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| Proposals for revisions to the Victorian Admitted Episodes Dataset (VAED) for 2024-25 |
| October 2023 |
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# Executive summary

Each year the Department of Health review the Victorian Admitted Episodes Dataset (VAED) to ensure that the data collection supports the department’s business objectives, including national reporting obligations, and reflects changes in hospital funding and service provision arrangements for the coming financial year.

To avoid duplication, the department has prepared a separate *Proposals* document that details proposals relating to items reported in more than one data collection. The *Proposals for revisions across multiple data collections (AIMS, ESIS, VAED, VEMD, and VINAH) for 2024-25* must be considered alongside the Proposals for Revisions to the VAED for 2024-25.

The proposed revisions for the VAED for 2024-25 include:

Addition of data elements

* Reason for Discharge Delay
* Diagnosis Cluster identifier (DCID) for implementation in 2025-26

Amendments to existing data elements

* Diagnosis Codes – increase number to 100
* Review of Procedure Start Date Time (and by extension Proceduralist ID)
* Admitting/Discharging Unit/Specialty – add code for Early Parenting Centre
* Triage Score on Admission – add code 999 no assessment, reporting mandatory from July 2024
* Impairment – add three COVID-19 codes
* Duration of NIV in ICU – amend reporting guide
* Medically Ready for Discharge Date – change to Clinically Ready for Discharge Date, amend reporting guide to include Care Type 5x
* Mental Health Statewide Patient Identifier – reporting changed to optional
* NDIS Participant Flag – amend reporting guide to include Care Type 5x

The proposed revisions across multiple data collections (including VAED) for 2024-25 include:

* Add Language spoken at home

# Introduction

This document is intended to invite comment and stimulate discussion on the proposals outlined. All stakeholders, including health services, software vendors and data users (including those within the Department of Health and Safer Care Victoria) should review this document and the *Proposals for revisions across multiple data collections (AIMS, ESIS, VAED, VEMD and VINAH) for 2024-25* and assess the feasibility of the proposals. Written feedback must be submitted in the feedback proforma by 5.00pm Friday 20 October 2023.

This proposal document and the [online feedback form](https://forms.office.com/Pages/ResponsePage.aspx?id=H2DgwKwPnESciKEExOufKII_2IfNHexFkH_EAj2AB_tUQ0dWRTBFVEVQVjM2TjU3SkxVR0RTUTNENiQlQCN0PWcu) are available at [HDSS annual changes](https://www.health.vic.gov.au/data-reporting/annual-changes)

<https://www.health.vic.gov.au/data-reporting/annual-changes>

*Specifications for revisions to the Victorian Admitted Episodes Dataset (VAED) for 2024-25* will be published later and may include additions, amendments or removal of information in this document.

## Orientation to this document

* New data elements are marked as (new).
* Changes to existing data elements are highlighted in green
* Redundant values and definitions relating to existing elements are ~~struck through~~.
* Comments relating only to the proposal document appear in *[square brackets and italics].*
* New validations are marked ###
* Validations to be changed are marked \* when listed as part of a data element or below a validation table.
* Anticipated changes are shown under the appropriate manual section headings.

The proposals in this document are numbered 5 through to 18 (proposals 7 and 17 were withdrawn, proposal 9 does not proceed for publication) . Proposals 1 through to 4 apply to multiple data collections including the VAED and are available in the *Proposals for revisions across multiple Data Collections for 2024-25 document.*

