Section 3 – Data elements

Victorian Integrated Non-Admitted Health (VINAH) minimum dataset manual


Version 2.0
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Victorian Integrated Non-Admitted Health (VINAH) minimum dataset manual
Version 2.0
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Information about each data element is presented in the following structured format:

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**Data element name**

Valid values include:

**Definition:**
A statement that expresses the essential nature of a data element and its differentiation from all other data elements.

**Form:**
The name of the form of representation for the data element.

Valid values include:

**Temporal forms**
- **Date:** A date value. A date value must never have a time component.
- **Time:** A time value. A time value must never have a date component.
- **Date and Time:** A combined date and time value. A combined date and time value. Note that a Date/Time may be provided with a lower precision, for example, if business rules permit a Date/Time value may omit the time component.

**Numeric forms**
- **Integer:** A quantitative value that must be reported as a whole number.
- **Real:** A quantitative value that must be reported as a real number.
  The Layout attribute will provide details on required precision.

**Character forms**
- **Identifier:** A number or set of characters that identifies something or someone.
- **Text:** A string of text, not further defined.
- **Name:** A name of something or someone.
- **Code:** A name of something or someone.
- **List:** A pre-defined set of values that have meaning in their own right.
  The qualifier ‘Structured’ may be added to indicate data structure.
  The qualifier ‘Repeatable’ may be added to indicate that multiple values may be provided.

Note: This section should be read in conjunction with Section 5 for information on implementation of repeatable values for transmission.

**Repeats:**
The minimum and maximum number of times that a data element may have repeating values, and whether or not duplicate values are permitted.

If there is no enforced maximum value, this will state ‘No limit’.

Note that a data element with an enumerated form (code or list) that is not allowed to have duplicates has a practical upper limit of the number of codes or list items in its value domain, even if no upper limit is enforced.

**Size:**
For Character forms, the minimum and maximum number of characters used to represent this data element.

For Numeric forms, the minimum and maximum values which the data element may take.

Where this is a temporal form this will be blank.

Where there is no defined minimum or maximum this will state ‘No limit’.
Note that the Section 3 data elements may restrict the field size to a tighter specification than that allowed by the transmission protocol rules.

**Layout:**

The layout of characters for the data element, expressed by a character string representation.

Note that in some episodes the Section 3 data elements may restrict the layout to a tighter specification than that allowed by the transmission protocol.

- Y Year
- M Month
- D Day date
- H Hour
- M Minute
- S Second
- ± Plus or Minus
- Z Time zone

**Numeric and Character Forms**

- N A numeric digit (0,1,2,3,4,5,6,7,8,9)
- . A decimal point
- A A letter of the alphabet (A-Z, a-z)
- U A letter of the alphabet, upper case only (A-Z)
- L Letter of the alphabet, lower case only (a-z)
- X Any alpha, numeric or other character such as spaces, apostrophes and hyphens

**Other Conventions**

- Square brackets ‘[]’ indicate optional components.
- Parentheses ‘( )’ enclosing a number indicate the number of repeats of the character immediately preceding the parentheses. Two numbers separated by a dash indicates the maximum and minimum number of repeats
- Parentheses enclosing ellipses ‘(...)’ indicate that the character immediately preceding the parentheses may repeat an unspecified number of times, this may be combined with a number and dash, for example the layout attribute string ‘A(5-...)’ indicates a minimum of 5 alpha characters with no maximum.
- Double quotes “” enclosing a string of characters indicates those characters are to be treated as literals within the layout string.

**Location:**

The location in the relevant transmission protocol where this data element is transmitted to the VINAH MDS and the associated transaction. See Section 5.

**HL7**

For HL7, the location is presented in the format: `<Message> (<Segment>\<Field Location>)`.

Field Location will include as many composite data types as needed to specify the final location.

Note that only authorised submitters may transmit this format. The department is phasing out support for this format and vendors and health services should not assume any further health services will be authorised to transmit flat files. Further, as this format does not fully support all VINAH functionality, it is unsuited to ongoing reporting and would only be authorised in situations where a health service has a need to ‘catch up’ on reporting a substantial amount of historical data.

**Reported by:**

The programs required to collect and report this data element.

**Reported for:**

The specified circumstances in which this item must be reported.
**Reported when:** The stage in the data submission cycle when this data element is to be reported to VINAH.

**Value domain:** All data transmission must be in accordance with the transmission schedule specified in Section 5 and the Policy and Funding Guidelines.

**Reporting guide:** Section 5 and the Policy and Funding Guidelines.

**Validations:** Where a validation rule relates specifically to the data element, it will be listed here.

Note that general validation rules that may be applied to the data element but do not relate specifically to it are not listed. These include:

- E001, E002, E003 - which relate to whether the data element is mandatory or prohibited within the context of VINAH or a specific Episode Program/Stream;
- E004 - which is applied to all data elements with an enumerated code set;
- E005 - which applies when a specific code is prohibited within an Episode Program/Stream;
- E006 - which indicates that the data element is of the wrong data type and is particularly relevant to dates.
- E007, E008 - which indicate that a date is in the future.
- E011 - which indicate that the data supplied does not match the required layout.
- E012 - which indicates that the data repeats a number of times that is not permitted.

There are a number of validation rules that may be applied to a VINAH transmission that do not relate to any data elements, for example, edit HL7006-File must have equal number of BHS/BTS segments.

**Related items:** A list of related data elements Business Rules Tables, Concept Definitions and Supplementary Code Lists that affect the assignment of a value for this data element.

**Administration**

**Purpose:** The main reason/s for the collection of this data element.

**Principal users:** Identifies the primary user/s of the data collected.

**Version history:** Provides information regarding modifications made to the data element. Listed are a version number, beginning with 1 and incremented by 1 for each subsequent revision as well as an effective date, describing the date the modification came into effect.

