health

Victorian Admitted Episodes Dataset (VAED)

Accessible and Restricted Data Fields

State Government Victoria

Department of Health

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Updated July 2012

VICTORIAN ADMITTED EPISODES DATASET (VAED)
List of Data Fields

ACCESSIBLE DATA FIELDS
Public hospital data only

Admission data	
Data Field Description	**Definition**
Month of Admission	Month on which a patient commences an episode of care.
Year of Admission	Year in which a patient commences an episode of care .
Care type	The nature of clinical service (type of care) provided to an admitted patient during an episode of care. There must be one and only one care type code per episode. A change in care type results in a statistical separation and a new episode with a statistical admission. 10 Posthumous Organ Procurement 1 NHT/Non-Acute P Designated Paediatric Rehabilitation Program/Unit 2 Designated Rehabilitation Program/Unit: Level 1 6 Designated Rehabilitation Program/Unit: Level 2 8 Palliative Care Program 5x Approved Mental Health Service or Psycho geriatric 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-site 0 Alcohol and Drug Program 4 Other care (Acute) including Qualified newborn U Unqualified newborn
Qualification Status	Qualification status indicates whether each patient day within a newborn episode of care is either qualified or unqualified. N Qualified Newborn U Unqualified Newborn X Not Applicable

Admission type	The type of admission relating to this episode of care: K Posthumous Organ Procurement S Statistical admission (change in Care Type within this hospital) Y Birth episode M Maternity C Emergency admission through Emergency Department at this hospital (VEMD reporting hospitals only) L Admission – from the Waiting List (ESIS reporting hospitals only) O Other emergency admission X Other admission
Admission type indicator	Admission type indicator derived from Admission type E Emergency L Elective M Maternity N Newborn (<= 9 days old) S Statistical
Criterion for Admission	This field indicates the criterion for admission for the episode of care. K Posthumous Organ Procurement N Qualified newborn U Unqualified newborn R Restorative Care: Off-site 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
Intended duration of stay	The intention of the responsible clinician, at the commencement of the episode, to discharge the patient either on the day of admission or a subsequent date. 1 Intended Same Day Stay 2 Intended Stay of Overnight (or Longer)
Admission weight	The birth weight of the live baby or the weight of the neonate or infant (under one year of age) on the date admitted, if this is different from the date of birth.
Barthel index on admission	The Barthel Index is a measure of the type and amount of assistance a patient requires for performing basic functional activities. It is reported within 48 hours of admission for Care Type 6 only and is numeric in the range: 000 to 100.
FIM Score on Admission	Functional Independence Measure (FIM™) Score, as assessed on admission. Only reported for Sub-acute records. Reported for Care Type 2, 6, 9, R1 and R2. The 18 different items contain a score between 1-7. Refer to the VAED manual for more information.
Admission/readmission to rehabilitation	For Care Types P, 2 and 6 this field indicates whether this is the first or subsequent rehabilitation episode for a particular injury/condition. 0 First rehabilitation admission

	1 Readmission for rehabilitation

RUG ADL on admission	RUG ADL (Resource Utilisation Groups Activities of Daily Living) score as assessed on admission. Cumulative score out of 18.
Source of referral to palliative care	Source of referral to the DH Palliative Care Program (Care Type 8). 01 Community sector – GP 02 Community sector – Specialist 03 Community sector - Self, Carer, Other (family member, neighbour) 04 Community sector- Community based agency 05 Hospital - Public - Admitted patient 06 Hospital - Private - Admitted patient 07 Hospital - Outpatient - Non-admitted 08 Residential care - Nursing home/hostel 09 Other