# Proposal 5 - Increase number of diagnosis codes reported to VAED

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| **It is proposed to** | Increase the number of diagnosis codes reported to VAED from 40 to 100 |
| **Proposed by** | Classification and Coding, Health Services Data, VAHI |
| **Reason for proposed change** | The VAED currently only accepts 40 diagnosis codes  Data analysis of multiday public hospital episodes shows that the number of episodes for which 40 diagnosis codes are reported has steadily increased over the last 11 years. Whilst the actual number of episodes with 40 reported diagnosis codes remain low e.g. 738 episodes in 2020-21 and 715 episodes in 2021-22, feedback from hospitals is that there are episodes with more than 40 diagnosis codes are assigned which are currently not reported to the VAED.This results in a loss of coded data being reported to DH which is available in a hospital’s internal system.  AR-DRG groupers and hospital Patient Administration Systems accept 100 diagnosis codes.  At the point of clinical coding, for episodes which exceed 40 diagnosis codes, the clinical coder must re-sequence codes to ensure that all codes that impact the DRG are within the 40 reported to the VAED or there will be a DRG mismatch between the hospital and DH. The clinical coder must also ensure that external cause, place of occurrence and activity codes are included in the 40 for any injury or complication to avoid triggering a sequencing validation error.  Whilst the clinical coder has used the resequencing workaround for many years which is not ideal, there are now additional drivers for increasing the number of codes reported to the VAED:   * With DH introducing the HAC adjustment there is potential for a hospital to code a HAC but if the codes assigned exceed 40 and the HAC codes are not sequenced to be within the 40 reported, the hospital will show a HAC adjustment but DH will not i.e. the episode will not be counted as a HAC when reported to DH and result in a discrepancy in HAC adjustment reconciliation between DH and hospital internal calculations * IHACPA is introducing ‘cluster coding’ for Thirteenth Edition effective 1 July 2025. The benefit of assigning a cluster ID to a group of related codes is richer, more complete data to help inform safety and quality, planning and research and allows for duplication of codes for capturing bilateral injuries and repeating of external cause, place of occurrence and activity codes to better understand injury cause and complications. This duplication of codes means that more episodes will exceed the current limit of 40 codes reportable to the VAED.   By increasing the limit of diagnosis codes reported to the VAED it will:   * Remove the need for the clinical coder to resequence clinical codes * Start to prepare DH systems for the introduction of Cluster ID data element |
| **Details of change** | Diagnosis Codes (amend)  New Diagnosis record – TBA |
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# Proposal 6 – Review of Procedure Start Date Time (and by extension Proceduralist ID)

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| **It is proposed to** | * Decouple the requirement to report Procedure Start Date Time and Proceduralist ID from the General Interventions (GI) and Non GI lists that has been developed for grouping purposes * Work with the users of this data to undertake a review of procedures for which these data elements are required to ensure the data collected reflects the needs of the data users and reduces the burden of reporting by hospitals |
| **Proposed by** | Classification and Coding, Health Services Data, VAHI |
| **Reason for proposed change** | Procedure Start Date Time was introduced in 2009 with the original purpose to enable analysis of wait times for procedures, to inform a suite of indicators. At that time a Procedure Start Date Time was required for the first coded procedure if it:  (i) Occurs in an operating room (as per the AR-DRG list of General Interventions) or  (ii) Occurs in a cardiac catheter laboratory or  (iii) Involves the use of a scope  It has since evolved to report Procedure Start Date Time for all procedures that are identified as a General Intervention (GI) or a Non GI as per the AR-DRG list of interventions, therefore going beyond the original scope of points (ii) and (iii) above.  Hospitals have long noted difficulty in reporting this data element for procedures that are performed in locations other than the traditional operating theatre such as an endoscopy suite, catheterisation lab or radiology as these procedures generally do not form part of a hospital’s theatre list and therefore the Procedure Start Date Time is not readily available. Hospitals have developed workarounds for collecting Procedure Start Date Time when it is not available in a Patient Administration System either because the episode is not part of the theatre list (or the data is contained in the EMR).  Additionally there are interventions for which the same procedure code is assigned regardless of whether the procedure is performed on the ward or in the operating theatre, such as debridement of skin and subcutaneous tissue (which is a general intervention as per the grouper) and also procedures have remained as requiring Procedure Start Date Time when the grouper no longer recognises a procedure as a GI or Non GI without review.  This reporting difficulty also extends to Proceduralist ID which uses the same subset of procedure codes as Procedure Start Date Time. |
| **Details of change** | Library file change |

