess Date < Adm Date or > 7 days after Adm Date

Effect Warning

Problem The S4 Sub-Acute record has a Functional Assessment Date on Admission which is up to 7 days before the Admission Date or is more than 7 days after the Admission Date. Functional Assessment should occur within two days of

admission.

Remedy Check Admission Date (E4) and Functional Assessment Date on Admission (S4). Where incorrect, amend as appropriate and re-transmit the E4 and/or S4.

624 Sep Funct Assess Date > 7 days after Sep Date

Effect REJECTION

Problem The S4 Sub-Acute record has a Functional Assessment Date on Separation which is more than 7 days after the Separation Date and the episode is not a statistical separation to Care Type ~~F, E,~~ 2, 6, ~~7,~~ R1, R2, or 9 ~~or K~~.

Remedy Check Separation Date (E4) and Functional Assessment Date on Separation (S4). Where incorrect, amend as appropriate and re-transmit the E4 and/or S4.

627 Care Type changed, Sub-Acute data deleted

Effect Warning

Problem Sub-Acute data previously submitted for this Unique Key has been deleted. An E4 record with Care Type ~~F, E,~~ P, 2, 6, ~~7,~~ R1, R2, or 9 ~~or K~~ and an S4 record have previously been accepted, but this E4 record has Care Type 1, 8, B, 10, 5x, 0, 4 or U and therefore Sub-Acute data should not be present.

Remedy If the Care Type was changed in error, the E4 and S4 records must be re-submitted with corrected data. If the Care Type was changed intentionally then no further action is required.

662 Adm FIM™/Functional Assessment Date/Care Type mismatch

Effect REJECTION

Problem The E4 Episode Record and S4 Sub-Acute Record have an invalid combination of Care Type, FIM™ Score on Admission and Functional Assessment Date on Admission. If the Care Type is ~~F, E,~~ 2, 6, ~~7,~~ R1, R2, or 9, a FIM™ Score on Admission and a Functional Assessment Date on Admission must be present. ~~Adm FIMTM is optional for Care Type K~~. For other Care Types, these fields must be spaces. This edit will trigger on the S4 record only.

Remedy Check Care Type (E4), Functional Assessment Date on Admission (S4), and FIM™ Score on Admission (S4), amend as appropriate and re-transmit the E4 and/or S4.

663 Sep FIM™/Functional Assessment Date/Care Type mismatch

Effect REJECTION

Problem The E4 Episode Record and S4 Sub-Acute Record have an invalid combination of Care Type, FIM™ Score on Separation and Functional Assessment Date on Separation. If the Care Type is ~~F, E,~~ 2, 6, ~~7,~~ R1, R2, or 9, a FIM™ Score on Separation and a Functional Assessment Date on Separation must be present, unless the Separation Mode is D Death in which case the Functional Assessment Date on Separation may be spaces. ~~Sep FIMTM is optional for Care Type K~~. For other Care Types, these fields must be spaces. This edit will trigger on the S4 record only.

Remedy Check Care Type (E4), Functional Assessment Date on Separation (S4), and Barthel Index Score on Separation (S4), amend as appropriate and re-transmit the E4 and/or S4.

Edits modified but no change to description of edit

389 Invalid Separation Referral
Separation Referral code E added to list of valid codes

390 Incompatible Care Type, Carer Availability, Age and Separation Mode
Modifications as per Section 4 tabular information in this document.

419 Invalid Contract/Spoke Identifier
Removal of Codes 0050 and 0070.

488 Incompatible Care Type/Admission Source Statistical
Refer to Business Rules (Tabular) *Admission Source and Care Type*

489 Incompatible Care Type/Separation Mode Statistical

Refer to Business Rules (Tabular) *Care Type and Separation Mode*

502 Statistical Episode: Care Type same as Next Episode
Change to Care Type codeset.

503 Statistical Episode: Care Type same as Previous Episode
Change to Care Type codeset.

511 Invalid Preferred Language
Change to codeset.

599 Carer Availability not required
Refer to Business Rules (Tabular) *Age, Care Type, Carer Availability and Separation Mode*

New edits

XXX Care Plan Documented Date is reported but Care Type is not sub-acute

Effect Warning

Problem A Care Plan Documented Date has been reported but the Episode Care Type is not P, 2, 6, 8, 9, R1 or R2.