**Definition source:** Identifies the authority that defined this data element.

**Value domain source:** Identifies the authority that developed the value domain for this data element.
Summary Tables for Data Elements

Data Elements to be reported by Program

The table below provides a reference of the business data elements that are to be reported by the various programs reporting to the VINAH MDS.

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<th>FCP</th>
<th>HARP</th>
<th>HBPCCT</th>
<th>Medi-Hotel</th>
<th>Specialist Clinics</th>
<th>Palliative Care</th>
<th>PAC</th>
<th>RIR</th>
<th>SACS</th>
<th>TCP</th>
<th>VRSS</th>
<th>VHS</th>
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Business Data Element Timing Summary

The following table provides a summary, for each business data element, of when it should be reported to the VINAH MDS. Note that data elements are only mandatory (and other reporting options) at a particular point in time when they are required for the program that is being reported. See Data Elements to be reported by Program for further information.

Note that for Programs/Streams where Contact/Client Service Event Client Present Status may be reported as ‘32- Patient/Client/Carer(s)/Relative(s) not present: Scheduled appointment not attended’, the reporting requirements for First Contact/Client Service Event Date/Time apply to the first contact/client service event that does not have this value.

The column ‘Episode TCP Care Transition Date’ means both ‘Episode TCP Bed-Based Care Transition Date’ and ‘Episode TCP Home-Based Care Transition Date’.

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<td>Report when Patient/Client Carer Availability = ‘1’</td>
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<td>Report when and only when Contact Account Class = ‘VX’, ‘TA’ or ‘WC’</td>
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<td>Report when and only when Account Contact Class = ‘WC’</td>
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<td>C6</td>
<td>Report when Contact Client Present Status = ‘10’, ‘11’ or ‘12’ (patient/client present)</td>
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<td>C7</td>
<td>Must be specified if a care plan was documented during the course of the Episode</td>
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<td>Must be reported if Episode Proposed Treatment Plan Completion = ‘27’ or Program is Palliative Care</td>
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<td>C10</td>
<td>Must be specified for HARP programs, optional for all others</td>
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<td>Must be specified if an advance care plan was documented previously or during the course of the Episode</td>
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<td>C12</td>
<td>Either Episode TCP Bed-Based Care Transition Date or Episode TCP Home-Based Care Transition Date must be reported</td>
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<td>C13</td>
<td>Must be specified if Contact Session Type = ‘2’</td>
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<td>C16</td>
<td>Mandatory for Specialist Clinics when Referral In Outcome is reported, and is not ‘98’ or ‘99’</td>
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<td>Mandatory for TCP when episode has an end date</td>
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## All Programs, not elsewhere specified

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### All Programs, not elsewhere specified

| DATA ELEMENT                                                                 | Referral In Receipt Acknowledgement Date | Referral In Received Date | Episode Start Date | Episode Patient/Client Notified of First Apppt Date | Episode Care Plan Documented Date | Episode TCP Care Transition Date | First Contact Date/Time | Second and Subsequent Contact Date/Time | Episode End Date | Referral Out Date | Patient/Client Death Date | Patient/Client Death Date Accuracy | Patient/Client Carer Availability | Patient/Client Carer Residency Status | Patient/Client Carer Availability | Patient/Client Carer Residency Status | Patient/Client Death Date | Patient/Client Death Date Accuracy | Patient/Client Death Place | Patient/Client DVA File Number | Patient/Client Identifier | Patient/Client Living Arrangement | Patient/Client Main Carer’s Relationship to the Patient | Patient/Client Sex | Patient/Client Usual Accommodation Type | Patient/Client Usual Residence Locality Name | Patient/Client Usual Residence Postcode | Referral In Clinical Referral Date | Referral In Clinical Urgency Category | Referral In Outcome | Referral In Program/Stream | Referral In Receipt Acknowledgment Date |
|-----------------------------------------------------------------------------|------------------------------------------|---------------------------|--------------------|-----------------------------------------------------|----------------------------------|----------------------------------|--------------------------|---------------------------------|-------------------|--------------------------|---------------------------------|---------------------------------|---------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
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Data Element Obligation by Transmission Protocol

The table below provides a summary, for each transition or other affected data element, of whether it must be reported to the VINAH MDS based on the transmission protocol in use.

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<td>Mandatory</td>
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<tr>
<td>M1</td>
<td>Primary key for Episodes; Foreign Key for Referrals Out and Contacts</td>
</tr>
<tr>
<td>M2</td>
<td>Primary key for Referrals; Foreign Key for Episodes</td>
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<tr>
<td>M3</td>
<td>The text component may be omitted and just the number supplied. e.g.: 'VINAH11' and '11' are both acceptable.</td>
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<tr>
<td>M7</td>
<td>Mandatory (required by HL7 standard)</td>
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<tr>
<td>O</td>
<td>Optional</td>
</tr>
<tr>
<td>C1</td>
<td>Required for the Send File transaction; optional for all others</td>
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<tr>
<td>C2</td>
<td>Required if the Transaction Type is 'M'</td>
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<tr>
<td>C3</td>
<td>Required for Reporting Organisation node, optional for other nodes. If omitted on the Reporting Organisation node, assumed to be 'N'</td>
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<td>DATA ELEMENT</td>
<td>HL7</td>
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<td>-------------------------------------------------</td>
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<td>Contact Identifier</td>
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<td>Contact Person Name Type</td>
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<td>Contact Professional Group Sequence Number</td>
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<td>Episode Identifier</td>
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<td>Episode Pathway Type</td>
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<td>File Processing Directive</td>
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<td>Message Accept Acknowledgement Code</td>
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<td>Message Type</td>
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<td>Message Version Code</td>
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<tr>
<td>Message Visit Indicator Code</td>
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<td>Patient/Client Prior Identifier</td>
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<tr>
<td>Procedure Bound Data Element</td>
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<td>Referral Identifier</td>
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<td>VINAH Version</td>
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Part I: Business Data Elements