# Proposal 8 – Add Reason for Discharge Delay (linked to Proposal 14)

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| **It is proposed to** | Add a new data element to capture Reason for Discharge Delay |
| **Proposed by** | Program Improvement, Health Services and Ageing, Commissioning and Safety Improvement |
| **Reason for proposed change** | Recommendations from the Improving Care Pathways project have been prioritised by National Cabinet through the First Secretaries Group. The recommendations identify the need for better data collection and sharing to enable real-time reporting (or as close to) on older people and National Disability Insurance Scheme (NDIS) participants who are in a hospital bed and clinically ready to be discharged but unable to be safely discharged because there are barriers in accessing appropriate community options, accessing critical funds and services or administrative processes are delayed or yet to be put in place.  Aiming to reduce delayed discharges for these two priority groups, National Cabinet has tasked Health and Disability Ministers with implementing the recommendations and reporting progress against tight timelines for delivery. Successfully reducing discharge delays will free hospital beds for other Victorians and save the Victorian government from spending millions of dollars on older people and NDIS participants that have no clinical requirement to remain in hospital.  A Medically Ready for Discharge Date was introduced into VAED in 2022/23 as a non-mandatory item. This proposal seeks to complement this item and provide more granular details to why a patient may remain in hospital when clinically able to be discharged.  The Commonwealth are looking to have this data element reported regularly by jurisdictions (as often as monthly) with the aim of establishing consistent hospital discharge protocols and responses. |
| **Details of change** | New data element |

## Section 3 Data definitions

## Reason for Discharge Delay (new)

Specification

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

# Proposal 10 – Amend Admitting/Discharging Unit/Specialty

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| **It is proposed to** | Add Admitting/Discharging Unit/Specialty code for Early Parenting Centre |
| **Proposed by** | Women’s Health, Public Health Division, Department of Health |
| **Reason for proposed change** | In Victoria, there are currently three EPCs operated by The Queen Elizabeth Centre (QEC), Tweddle Child and Family Health Service (Tweddle) and Mercy Health O’Connell Family Centre (OFC).  As part of a $148 million expansion of EPCs, the number of services in Victoria will increase to 13 by 2025-26. The new EPCs will be operated by existing health services including QEC, Tweddle, Mercy OFC, Monash Health, Bendigo Health, Barwon Health and Grampians Health.  As part of the expansion, it is essential the department collects up to date patient-level data for this program. A recent EPC Funding Model Review and Implementation Project found a need to revise data collection mechanisms to ensure new EPC activity can be identified at health services operating EPCs.  Currently, the three existing EPCs all have unique campus codes enabling their EPC activity to be easily identified. However, this won’t be the case for all of the new EPCs as some will be located on sites that have existing campus codes. To ameliorate this, the creation of a new specialist code will enable the EPC specific activity to be clearly identifiable in the VAED. Using a specialist code such as EPCS – Early Parenting Centre Service, OR EPSS- Early Parenting Support Services will enable both the department and health services to easily identify EPC-specific activity. |
| **Details of change** | Amend code set |

## Section 3 Data definitions

## Admitting/Discharging Unit/Specialty (amend)

Specification

|  |  |
| --- | --- |
| **Definition** | (a) Unit/Specialty patient is admitted under  (b) Unit/Specialty at separation |
| **Layout** | AAAA or AAAspace | |
| **Location** | Episode Record | |
| **Reported by** | All Victorian hospitals (public and private) |
| **Reported for** | All admitted episodes of care |
| **Reported when** | (a) The Episode Record is reported  (b) A Separation Date is reported in the Episode Record |
| **Code set** | Code Descriptor  EPCS Early Parenting Centre Services |
|  | *[only new code shown]* |
| Reporting guide | Report the most appropriate category that best reflects the hospital unit’s activity. There is no requirement for hospitals to further split their own units to match the standard unit codes. Hospitals without separate specialty units should report the most appropriate general medical or surgical code.  Stroke Unit care is organised care within a specific ward in a hospital provided by a multidisciplinary team who specialise in stroke management (*National Acute Stroke Services Framework 2019*). |
| Validations | 715 Invalid Admitting Unit/Specialty\*  716 Invalid Discharging Unit/Specialty\*  ### Admitting/Discharging Unit/Specialty EPCS, campus not approved |