Demographic data	
Data Field Description	**Definition**
5 Year age groups	Five year age groups: 00-04 05-09 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75-79 80-84 85+
Sex of patient	The sex of the patient: 1 Male 2 Female 3 Indeterminate (only for infants < 90 days old) 4 Intersex
Statistical local area (5 digit)	The patient's Statistical Local Area of residence. Based on Australian Standard Geographical Classification (ASGC) 2009 boundaries and derived from the locality and postcode.
Local government area	The patient's Local Government Area of residence. Based on Australian Standard Geographical Classification (ASGC) 2004 boundaries for Victoria, and 1999 boundaries for the rest of Australia.
Region of residence	The code for the Department of Health/Human Services Region in which the patient resides; derived from the field 'SLA'. 1 Barwon South Western 2 Grampians 3 Loddon Mallee 4 Hume 5 Gippsland 8 Eastern 9 Southern A North-Western I Interstate M Missing
State of residence	State of patient residence derived from SLA: 0 Unknown/Itinerate/Overseas 1 New South Wales 2 Victoria

	3 Queensland 4 South Australia 5 Western Australia 6 Tasmania 7 Northern Territory 8 Australian Capital Territory 9 Other Territories
Carer availability	A record of whether a person, such as a family member, friend or neighbour has been identified as providing regular on-going care or assistance, which is not linked to a formal service. 1 Carer not needed/ not applicable 2 Lives alone, has a carer 3 Lives alone, has no carer 4 Lives with another, has no carer 5 Lives with another, has a resident carer 6 Lives with another, has a non-resident carer 7 Lives in a mutually dependent situation 8 Missing or not recorded
Hospital Region	Metropolitan/Rural flag of hospitals.

Separation data	
Data Field Description	**Definition**
Month of separation	Month of separation, eg Jul, Aug
Year of separation	Year of episode separation, e.g. "2010-11".
Length of stay	The length of stay is calculated during the PRS/2 processing, summing the total patient days in each of the status segments *minus* leave with and without permission days.
Length of stay type	Type of stay, derived from LOS field: M Multi day stay S Same day stay (admitted & separated on same day) O Overnight stay.
Sameday separation flag	Flag indicating if the separation was a sameday episode (admission date equal to separation date): Y Yes (sameday) N No (non sameday)
Contract leave days total	The total number of days during this episode of care that the patient was out of the hospital "on contract leave" including days from previous financial year(s).
Hospital in the home length of stay	Hospital in the Home Length of Stay.
Hospital in the Home separation	Flag to indicate that the episode includes a "Hospital In The Home" component.
Leave With Permission Days Total	The total number of days during the current episode that the patient was out of hospital on "normal" leave, including days from the previous financial year(s). Used in calculating *LOS*.
Leave Without Permission Days Total	The total number of days during this episode of care that the patient was out of hospital 'on leave without permission', including days from the previous financial year(s).

Intention to readmit	For formal separations (other than death, transfer or left against medical advice) this field indicates the intention of the responsible clinician, at the time of patient's separation from hospital, whether that patient will be readmitted within 28 days to either this or another acute hospital. 0 Not applicable (statistical separations, death, transfers and left against medical advice) 1 Readmission planned to this hospital within 28 days and booking arranged 2 Readmission planned to this hospital within 28 days but no booking yet arranged 3 Readmission planned to another acute hospital within 28 days and booking arranged 4 Readmission planned to another acute hospital within 28 days but no booking yet arranged 9 No plan to readmit within 28 days
Patient type	Patient type derived from Separation Account: H Public P Private S Compensable V DVA X Ineligible
Duration of unit stay	Identifies the duration of stay within a specific campus unit. E Entire admission was at the specified campus unit P Part of the admission was at the specified campus unit.
Accommodation type on separation	The accommodation occupied by the patient on their last (counted) patient day.
Barthel index on separation	The Barthel Index on separation is assessed on the day on which the decision is taken to cease rehabilitation (for Care Type 6 only).
FIM Score on Separation	Functional Independence Measure (FIM™) Score, as assessed on separation. Only reported for Sub-acute records. Reported for Care Type 2, 6, 9, R1 and R2. Refer to *'FIM score on admission'* variable for table of code details.
RUG ADL on separation	RUGADL (Resource Utilisation Groups Activities of Daily Living) score as assessed on separation (for Care Type 8). Cumulative score out of 18.

Diagnosis and procedure data	
Data Field Description	**Definition**
Victorian Adjusted AR-DRGv6	Victorian Adjusted Australian Revised Diagnosis Related Group v6.0x is the same as AR-DRG v6 except where adjustments are made utilising the Vic DRG v 6.0 x fields, for the purposes of casemix payments.