Contact Account Class

**Definition:** The agency/individual chargeable for this contact and associated sub categories.

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<thead>
<tr>
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<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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**Location:**
- **Transmission protocol:** HL7 Submission
- Contact (insert) ADT_A03 (PV1\PV1.20\FC.1)
- Contact (update) ADT_A08 (PV1\PV1.20\FC.1)
- Contact (delete) ADT_A13 (PV1\PV1.20\FC.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified
- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - First Contact Date/Time (Mandatory)
  - Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

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<thead>
<tr>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>MP</td>
<td>Public eligible</td>
</tr>
<tr>
<td>ME</td>
<td>Ineligible: hospital exempt</td>
</tr>
<tr>
<td>MF</td>
<td>Ineligible: asylum seeker</td>
</tr>
<tr>
<td>MA</td>
<td>Reciprocal health care agreement</td>
</tr>
<tr>
<td>PI</td>
<td>Private patient: insured</td>
</tr>
<tr>
<td>PO</td>
<td>Private patient: other payer</td>
</tr>
<tr>
<td>PS</td>
<td>Private patient: self-funded</td>
</tr>
<tr>
<td>QM</td>
<td>Private clinic: MBS funded</td>
</tr>
<tr>
<td>QT</td>
<td>Commonwealth funded: TCP</td>
</tr>
<tr>
<td>VX</td>
<td>Department of veterans' affairs (DVA)</td>
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<tr>
<td>AS</td>
<td>Armed services</td>
</tr>
<tr>
<td>OO</td>
<td>Other compensable</td>
</tr>
<tr>
<td>WC</td>
<td>WorkSafe Victoria</td>
</tr>
<tr>
<td>TA</td>
<td>Transport accident commission (TAC)</td>
</tr>
<tr>
<td>SS</td>
<td>Seamen</td>
</tr>
</tbody>
</table>
CL Common law recoveries
JP Prisoner
XX Other non-compensable

**Reporting guide:** **MP - Public eligible**
An eligible person who elects to be treated as a public patient. The hospital provides comprehensive care including all necessary medical, nursing and diagnostic services and, if available, dental and paramedical services, by means of its own staff or by other agreed arrangements, without charge to the patient.

Includes:
- Persons holding a current Interim Medicare Card.
- Persons treated in a specialist public outpatient clinic not funded through VACS or a Specified Grant.
- Persons treated under the Transition Care Program who have exceeded the Commonwealth-funded care period and are now funded by the Victorian government.

Excludes:
- Persons holding an expired Interim Medicare Card (report 'XX-Ineligible')
- A person where the clinician bulk bills Medicare for the patient’s treatment (report 'QP-Private Clinic: MBS funded').
- Persons treated under the Transition Care Program who are funded by the Commonwealth government (Use code 'QT').

**ME - Ineligible: hospital exempt**
An ineligible non Australian resident:
- Specifically referred to Australia for hospital services not available in the patient’s own country and for whom the Secretary of the Department has determined that no fee be charged; or
- Who has been declared a safe haven resident and whose treatment is provided or arranged by a designated hospital.

**MF - Ineligible: asylum seeker**
A Medicare ineligible asylum seeker.

**MA - Reciprocal health care agreement**
A visitor to Australia who is ordinarily resident in a country with which Australia has a Reciprocal Health Care Agreement (RHCA), who receives a non-admitted service for necessary medical treatment (but only as a public patient), as is clinically necessary for the diagnosis, alleviation or care of the condition requiring attention, on terms no less favourable than would apply to a resident.

**PI - Private patient: insured**
A patient/client who holds an insurance policy with an Australian Registered Health Fund, and where the intended treatment of the patient is wholly or partly covered by that fund.

**PO - Private patient: other payer**
A patient/client who elects to be treated as a private patient but a third party is wholly or partly funding the intended treatment of the patient.

Includes:
- Travel insurance
- Insurance with a non-Australian Registered Health Fund
- Pharmaceutical company

**PS - Private patient: self-funded**
A patient/client who elects to be treated as a private patient but who does not hold an insurance policy with an Australian Registered Health Fund or other external...
payer, and therefore is personally responsible for paying the charges referred to in clause 49 of the 2003-08 Australian Health Care Agreement.

QM - Private clinic: MBS funded
Includes:
- Persons in-scope for reporting whose treatment is funded through Medicare under a right-of-private-practice arrangement.

QT - Commonwealth funded: TCP
Includes:
- Patients/clients approved by an Aged Care Assessment Team for Commonwealth-funded Transition Care Program and who have not exceeded the Commonwealth-stated outlier period on the program.

Excludes:
- Patients/clients receiving TCP who have exceeded the Commonwealth-stated outlier period and are now funded by the Victorian government (use code MP).

AS - Armed services
An eligible person whose charges for this contact are met by the Department of Defence.

OO - Other compensable
An eligible person who is entitled under a law that is or was in force in Victoria, other than Veterans’ Affairs legislation, Transport Accident Commission, WorkSafe Victoria, Armed Services, Seamen, or Common Law Recoveries, to the payment of, or who has been paid compensation for, damages or other benefits (including a payment in settlement of a claim for compensation, damages, or other benefits) in respect of the injury, illness or disease for which he/she is receiving hospital services.

Clause 49 of the Australian Health Care Agreement states ‘Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria.’

WC - WorkSafe Victoria
An eligible person who is entitled under a law that is or was in force in Victoria to the payment of, or who has been paid compensation for, damages or other benefits in respect of an injury by the WorkSafe Victoria (Victorian WorkCover Authority).

TA - Transport Accident Commission (TAC)
An eligible person who is entitled under a law that is or was in force in Victoria to the payment of, or who has been paid compensation for, damages or other benefits in respect of an injury by the Transport Accident Commission.