# Proposal 11 – Amend Triage Score on Admission

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| **It is proposed to** | Add code ‘999’. The codeset will be: 000 to 100 and 999. Any values outside this range are invalid. |
| **Proposed by** | Department of Health, Health Services & Aged Care Policy, Improvement and Engagement, Commissioning & System Improvement |
| **Reason for proposed change** | The VAED Triage Score on Admission (Score 0 to 100) is to be mandatory from 1 July 2024.  This new change will help distinguish between a clinical urgency score of ‘0’ obtained when using the evidence-based triage tool and a ‘null’ result reported when the triage tool was not used.  Inclusion of the value ‘999’ in the VAED Triage Score on Admission will align it with the community palliative care data item of VINAH First Triage Score. |
| **Details of change** | Amend code set  Amend reporting guide |

## Section 3 Data definitions

## Triage Score on Admission (amend)

### Specification

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| --- | --- |
| **Definition** | The score derived from use of the evidence-based palliative care triage tool that considers the clinical status and the person and family/carer situation |
| **Field size** | 3 |
| **Layout** | NNN or spaces  Right justified, zero filled |
| **Location** | Palliative Record |
| **Reported by** | Public hospitals |
| **Reported for** | Episodes with Care Type 8 Palliative Care  ~~Optional from 1 July 2021~~  Mandatory from 1 July 2024 |
| **Reported when** | A Separation Date is reported in the Episode Record |
| **Code set** | 000 to 100 score from assessment  999 Not stated or unknown (no assessment) |
| **Reporting guide** | This is the Triage Score of 0 to 100 determined prior to admission or transfer to the unit.  The triage score is calculated based on a validated tool with seven items across physical, psychosocial and caregiver domains, and provides a score from 0 to 100 points.  Triage is to be completed by a clinician or triage officer who has an appropriate level of training and clinical experience in palliative care to ascertain accurate assessments of the triage factors from the referrer.  Code 999 should only be reported when the evidence-based triage tool was not used to determine clinical urgency. |
| **Validations** | 725 Invalid Triage Score on Admission\* |
| **Related items** | Section 5 Palliative Record |

# Proposal 12 – Amend Impairment codeset

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| **It is proposed to** | Add three COVID-19 Impairment codes |
| **Proposed by** | Funding Policy and Accountability, Funding Policy, Accountability and Data Insights, Commissioning and System Improvement |
| **Reason for proposed change** | The proposed change is required to align state reporting to national reporting requirements from 2024-25.  The Independent Health and Aged Care Pricing Authority (IHACPA) has advised that from the 2024-25 reporting year they will implement three Australasian Rehabilitation Outcomes Centre (AROC) COVID-19 impairment codes and amend the relevant data request specifications and Australian National Subacute and Non-Acute Patient (AN-SNAP) groupers which is used to classify subacute and non-acute activity. The three codes which will be introduced are:   * 18.1 COVID with pulmonary issues; * 18.2 COVID with deconditioning; and * 18.9 COVID all other.   AROC impairment codes are used to classify rehabilitation episodes into impairment groups (METEOR 498498) and mapped to AN-SNAP Version 5 end classes. AN-SNAP Version 5 classification will be used for pricing admitted subacute and non-acute services in 2024-25. It is therefore necessary for Victoria to align to the reporting requirements to ensure that Victoria both meets its reporting obligations and that the relevant episodes of care can be classified correctly. Changes to how episodes are classified will improve IHACPA’s classification models, ensuring that price weights correspond with average costs, and subsequently ensuring the level of funding for this activity correlates with the cost of its delivery. |
| **Details of change** | Amend code set |