Remedy

XXX Care Type Sub-acute, Sep Date reported, Care Plan Documented Date is null

Effect Warning

Problem The Episode Care Type is P, 2, 6, 8, 9, R1 or R2 but a Care Plan Documented Date has not been reported.

Remedy

XXX Phase of Care reported but Care Type is not 8

Effect REJECTION

Problem A P5 Palliative Record has been reported but the E5 Episode Record's Care Type is not 8 *Palliative Care*.

Remedy

XXX Care Type is 8 but Phase of Care is null

Effect Warning

Problem The E5 Episode Record's Care Type is 8 *Palliative Care,* a Separation Date has been reported, but there is no P5 Palliative Record.

Remedy

XXX Not sufficient fields: Phase of Care change

Effect REJECTION

Problem A P5 Palliative Record has been submitted but does not contain all data elements required.

Remedy Check the specifications for the P5 Palliative Record, re-submit with missing element(s).

XXX Deleted – Episode is Palliative

Effect Warning

Problem An E4 Episode Record has been successfully deleted; if a P5 Palliative Record was also recorded in PRS/2, the P5 has also been deleted.

Remedy If there was no such record no further action is necessary.

If another E4 is to be re-transmitted for this episode and the Care Type is 8, the P5 must also be re-transmitted.

XXX Tran Pt ID not Same as Episode or Pall

Effect Warning

Problem The Public Hospital P5 Palliative Record's Unique Key/Patient Identifier does not match that in an E5 Episode Record or a P5 already on file for this Unique Key.

Remedy Check Patient Identifier in both the P5 and E5, amend as appropriate, and re-transmit the E5 and/or P5.

If there is an P5 already on file with an incorrect Patient Identifier, this new P5 will have altered that Patient Identifier, so no further action is required if this new P5's Patient Identifier is correct.

If the Patient Identifier in the P5 already on file was correct, and this new P5's Patient Identifier is wrong, correct the Patient Identifier and re-transmit the P5.

XXX Palliative Care: No Palliative Record

Effect Warning

Problem The Public Hospital E5 Episode Record's Care Type is 8 *Palliative Care*, and a Separation Date is present, however there has been no P5 Sub-Acute Record accepted for this patient.

Remedy Check Care Type and Separation Date (E5), amend as appropriate, and re-transmit the E5 and/or P5.

If Care Type is correct, investigate why no P5 is recorded: if it has been submitted but rejected, amend and re-transmit; if the information is not yet available, ensure the P5 is submitted as soon as possible.

If the patient is not yet separated, delete the Separation Date.

XXX Palliative Record not Required

Effect REJECTION

Problem An P5 Palliative Record has been transmitted, however in an E5 Episode Record with the same Unique Key, the Care Type is not reported as 8 Palliative Care.

Remedy Check Care Type (E5), amend as appropriate and re-transmit the E5 and/or P5.

XXX Care Type R1/R2, not approved for Restorative Care

Effect REJECTION

Problem The E5 Episode Record's Care Type is R1 or R2 Restorative Care but the Hospital Campus is not approved to provide such care.

Remedy Check Care Type, amend as appropriate and re-transmit the E5.

If you believe the Hospital Campus is approved to report this Care Type, contact the HDSS Help Desk.

Refer to:
Supplementary Code Lists *Care Type R1/R2: Approved Restorative Care*
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Deleted edits

251 Invalid Admission Barthel

252 Invalid Separation Barthel

292 Separation Barthel Present

293 Clinical Sub-Program or Impairment Present

298 Admission Barthel Present

305 Admission RUG ADL Present

306 Separation RUG ADL Present

341 Source of Referral to Palliative Care Present

453 Wrong Principal Diagnosis for Interim Care

454 Incompatible Fields for Interim Care

474 Care Type E, LOS > 35 days

475 Care Type E or F, not approved for Interim Care

541 Care Type K, not approved for Non-Designated Rehabilitation

588 Care Type 7, not approved for Rehabilitation Level 3

620 Admission Barthel / Functional Assessment Date / Care Type mismatch

621 Separation Barthel / Functional Assessment Date / Care Type mismatch

650 Program Identifier 03, not approved for Restorative Care