JP - Prisoner
A person who is currently in the custody of Correctional Services in Victoria.
- Prisoners may be transferred to a public hospital for treatment on an admitted or non-admitted basis. Funding for these services is not provided by the Commonwealth through the Australian Health Care Agreement. Hence, DHHS does not recognise these patients for casemix or VACS payments. Funding for prisoners' health care is provided to prison authorities by the Department of Justice and prison authorities are responsible for meeting all costs incurred by hospitals in the treatment of such patients.
- Hospitals are required to bill ‘Australian Correctional Management’ directly.
XX - Other non-compensable
A person who is not eligible for Medicare and therefore not exempted from fees. Includes:

- Persons holding expired interim Medicare cards (these patients should be billed for services).
- Clause 49 of the Australian Health Care Agreement states ‘Private patients, compensable patients and ineligible patients may be charged an amount for public hospital services as determined by Victoria’.

Validations:

- **E356** Contact is Compensable (<AccountClass>) but there is no client identifier
- **E357** A Patient/Client's Legal Family Name or Given Names are provided but Account Class is not VX (DVA) or TA (TAC) or WC (VWA)
- **E358** Account Class is VX (DVA) or TA (TAC) or WC (VWA), but the Patient's Legal Name or Given Names are not provided
- **E368** Contact Account Class (AccountClass) is incompatible with Patient/Client Medicare Number (<medicare_number>).

Related items:
- Contact Client Medicare Number
- Contact Date/Time
- Contact Family Name
- Contact Given Name(s)
- Contact TAC Claim Number
- Contact VWA File Number
- Patient/Client DVA File Number

Administration

Purpose: To assist in analyses of utilisation to facilitate reimbursement by third party paying organisations for patients/clients with entitlements.

Related items: Department of Health and Human Services

Version history:

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<td>Contact/Client Service Event Account Class</td>
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<tr>
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Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
**Contact Care Model**

**Definition:** The model of care in use when the palliative care contact takes place.

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<tr>
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<tr>
<td>Contact (delete)</td>
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**Reported by:** Palliative Care

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

First Contact Date/Time (Mandatory)
Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

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<tr>
<td>2</td>
<td>Shared care</td>
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<tr>
<td>3</td>
<td>Consultancy care with ongoing patient/client follow-up</td>
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<tr>
<td>4</td>
<td>Consultancy care with no further planned follow-up</td>
</tr>
<tr>
<td>8</td>
<td>Unknown, not stated or question not asked</td>
</tr>
<tr>
<td>9</td>
<td>Not applicable – patient/client not present</td>
</tr>
</tbody>
</table>

**Reporting guide:** This data item refers to the model of care being used to meet the patient/client’s palliative care needs.

1 - Direct care/complete care

The patient/client or carer/family/friend identifies this service as the service that is responsible for meeting their palliative care needs at this time. While other services or health professionals may be involved, the patient/client does not identify them as being responsible for meeting their palliative care needs at this time.

2 - Shared care

The patient/carer identifies this service as one of at least two services or health professionals that are sharing responsibility for meeting their palliative care needs at this time. Partners in the patient’s/client’s care may include their general practitioner, primary care nurses or other specialist services.

3 - Consultancy care with ongoing patient/client follow-up

The patient/client identifies another service or health professional (e.g. general practitioner, hospital, primary care nurse) as the service that is responsible for meeting their palliative care needs at this time. The community palliative care service is providing advice, back-up and/or support. The community palliative care service has ongoing planned involvement with a patient/client and/or their treating clinicians.
4 - Consultancy care with no further planned follow-up
The patient/client identifies another service or health professional (e.g. general practitioner, hospital, primary care nurse) as the service that is responsible for meeting their palliative care needs at this time. The community palliative care service is providing advice, back-up and/or support. The community palliative care service undertakes a comprehensive palliative care assessment and there is no planned review or involvement with the patient/client and/or their treating clinicians.

8 - Unknown, not stated or question not asked
Report this code in the instance where a clinician is unavailable or it is not possible to determine the phase of care.

9 - Not applicable - patient/client not present
Report this code when the value of Contact/Client Service Event Client Present Status is not ‘11’ and not ‘12’.

Validations: E363 <Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting > is <9-Not applicable – patient/client not present’ |’5 – Bereavement Phase’|’98-Not applicable – patient/client not present’> but Contact Client Present Status is ‘11- Patient/Client present only’,’12- Patient/Client present with carer(s)/relative(s)’ or ‘13 - Patient/Client via telehealth’

E364 Where Contact Client Present status is ‘20 - Carer(s)/Relative(s) of the patient/client only’ or ‘31 -Patient/Client/Carer(s)/Relative(s) not present: Indirect Contact’, <Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting> must be ’9-Not applicable – patient/client not present’ |’5 – Bereavement Phase’|’98-Not applicable – patient/client not present’>

Related items: Contact Care Phase
Contact Date/Time
Contact Preferred Care Setting
Contact Preferred Death Place

Administration

Purpose: To assist with outcome analyses and service planning, and meeting national reporting requirements.

Principal users: Department of Health and Human Services

Version history:

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Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
**Contact Care Phase**

**Definition:** The phase of care when the palliative care contact takes place.

**Repeats:**

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**Location:**

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<th>Transmission protocol:</th>
<th>HL7 Submission</th>
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<tbody>
<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PV2\PV2.40\CE.1)</td>
</tr>
<tr>
<td>Contact (update)</td>
<td>ADT_A08 (PV2\PV2.40\CE.1)</td>
</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PV2\PV2.40\CE.1)</td>
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</table>

**Reported by:** Palliative Care

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

Table identifier: HL70432

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<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>1</td>
<td>Stable phase</td>
</tr>
<tr>
<td>2</td>
<td>Unstable phase</td>
</tr>
<tr>
<td>3</td>
<td>Deteriorating phase</td>
</tr>
<tr>
<td>4</td>
<td>Terminal phase</td>
</tr>
<tr>
<td>5</td>
<td>Bereavement phase</td>
</tr>
<tr>
<td>8</td>
<td>Unknown, not stated or question not asked</td>
</tr>
<tr>
<td>9</td>
<td>Not applicable – patient/client not present</td>
</tr>
</tbody>
</table>

**Reporting guide:**

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.
5 - Bereavement phase
The bereavement phase can only be entered once the patient has deceased. The carer(s)/family/friends can only receive grief and bereavement support during this phase. Report this code when the value of Contact Client Present is ‘20’ (Carer(s)/Relative(s) of the patient/client is deceased).