## Section 3 Data definitions

## Impairment (amend)

Specification

|  |  |
| --- | --- |
| **Definition** | The impairment group according to the primary reason for the current episode of rehabilitation care |
| **Field size** | 6 |
| **Layout** | NNNNNN or spaces Left justified, trailing spaces |
| **Location** | Subacute Record |
| **Reported by** | Public hospitals |
| **Reported for** | Mandatory if Care type is 6 or P.  For Care Type 9, report spaces |
| **Reported when** | A Separation Date is reported in the Episode Record |
| **Code set** | Code Descriptor |
|  | *[only new codes shown]* |
| **COVID conditions** | 181 COVID with pulmonary issues  182 COVID with deconditioning  183 COVID all other |
|  | *[no change to remainder of data element]* |
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# Proposal 13 – Amend reporting guide for Duration of NIV in ICU

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| **It is proposed to** | Amend reporting guide for Non-invasive Ventilation (NIV) |
| **Proposed by** | Data Collections, Data and Digital, VAHI |
| **Reason for proposed change** | For consistency with reporting guides for Duration of Mechanical Ventilation in ICU and Duration of Stay in ICU |
| **Details of change** | Amend reporting guide |

## Section 3 Data definitions

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

Specification

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| --- | --- |
| **Definition** | Total number of hours of non-invasive ventilatory support (including High Flow Therapy) without the use of an ETT or tracheostomy provided to patients in an approved Intensive Care Unit (ICU). |
| **Field size** | 4 |
| **Layout** | NNNN or spaces Right justified, zero filled |
| **Location** | Diagnosis Record |
| **Reported by** | Mandatory for public hospitals providing NIV in an approved Intensive Care Unit (ICU) or combined Intensive Care Unit/Coronary Care Unit.  Includes:  NIV provided in a Paediatric Intensive Care Unit (PICU)  Excludes:  NIV provided in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN)  Private hospitals report spaces |
| **Reported for** | Episodes of care for patients receiving NIV in an ICU  Otherwise, report spaces. |
| **Reported when** | A Separation Date is reported in the Episode Record. |
| **Code set** | A number in the range 0001 to 9999 |
| **Reporting guide** | **Count all hours of NIV received in ICU:**  ~~Refer to ACS 1006 Ventilatory support~~   * Count NIV hours rounded to the nearest ~~completed~~ hour. For example, if the total duration of NIV in ICU was 98 hours 15 minutes, report 98 hours. If the total duration of NIV in ICU was 125 hours 30 minutes, report 126 hours.   *[no change to remainder of data element]* |

# Proposal 14 – Amend Medically Ready for Discharge Date title and reporting guide (linked to Proposal 8)

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| **It is proposed to** | Change the title to Clinically Ready for Discharge Date.  Change the wording of the definition to ‘Date on which the medical team responsible for the patient’s clinical care deems that the patient has no acute or subacute care needs requiring hospitalisation and is clinically ready to be discharged’.  Allow this data element to be reported on admission or updated at any time during the episode.  Include care type 5x (mental health). |
| **Proposed by** | Program Improvement, Health Services and Ageing Commissioning and Safety Improvement |
| **Reason for proposed change** | Recommendations from the Improving Care Pathways project have been prioritised by National Cabinet through the First Secretaries Group. The recommendations identify the need for better data collection and sharing to enable real-time reporting (or as close to) on older people and National Disability Insurance Scheme (NDIS) participants who are in a hospital bed and clinically ready to be discharged but unable to be safely discharged.  Aiming to reduce delayed discharges for these two priority groups, National Cabinet has tasked Health and Disability Ministers with implementing the recommendations and reporting progress against tight timelines for delivery. Successfully reducing discharge delays will free hospital beds for other Victorians and save the Victorian government from spending millions of dollars on older people and NDIS participants that have no clinical requirement to remain in hospital.  There is currently no mechanism that enables real-time reporting (or as close to) of this data element. Health services currently voluntarily report the Medically Ready for Discharge Date when reporting a separation date. To collate data on NDIS participants whilst they are still admitted as inpatients and clinically ready for discharge, the department currently undertakes a biannual Data Snapshot Survey. The survey requires manual input and is labour intensive for both the department and health services.  Changing the requirement to report this data element on admission or at any time during the episode will enable the department to access the clinically ready for discharge date in the shortest timeframe possible and share this critical piece of data with key stakeholders that have a role to play in solving exit block. Having this data element while the older person or NDIS participant is an inpatient will also enable the department to steward cross-jurisdictional program strategies that will reduce the discharge delays for those patients. The current method of this data element being provided retrospectively at separation prevents the department from achieving these outcomes.  The Commonwealth are looking to have this data element reported regularly by jurisdictions (as often as monthly) for patients over 65 years waiting for residential aged care and NDIS participants with the aim of establishing consistent hospital discharge protocols and responses.  A separate proposal has been prepared linked to this one which seeks to add a Reason for Discharge Delay code set that further defines the reason for the patient not being able to be discharged in a timely way. |
| **Details of change** | Amend data element |