Victorian adjusted AR-MDCv6	The Australian Revised Major Diagnostic Category (AR-MDC) Version 6.0 is derived through the same grouping process as the AR-DRG v6.
Clinical speciality	Clinical speciality mapped from VIC. DRG (665 DRGs mapped into 27 Clinical Specialties): 01 Neurosurgery 03 Vascular 04 Orthopaedics 05 Neurology 06 Ophthalmology 07 ENT 08 Cardio-thoracic 09 Cardiology 10 Rehabilitation 11 Dental 12 Rheumatology 13 Plastics 14 General Medicine 15 Psychiatry 16 General Surgery 17 Nephrology 18 Renal Dialysis 19 Urology 20 Gynaecology 21 Obstetrics & Ante-natal 22 Neonatology 23 Haematology 24 Respiratory 25 Oncology/Radiology 26 Endocrinology 27 Gastroenterology 28 Other/Ungroupable
DRG Type	DRG type: M Medical S Surgical O Other
DRG Coding status	Coding status of separation records: C Coded P Problem DRG (AR-DRG 6.0: 801A, 801B, 801C) <Blank> Not Coded
First external-cause activity	The first diagnosis code in the range U50 – U73.
First external-cause place of occurrence	The first diagnosis code commencing with Y92.
Principal external-cause	If the first diagnosis is an injury or poisoning, i.e. in the range S00 to T98, then the principal external cause is the first code in the range of V01 to Y91 or Y95 to Y98.
Principal external-cause activity	If the first diagnosis is an injury or poisoning i.e. in the range S00 to T98, and principal external cause in range V01-Y34, then activity is the first diagnosis code in the range U50 – U73.
Principal external-cause place of occurrence	If the first diagnosis is an injury or poisoning, i.e. in the range S00 to T98, and principal external cause in range V01 – Y89, then "place of occurrence" is the first diagnosis code commencing with Y92.

Lithotripsy separation flag	Flag to identify separations involving lithotripsy. (AR-DRG 5.2 L42Z): Y Yes N No
Renal flag	Flag identifying separations involving dialysis. ARDRG6.0 L61Z Renal (Extracorporeal) Dialysis (WIES funded) & ARDRG6.0 L68ZPeritoneal Dialysis (not WIES funded). Y Yes N No
Duration of stay (hours) in intensive care unit	Total duration of stay (hours) in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU), during this episode of care. Duration is reported in hours, rounded up to the nearest hour.
Duration of Mechanical Ventilation in ICU	Total duration of Mechanical Ventilation (MV) in hours provided in an approved Intensive Care Unit (ICU) or Neonatal Intensive Care (NICU) during this episode of care.
Duration of stay (hours) in Coronary Care Unit (CCU)	The total duration of stay (hours) in an approved Cardiac/Coronary Care Unit (CCU) during this episode of care. If the patient has more than one period in a CCU during this episode, the total duration of all such periods is reported.
Duration of Non Invasive Ventilation	Total number of hours of non-invasive ventilatory assistance given via any route other than intubation or tracheostomy, provided to patients in an approved Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN) or Intensive Care Unit (ICU).
Clinical Sub-program	The diagnosis, based on the body system manifesting the reason for rehabilitation. Reported for Care Types 2, 6, P, R1 and R2. Clinical Sub-Program is assigned by the treating clinician.
Impairment	A code assigned, based on the body system manifesting the reason for rehabilitation. Only reported for Sub-acute records. Reported Care Type 2, 6, P, R1 and R2. Introduction of Version 1 Australian Impairment code set for Sub-Acute episodes as an optional field.