8 - Unknown, not stated or question not asked
Report this code in the instance where a clinician is unavailable or it is not possible to determine the phase of care.

9 - Not applicable – patient/client not present
Report this code when the value of Contact/Client Service Event Client Present Status is not ‘11’ and not ‘12’.

Validations:
E363 <Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting> is <‘9-Not applicable – patient/client not present’ |‘5 – Bereavement Phase’ |‘98-Not applicable – patient/client not present’> but Contact Client Present Status is ‘11-Patient/Client present only’, ‘12-Patient/Client present with carer(s)/relative(s)’ or ‘13 - Patient/Client via telehealth’

E364 Where Contact Client Present status is ‘20 - Carer(s)/Relative(s) of the patient/client only’ or ‘31 -Patient/Client/Carer(s)/Relative(s) not present: Indirect Contact’, <Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting> must be ‘9-Not applicable – patient/client not present’ |‘5 – Bereavement Phase’ |‘98-Not applicable – patient/client not present’>

Related items:
Contact Care Phase
Contact Date/Time
Contact Preferred Care Setting
Contact Preferred Death Place

Administration
Purpose: To assist with outcome analyses and service planning, and meeting national reporting requirements.

Principal users: Department of Health and Human Services

Version history:
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<th>Version</th>
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<th>Effective Date</th>
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<tr>
<td>3</td>
<td>Contact Care Phase</td>
<td>2014/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Contact Care Phase</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Contact/Client Service Event Phase of Care</td>
<td>2009/07/01</td>
</tr>
</tbody>
</table>

Definition source: Proposed Pall Care NMDS

Value domain source: Proposed Pall Care NMDS (DHHS modified)
**Contact Client Medicare Number**

**Definition:** Personal identifier allocated by Medicare Australia to eligible persons under the Medicare scheme.

**Repeats:**

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<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<td>Layout: N(11) or A-A</td>
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**Location:**

**Transmission protocol:** HL7 Submission

- Contact/Client Service Event (insert) ADT_A03 (PID\:PID.3\:CX.1)
- Contact/Client Service Event (update) ADT_A08 (PID\:PID.3\:CX.1)
- Contact/Client Service Event (delete) ADT_A13 (PID\:PID.3\:CX.1)

**Reported by:** All programs, dependent on transmission protocol

- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** The patient's/client's Medicare Number, issued by Medicare Australia.

**Reporting guide:**

- The Medicare Number is printed in the centre of the Medicare Card. The Medicare Code is also called the 'eleventh character' of the number. It is the number printed to the left of the name of the patient.
- The following regular expression is used to validate Medicare Numbers:

  `^[2-6][1-9][0-9]*$|C-U|N-E|P-N`

- This can be tested with online tools such as [http://www.regexplanet.com/advanced/java/index.html](http://www.regexplanet.com/advanced/java/index.html)

Valid Medicare Numbers are:

- First character can only be: 2, 3, 4, 5, or 6
- Numeric
- Check digit (ninth character) is the remainder of the following equation: 

  `[(1st digit * 1) + (2nd digit * 3) + (3rd digit * 7) + (4th digit * 9) + (5th digit * 1) + (6th digit * 3) + (7th digit * 7) + (8th digit * 9)] / 10`

- Invalid Medicare Numbers are:
- Special characters (for example, $, #)
- Alphabetic characters
Supplementary values:
• C-U: The patient's Medicare Card is unavailable
• N-E: The patient is not eligible for Medicare
• P-N: The patient is a prisoner

When reporting Contact Client Medicare Number, a value of ‘AUSHIC’ must be reported as the Local Identifier Assigning Authority (Table Identifier HL70363, (PID\PID.3\CX.4)).

Validations: E368 Contact Account Class (AccountClass) is incompatible with Patient/Client Medicare Number (<medicare_number>).

Related items: Contact Account Class
Contact Date/Time
Contact TAC Claim Number
Contact VWA File Number
Patient/Client DVA File Number
Patient/Client Identifier

Administration

Purpose: To fulfil the department's reporting obligations to the Commonwealth. To assist in monitoring continuity of care across hospitals. To ensure eligibility for publicly-funded health care.

Principal users: Department of Health and Human Services

Version history:  
1 Contact Client Medicare Number 2012/07/01

Definition source: NHDD METeOR ID 270101

Value domain source: Medicare Australia
Contact Client Present Status

**Definition:** An indicator of the presence or absence of a patient/client at a contact.

**Repeats:**
- Min.
- Max.
- Duplicate

**Form:** Identifier
- Min.: 1
- Max.: 1
- Duplicate: Not applicable

**Layout:** NN
- Size: Min.: 2
- Max.: 2

**Location:**
- Transmission protocol: HL7 Submission
  - Contact (insert) ADT_A03 (PV2:PV2.7)
  - Contact (update) ADT_A08 (PV2:PV2.7)
  - Contact (delete) ADT_A13 (PV2:PV2.7)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated
- Table identifier HL70130

**Code** | **Descriptor**
--- | ---
*Not PC | 10 | Patient/Client present with or without carer(s)/relative(s)
11 | Patient/Client present only
12 | Patient/Client present with carers(s)/relative(s)
13 | Patient/Client via telehealth
20 | Carer(s)/Relative(s) of the patient/client only
*PC | 31 | Patient/Client/Carer(s)/Relative(s) not present: Indirect contact
*Not PC | 32 | Patient/Client/Carer(s)/Relative(s) not present: Scheduled appointment not attended

**Reporting guide:** Providing care to a patient/client can encompass the provision of services (for example counselling, education) to the patient's/client's carer(s) and/or family, whether or not the patient/client is present when these services are delivered. The carers and family members are not, in these situations, considered to be patients/clients in their own right.