## Section 3 Data definitions

## ~~Medically~~ Clinically Ready for Discharge Date (amend)

Specification

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| **Definition** | Date on which the medical team responsible for the patient’s clinical care deems that the patient has no acute or subacute care needs requiring hospitalisation and is clinically ready to be discharged ~~is medically ready to be discharged from a hospital bed, assuming that all necessary administrative arrangements are in place to allow the transfer of the patient to home or community settings, or transfer to a step-down service~~ |
| **Field size** | 8 |
| **Layout** | DDMMYYYY |
| **Location** | Extra Episode Record – TBA |
| **Reported by** | Public hospitals |
| **Reported for** | Multiday episodes for Care Type 1, 4, 5x, 6, 8, 9, P, and MC (optional) |
| **Reported when** | ~~A Separation Date is reported in the Episode Record~~  On admission or updated at any time during the episode |
| **Reporting guide** | A Clinically Ready for Discharge Date should be reported where there is an administrative or non-clinical reason delaying discharge from hospital.  ~~Medical~~ Clinical assessment of the Ready for Discharge date should be made by the primary consultant responsible for the patient’s care. The Ready for Discharge date may change during an episode of care due to a change in the patient’s health status or condition. Only the final Ready for Discharge date should be reported.  ~~The Medically Ready for Discharge Date may be the same as the Separation Date if necessary administrative arrangements are in place.~~ |
|  | Examples of administrative arrangements delaying discharge:   * ~~Transfer to another care type, such as subacute, mental health~~ * NDIS eligibility determination, plan approval, implementation of supports (including equipment/home modifications) and other disability services/accommodation * Equipment/home modifications (non-NDIS) * ACAS * ~~Residential Aged Care~~ Commonwealth Aged Care Service * Guardianship determination (VCAT/OPA) * Ambulatory or community service (non-NDIS) * Homelessness service/accommodation |
| **Validations** | 736 ~~Medically~~ Clinically Ready for Discharge Date invalid\*  745 ~~Medically~~ Clinically Ready for Discharge Date prior to Admission Date\* |
| **Related items** | ~~Separation Date~~  NDIS Participant Flag  NDIS Participant Identifier  Reason for Discharge Delay |

# Proposal 15 – Mental Health State Wide Patient Identifier no longer mandatory

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| **It is proposed to** | Make reporting of Mental Health State Wide Patient Identifier optional |
| **Proposed by** | Transformation and Evidence Branch, Mental Health and Wellbeing Division |
| **Reason for proposed change** | As part of policy changes to support the eMental Health and Wellbeing Record, the Mental Health and Wellbeing Division have indicated their preference to move from the legacy approach of mental health consumers being registered and allocated a Statewide URN, as occurs with CMI/ODS, to the UPI approach (policy decision in progress). This change will commence during 2024-25 , and will impact on VAED validations, as there will no longer be a Mental Health Statewide Patient Identifier. |
| **Details of change** | Change effect of validations 575 and 660 from REJECTION to WARNING |

## Section 8 Validation

## 575 Care Type 5x, MHSWPI blank (amend)

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| Effect | ~~REJECTION~~ Warning |
| Problem | The E5 Episode Record’s Care Type is 5x Mental Health Service, but the Mental Health Statewide Patient Identifier is blank. |
| Remedy | Check Care Type and Mental Health Statewide Patient Identifier, amend as appropriate and re-submit the E5. |