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List of Data Fields

RESTRICTED DATA FIELDS
Public hospital data only

Admission data	
Data Field Description	**Definition**
Accommodation type during admission	The Accommodation Type(s) occupied by the patient during the admission, including changes to this item. 1 Overnight accommodation - shared room 2 Overnight accommodation - single room 3 Same Day accommodation 4 In the Home (Hospital - HITH) 6 Emergency Department accommodation 7 Ward Based / Medi hotel combination B *Other Nursery* accommodation or mother's bedside (rooming in) C Nursery accommodation: NICU/SCN M Medical Assessment and Planning Unit (MAPU) S Short Stay Observation Unit (SOU)
Mental Health legal status	A funding-source indicator for involuntary patients: 1 Involuntary for all or part of this episode 2 Not involuntary at any time during this episode 9 Not Applicable
Admission Source	Describes where the patient was residing or living prior to the commencement of an episode of care. K Posthumous Organ Procurement S Statistical Admission (change in Care Type within the hospital) Y Birth episode T Transfer from acute hospital/extended care/rehabilitation/geriatric centre B Transfer from Transition Care bed based program A Transfer from mental health residential facility N Transfer from aged care residential facility H Admission from private residence/accommodation

Demographic data	
Data Field Description	**Definition**
Age in years	Admission age in years.
Age in months	Age in calendar month at time of admission. Only calculated if AGE in years is "0".
Campus code	Indicates the hospital campus where the episode of care was provided. Patient activity must be reported under the campus code at which it occurred.
Name of campus	Unique hospital site (Campus) name.
Interpreter Required	The patient's need for an interpreter, as perceived by the patient or person consenting for the patient. 1 Yes

	2 No 9 Not Stated/Inadequately described
Marital status	The current marital or living status of the patient at the time of admission: 1 Never married 2 Widowed 3 Divorced 4 Separated 5 Married 6 De Facto 9 Not stated/inadequately described
Preferred Language	The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

Separation data	
Data Field Description	**Definition**
Aged Care Assessment Service	The type of involvement of the Aged Care Assessment Service (ACAS) patient discharge. 1 ACAS Assessment completed during this episode 2 ACAS assessment incomplete: referral to Sub- acute services 3 ACAS assessment incomplete: other reason 4 ACAS consultation only during this episode 5 No ACAS involvement during this episode
Transfer Source (FROM)	Identification of the hospital campus the person has been transferred from, following separation from that hospital.
Account class on separation	The patient account classification on separation.
Transfer destination (TO)	Identification of the hospital campus to which the patient is transferred after separation from this hospital.
WIES	Total Weighted Inlier Equivalent Separations including co-payments.
WIES fundable flag	Indicates if the *separation* was WIES fundable: Y Yes N No U Uncoded (but eligible for WIES funding when coded)
Separation Mode	Type of separation: G Posthumous Organ Procurement S Statistical Separation (change in Care Type within this hospital) D Death Z Left against medical advice T Separation and transfer to other acute hospital/extended care/rehabilitation/geriatric centre B Separation and transfer to Transition Care bed based program A Separation and transfer to mental health residential facility N Separation and transfer to aged care residential facility H Separation to private residence/accommodation

Separation referral	Clinical care and support services arranged by the hospital to meet the person's recuperative needs when discharged to private accommodation or home. Up to four referrals can be transmitted in the one field. 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

Diagnosis and procedure fields	
Data Field Description	**Definition**
Tertiary status	A clinical-complexity grading of DRGs: 1 Primary (least complex) 2 Secondary 3 Tertiary (most complex).
Victorian prefix to ICD-10-AM Diagnosis codes	Single character prefix to ICD-10-AM diagnosis codes. In the first field, the character will be P. For the remaining 39 fields, if a diagnosis code is present, the corresponding TPREF field will contain one of the following codes: P Primary diagnosis A Associated condition

	C Complication M Morphology
ICD-10-AM Diagnosis	Diagnoses codes (as reported by the medical practitioner) reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care. One principal diagnosis and up to 39 other diagnoses can be reported, using the International Classification of Diseases, 10th Revision, Australian Modification (ICD-10-AM) 7th Ed., in accordance with the Australian Coding Standards (ACS) & Victorian Additions to the Australia Coding Standards.
Procedure block number	A one to four digit number that identifies a group of related procedure codes.
ACHI Procedure	Procedure codes reflecting the interventions used for the diagnosis and/or treatment of ill health during this episode of care. Up to 40 codes can be reported using Australian Classification of Health Interventions, 7th Ed, in accordance with the Victorian Additions to the Australia Coding Standards.