10 – **Patient/Client present with or without carer(s)/relative(s)**
- Code not to be used by Palliative Care; this program must provide the more specific information in codes 11 and 12.
- Use this code when Contact Delivery Mode is ‘telehealth’ and the patient is physically present at this health service.
11 – Patient/Client present only
For Palliative Care only, this may include contacts up to 24 hours post patient/client death. Use this code when Contact Delivery Mode is ‘telehealth’ and the patient/client is physically present at this health service.

12 – Patient/Client present with carer(s)/relative(s)
For Palliative Care only, this may include contacts up to 24 hours post patient/client death. Use this code when Contact Delivery Mode is ‘telehealth’ and the patient/client is physically present at this health service.

13 – Patient/Client present via telehealth
Use this code when Contact Delivery Mode is ‘telehealth’ and the patient is not physically present at the health service.

20 - Carer(s)/Relative(s) of the patient/client only
For Residential In-Reach (RIR) only, this may include a paid carer. For all other programs, this refers to unpaid carers or family members.

31 - Patient/Client/Carer(s)/Relative(s) not present: Indirect contact
Includes contacts between a service provider and another person who is not the patient/client/carer/relative; for example, another service provider. Mandatory for Palliative Care. Optional for Residential In-Reach (RIR).

32 - Patient/Client/Carer(s)/Relative(s) not present: Scheduled appointment not attended
Includes contacts where the health service was expecting the patient/client to attend the contact/client service event on the scheduled date at the scheduled time. This therefore excludes instances where the patient/carer provided notice that they would not be attending the scheduled contact.

Not in scope for Palliative Care.

Validations:
E361 Contact Date (ccs:date) is after Date of Death (dod), but Client Present Status (val) is not ‘20 - Carer(s)/Relative(s) of the patient/client only’ or ‘31 - Patient/Client/Carer(s)/Relative(s) not present: Indirect Contact’.

Related items: Contact Date/Time
Patient/Client Death Date

Administration

Purpose: To monitor and plan resource utilisation.
Principal users: Department of Health and Human Services

Version history:

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<td>6</td>
<td>Contact Care Present Status</td>
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<td>5</td>
<td>Contact Care Present Status</td>
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<td>4</td>
<td>Contact Care Present Status</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Contact/Client Service Event Client Present Status</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Contact/Client Service Event Client Present Status</td>
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<tr>
<td>1</td>
<td>Contact/Client Service Event Client Present Status</td>
<td>2005/07/01</td>
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Definition source: NHDD
Value domain source: NHDD 000436
Contact Clinic Identifier

**Definition:** A health-service assigned identifier for the Specialist Clinic (Outpatient) that is providing services for a particular contact.

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**Location:**
- **Transmission protocol:** HL7 Submission
- Contact (insert) ADT_A03 (PV2\PV2.23\XON.1)
- Contact (update) ADT_A08 (PV2\PV2.23\XON.1)
- Contact (delete) ADT_A13 (PV2\PV2.23\XON.1)

**Reported by:** Specialist Clinics (Outpatients)

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:** Reporting this data element is mandatory. If supplied it should match the clinic identifier used in the Non-admitted Clinic Management System. The identifier may contain any ASCII or ASCII-equivalent Unicode characters with an ASCII code value greater than 31, except for those used as delimiters by the transmitting protocol.

That is, for HL7: `| ~ ^ &`

**Validations:** E159 Code `<CodeSupplied>` for Data Element `<FieldName>` is not valid as the Contact Date

**Related items:** Contact Date/Time
- Patient/Client Birth Country
- Patient/Client Carer Availability
- Patient/Client Death Place
- Patient/Client Living Arrangement
- Patient/Client Main Carer’s Relationship to the Patient
- Patient/Client Usual Accommodation Type
- Patient/Client Usual Residence Locality Name
- Patient/Client Usual Residence Postcode

**Administration**

**Purpose:** To assist linking patient-level data to a Tier 2 class for national reporting requirements and to assist in developing clinical costing models for specialist clinic services.

**Principal users:** Department of Health and Human Services

**Version history:**

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<td>Contact Clinic Identifier</td>
<td>2011/07/01</td>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Health services
Contact Clinic Program Stream

**Definition:** The program/stream for the Specialist Clinic (Outpatient) that is providing services for a particular contact.

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<th>Max.</th>
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**Location:**

- Transmission protocol: HL7 Submission
  - Contact (insert): ADT_A03 (PV1:PV1.10)
  - Contact (update): ADT_A08 (PV1:PV1.10)
  - Contact (delete): ADT_A13 (PV1:PV1.10)

**Reported by:** Specialist Clinics (Outpatients)

**Reported for:** All contacts during the current reporting period.

**Reported when:** The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Contact Clinic Identifier (Mandatory)

**Value domain:** Enumerated

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**Code**

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<td>103</td>
<td>Cardiology</td>
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<td>106</td>
<td>Gastroenterology</td>
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<td>107</td>
<td>Haematology</td>
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<td>109</td>
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<td>Oncology</td>
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<tr>
<td>114</td>
<td>Infectious diseases</td>
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<tr>
<td>116</td>
<td>Immunology, includes Allergy</td>
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<tr>
<td>117</td>
<td>Endocrinology, includes Diabetes</td>
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<tr>
<td>118</td>
<td>Hepatobiliary and pancreas</td>
</tr>
<tr>
<td>119</td>
<td>Burns</td>
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<td>201</td>
<td>General surgery</td>
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<td>Orthopaedic applications</td>
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<td>304</td>
<td>Wound care</td>
</tr>
<tr>
<td>313</td>
<td>Allied health – stand-alone</td>
</tr>
<tr>
<td>350</td>
<td>Psychiatry and behavioural disorders, includes Alcohol and drug</td>
</tr>
</tbody>
</table>
Obstetrics
Gynaecology
Reproductive medicine and family planning

**Reporting guide:** The value domain is similar to Referral in and Episode Program/Stream. The difference is the program/stream is assigned at the clinic template level.