## 660 Care Type ≠ 5x, Procedure Code 14224-xx, MHSWPI mismatch (amend)

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| Effect | REJECTION Warning (X5 NEW/UPD, AND E5 UPD) |
| Problem | The Care Type in the E5 Episode Record is not equal to 5x, but either:   * The X5 Diagnosis Record contains an ACHI code in the range 14224-xx but the E5 Episode Record does not contain a Mental Health Statewide Patient Identifier; OR * The E5 Episode Record contains a Mental Health Statewide Patient Identifier but the X5 Diagnosis Record does not contain an ACHI code in the range 14224-xx |
| Remedy | Check Care Type, and MHSWPI and ACHI procedure codes, amend as appropriate and re-submit the E5/X5. |

# Proposal 16 – Amend NDIS Participant Flag

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| **It is proposed to** | Add Care Type 5x (mental health) to report this data element |
| **Proposed by** | Department of Health, Health Services & Aged Care Policy, Improvement and Engagement, Commissioning & System Improvement |
| **Reason for proposed change** | Recommendations from the Improving Care Pathways project have been prioritised by National Cabinet through the First Secretaries Group. The recommendations identify the need for better data collection and sharing to enable real-time reporting (or as close to) on National Disability Insurance Scheme (NDIS) participants who are in a hospital bed and clinically ready to be discharged but unable to be safely discharged.  NDIS Participants admitted to mental health services represent approximately 30% of the NDIS participants that are experiencing exit block. Changing the requirement to report Care Types 5 from "Optional” to “Mandatory” will enable the department to capture data on NDIS participants in all care types where exit block exists.  Aiming to reduce delayed discharges for NDIS participants, National Cabinet has tasked Health and Disability Ministers with implementing the recommendations and reporting progress against tight timelines for delivery. Successfully reducing discharge delays will free hospital beds for other Victorians and save the Victorian government from spending millions of dollars on NDIS Participants that have no clinical requirement to remain in hospital. |
| **Details of change** | Amend reporting guide |

## Section 3 Data definitions

## NDIS Participant Flag (amend)

### Specification

|  |  |
| --- | --- |
| **Definition** | National Disability Insurance Scheme (NDIS) participant status of person |
| **Field size** | 1 |
| **Layout** | N |
| **Location** | Episode Record |
| **Reported by** | Public hospitals |
| **Reported for** | Episodes with:  Care Types 1, 4, 5x, 6, 8, 9, P, MC  ~~Optional for episodes with:~~  ~~Care Types 5x~~ |
|  | *[No change to remainder of data element]* |

# Proposal 18 – Add Diagnosis Cluster identifier (DCID) for implementation in **2025-26**

Note: this proposal is for implementation from 1 July 2025 and is included in this document because it is anticipated that significant lead time will be required for vendors and health services to implement system changes by 1 July 2025.

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| --- | --- |
| **It is proposed to** | Add data element Diagnosis Cluster identifier (DCID) to support cluster coding from **1 July 2025** |
| **Proposed by** | Classification and Coding, Health Services Data, VAHI |
| **Reason for proposed change** | The DCID will enable clinical codes that relate to each other to be explicitly identified in the admitted patient care data and is required to meet national reporting requirements.  The creation of the DCID field will enable Victoria to meet national reporting requirements from **1 July 2025** as the DCID will be introduced into the Admitted Patient Care (APC) from **1 July 2025** and to prepare the clinical coding workforce for the implementation of ICD-11 (date yet to be determined by Australia) where the design of ICD-11 relies significantly on the linking of codes that are related to each other.  Admitted patient care data is used to understand, benchmark and improve health services in both public and private hospitals across Australia and internationally. Clinical codes in admitted patient care data is sourced from clinical documentation that is used by clinical coders to assign classification codes that represent conditions based on a number of conventions, guidelines and criteria.  Multiple clinical codes are sometimes required to describe a single condition or injury. Currently, if multiple clinical codes are related, this relationship can only be reflected in admitted patient care data by sequencing these codes together in the patient administration system. For example, the relationship between an injury/poisoning and the causes of that injury/poisoning (known as external causes, that represent how the injury occurred, where and in what circumstances) can only be reflected by sequencing the external cause and place of occurrence code immediately after the injury/poisoning to which it relates.  However, sequencing is not always maintained within patient administration systems due to limitations of storage, reporting or data quality processes and the lack of an explicit connection between codes compromises the ability of recipients of the data – human or software – to understand if codes are related. In the example of an injury and its external causes, if there are multiple injury events in an episode of care it becomes unclear which injury has been caused by which external cause.  The data collections for admitted patient care have evolved over decades to capture additional information to further contextualise hospital activity, including the national condition onset flag in 2008 (in Victoria known as Prefixes which have been available longer than the national COF) and the introduction of the supplementary codes for chronic conditions in 2015. |
| **Details of change** | New data element |