**Validations:**
- E259 This Organisation (<?OrganisationIdentifier?>) is not approved to report
  Contacts under this program/stream (<?program_stream?>) is mandatory but no value supplied

**Related items:**
- Contact Date (Mandatory)
- Contact Clinic Identifier (Mandatory)

**Administration**

**Purpose:** To monitor activity and assist with service planning.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
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<th>Version</th>
<th>Previous Name</th>
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<tr>
<td>1</td>
<td>Contact Clinic Program Stream</td>
<td>2015/07/01</td>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
Contact Date/Time

**Definition:**
The date and start time of the contact.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tr>
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**Form:**
Text

**Layout:**
YYYYMMDDhhmm

**Size:**
Min. Max.

**Location:**

**Transmission protocol:**
HL7 Submission

- Contact (insert) ADT_A03 (PV1\PV1.44\TS.1)
- Contact (update) ADT_A08 (PV1\PV1.44\TS.1)
- Contact (delete) ADT_A13 (PV1\PV1.44\TS.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:**
All contacts completed in the current reporting period.

**Reported when:**
All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:**
Valid date and time.

**Reporting guide:**
Contacts may be of any duration.

**Validations:**

- E020 <SucceedingEvent> (<SucceedingEventValue>) is before <Preceding Event> (<PrecedingEventValue>)

- E361 Contact Date (<ccsedate>) is after Date of Death (<dod>), but Client Present Status (<val>) is not '20 - Carer(s)/Relative(s) of the patient/client only' or '31 - Patient/Client/Carer(s)/Relative(s) not present: Indirect Contact'

**Related items:**
Contact Client Present Status
Contact Date/Time
Episode End Date
Episode First Appointment Booked Date
Episode Malignancy Flag
Episode Patient/Client Notified of First Appointment Date
Episode Start Date
Administration

**Purpose:** To enable occasions of service and group sessions to be derived for accountability reporting.

**Principal users:** Victorian and Australian Governments.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>4</td>
<td>Contact Date/Time</td>
<td>2010/07/01</td>
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</table>

**Definition source:** NHDD

**Value domain source:** ISO8601:2000
Contact Delivery Mode

**Definition:** The mode of provision of the service during the contact.

<table>
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<th>Repeats</th>
<th>Min.</th>
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**Location:**

- **Transmission protocol:** HL7 Submission
  - Contact (insert)  ADT_A03 (ROL\ROL.10\CE.1)
  - Contact (update)  ADT_A08 (ROL\ROL.10\CE.1)
  - Contact (delete)  ADT_A13 (ROL\ROL.10\CE.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - First Contact Date/Time (Mandatory)
  - Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>In person (face-to-face)</td>
</tr>
<tr>
<td>2</td>
<td>Telephone</td>
</tr>
<tr>
<td>3</td>
<td>Telehealth</td>
</tr>
<tr>
<td>4</td>
<td>Written (postal/courier)</td>
</tr>
<tr>
<td>5</td>
<td>Electronic mail</td>
</tr>
<tr>
<td>9</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Reporting guide:** Patient/client includes carer and/or relative, except where the patient/client and carer and/or relative have a different delivery mode, in which case the delivery mode of the patient/client should be reported.

The existence of a code in this value domain does not in itself mean that a contact delivered by one of these modes can be reported. Refer to Section 2: Contact to determine whether the contact meets the criteria to be reported to VINAH.
1 - In person - Face-to-face
The healthcare provider delivers the service in the physical presence of the patient (i.e., in the same room).

2 - Telephone
This code is not to be used to record administrative contact with a patient/client.

3 - Telehealth
The healthcare provider delivers the service to a patient using videoconference. Where a patient is in the physical presence of a health care provider(s) at one health service and care delivery involves the participation of a health care provider from another health service via Telehealth, the contact should be reported by both health services using a contact delivery mode of (3) Telehealth.

4 - Written - Postal/courier
Written communication that is clinical in nature.
Includes the following formats:
• Fax
• Paper - Postal/courier service
Excludes written information provided as part of a Contact with a different Delivery Mode.

5 - Electronic mail
Written communication that is clinical in nature delivered via electronic mail.
Excludes written information provided as part of a Contact with a different Delivery Mode.

9 - Not applicable
Use when the patient/client does not attend a scheduled appointment. Not in scope for Palliative Care.

Validations: General edits only, see Format.
Related items: Contact Date/Time

Administration
Purpose: To monitor and plan resource utilisation.
Principal users: Department of Health and Human Services

Version history:

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<th>Version</th>
<th>Previous Name</th>
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<td>2014/07/01</td>
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<tr>
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<td>Contact Delivery Mode</td>
<td>2013/07/01</td>
</tr>
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<td>4</td>
<td>Contact Delivery Mode</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Contact/Client Service Event Delivery Mode</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Contact/Client Service Event Delivery Mode</td>
<td>2007/07/01</td>
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<tr>
<td>1</td>
<td>Client Service Event Delivery Mode</td>
<td>2005/07/01</td>
</tr>
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</table>

Definition source: NHDD
Value domain source: NHDD 000439 (DHHS modified)
## Contact Delivery Setting

**Definition:** The type of setting in which the contact is experienced by the patient/client.

**Repeats:**

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**Location:**

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<th>HL7 Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PV1:PV1.3:PL.6)</td>
</tr>
<tr>
<td>Contact (update)</td>
<td>ADT_A08 (PV1:PV1.3:PL.6)</td>
</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PV1:PV1.3:PL.6)</td>
</tr>
</tbody>
</table>