## Section 3 Data definitions

## Diagnosis Cluster identifier (DCID) (new)

### Specification

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| --- | --- |
| **Definition** | The DCID contains a value that identifies that a set of codes are related. Codes are considered ‘related’ when they connect the circumstances of an event together. For example, a fractured radius (injury/condition), of a pedestrian struck by motor vehicle (external cause), on the pedestrian crossing (place of occurrence), while walking their dog (activity). Carla’s definition:  A code set representing the relationship of conditions relative to other conditions within an episode of admitted patient care through the use of diagnosis clustering *[Meteor identifier 767923]* |
| **Field size** | 2 |
| **Layout** | AA, A, N Left justified, trailing space |
| **Location** | TBA |
| **Reported by** | All Victorian hospitals (public and private) |
| **Reported for** | Separations on and from **1 July 2025** |
| **Reported when** | A separation date is reported in the Episode Record |
| **Code set** | Code Descriptor  A-ZZ (DCID A-ZZ) Diagnosis cluster identifier  0 Chronic condition cluster  8 Not clustered  9 Not reported |
| **Reporting guide** | Clinical coders will apply Australian Coding Standard ACS 0004 Diagnosis Cluster identifier to determine the appropriate values in the codeset to be reported.  Where a diagnosis cluster is identified, the first diagnosis cluster identifier code (DCID) value assigned should be A. Record the same DCID value against each ICD-10-AM code in the diagnosis cluster (eg. injuries, procedural complications, and adverse effects) together with their associated external cause, place of occurrence codes and activity type codes.  Subsequent clusters in the same episode of care should proceed to be allocated the next sequential alphabetic letter (i.e. B, C, D, etc through to Z, and then AA, AB through to ZZ if required).  **8 Not clustered**  ICD-10-AM code that has not been assigned to a diagnosis cluster or chronic condition cluster |
|  | **9 Not reported**  Used when health service is not supplying DCID values A-ZZ, 0-8 |
| **Validations** | The 2025-26 VAED ICD-10-AM/ACHI library file will be updated to flag the codes in scope for DCID |
| **Related items** | Section 3 Diagnosis Codes |

# Proposal not proceeding

At the first Annual Changes Governance Committee meeting it was decided that the proposal below will not proceed to the next phase of the process.

**Proposal 9 – Add a new data element for patient deterioration data**

The VAED is not the appropriate data collection for reporting of Medical Emergency Team (MET) calls.

# Proposals withdrawn

The following proposals were withdrawn during the course of Health Services Data staff review of proposals and/or consultation with proposers:

**Proposal 7 Review procedures requiring Procedure Start Date Time**

This proposal was withdrawn because it is very similar to Proposal 6 Review of Procedure Start Date Time (and by extension Proceduralist ID).

**Proposal 17 – Amend Qualification Status of newborns receiving phototherapy**

This proposal was withdrawn because the proposed change is out of scope for annual changes because the VAED definition of a qualified newborn is based on the national definition and Victoria’s funding of unqualified episodes is in line with the national funding model.