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

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<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>11</td>
<td>Hospital setting - inpatient setting</td>
</tr>
<tr>
<td>12</td>
<td>Hospital setting - clinic/centre</td>
</tr>
<tr>
<td>13</td>
<td>Hospital setting - emergency department</td>
</tr>
<tr>
<td>14</td>
<td>Hospital setting - other non-inpatient setting</td>
</tr>
<tr>
<td>15</td>
<td>Hospital setting - palliative care unit</td>
</tr>
<tr>
<td>18</td>
<td>Hospital setting – urgent care centre</td>
</tr>
<tr>
<td>21</td>
<td>Community based health facility</td>
</tr>
<tr>
<td>22</td>
<td>General practice setting</td>
</tr>
<tr>
<td>23</td>
<td>Residential care</td>
</tr>
</tbody>
</table>

*Not OP

11   | Hospital setting - inpatient setting |
12   | Hospital setting - clinic/centre |
13   | Hospital setting - emergency department |
14   | Hospital setting - other non-inpatient setting |
15   | Hospital setting - palliative care unit |
18   | Hospital setting – urgent care centre |
21   | Community based health facility |
22   | General practice setting |
23   | Residential care |

*Not TCP

24   | Supported accommodation setting |

*TCP

241  | Supported accommodation setting - TCP - home based |
242  | Supported accommodation setting - TCP - bed based |
31   | Home |
41   | Educational institution setting |
98   | Not applicable |
99   | Other |
**Reporting guide:** This item should be coded to reflect the delivery location from the patient’s/client’s perspective, not the location of the health service professional(s).

**11 - Hospital setting - inpatient setting**
This code should be used where a patient/client is an admitted patient and physically present in the hospital at the time of the contact/client service event.

Excludes:
- HITH (use code 31)
- Emergency department (use code 13)
- General practice clinics (use code 22)
- Palliative care unit (use code 15)
- This code may not be used for Specialist Clinics (Outpatients) services, as they are not in scope for this collection.

**12 - Hospital setting - clinic/centre**
Includes:
- Specialist Clinics (Outpatients)
- CRC within a hospital

Excludes:
- Palliative care unit (use code 15)

**13 – Hospital setting – emergency department**
To be used by health services who report VEMD and the patient/client receives their entire care within the emergency department.

**14 - Hospital setting - other non-inpatient setting**
Includes:
- Bed-based TCP patients

**18 - Hospital setting – urgent care centre**
This code should be used by health services exempt from reporting VEMD and the patient/client receives their entire care within the urgent care centre.

**21 - Community based health facility**
Includes:
- Community based palliative care facility
- Community health centres
- CRCs not within a hospital

**23 - Residential care**
Includes when this is where the patient/client usually resides.

**24 - Supported accommodation setting**
Includes when this is where the patient/client usually resides. The TCP program may not report this code, but must use one of the more detailed codes below.

**241 - Supported accommodation setting - TCP - home based**
Includes:
- Patients/clients residing in a non-Commonwealth-funded supported accommodation setting while on the TCP home-based program
- Patients/clients residing in DHHS-funded community residential units while on the TCP home-based program

**242 - Supported accommodation setting - TCP - bed based**
Includes:
- Only patients/clients residing in a supported accommodation setting while on the TCP bed-based program
31 - Home
Includes:
• Patients/clients receiving an intervention by telephone or telemedicine in their home
• Patients/clients concurrently HITH patients
• Patients/clients on the TCP home-based program
Excludes patients living in a:
• Nursing home (use code 23)
• Supported Residential Service (SRS) (use code 24, 241 or 242)

41 - Educational Institution Setting
Includes:
• Preschool/kindergarten
• School
• College
• TAFE
• Training centre/institute setting
• University

98 - Not applicable
Includes:
• Indirect contacts
• Direct contacts: scheduled appointment not attended

99 - Other
This code should be used for situations not covered by the other options, for example where a contact/client service event is delivered to a patient/client in another community setting such as a leisure centre, shopping centre or temporary accommodation shelter.

Validations: General edits only, see Format.
Related items: Contact Date/Time

Administration

Purpose: To monitor and plan resource utilisation.
Principal users: Department of Health and Human Services

Version history:

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<th>Version</th>
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<td>5</td>
<td>Contact Delivery Setting</td>
<td>2010/07/01</td>
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<tr>
<td>4</td>
<td>Contact/Client Service Event Delivery Setting</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Contact/Client Service Event Delivery Setting</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Client Service Event Delivery Setting</td>
<td>2006/07/01</td>
</tr>
<tr>
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<td>2005/07/01</td>
</tr>
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Definition source: Department of Health and Human Services
Value domain source: CATCH (DHHS modified)
Contact Family Name

**Definition:** The family name(s) of the patient/client.

**Repeats:**

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<th>Duplicate</th>
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**Form:** Name

**Layout:** UX (0-23)

**Size:**

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**Transmission protocol:** HL7 Submission
- Contact (insert) ADT_A03 (PID\PID.5\XPN.1\FN.1)
- Contact (update) ADT_A08 (PID\PID.5\XPN.1\FN.1)
- Contact (delete) ADT_A13 (PID\PID.5\XPN.1\FN.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Contacts in the current reporting period where, and only where, Account Class is 'VX - Department of Veterans’ Affairs (DVA)' or 'WC - WorkSafe Victoria' or 'TA - Transport Accident Commission (TAC)'.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- First Contact Date/Time (Report when and only when Contact Account Class = 'VX', 'TA' or 'WC')
- Second and Subsequent Contact Date/Time (Report when and only when Contact Account Class = 'VX', 'TA' or 'WC').

**Value domain:** A person's name.

**Reporting guide:** The family name(s) of the patient/client.

Permitted characters: A to Z (uppercase), space, apostrophe, hyphen.

The first character must be an alpha character.

Where not required by the value of Account Class, must be left blank.

Note that VINAH requires only 24 characters of the family name to be reported, organisations may collect names longer than 24 characters in full, for their own purposes.

When instructed to leave or report blank, in VINAH this means that the corresponding field in the transmission file must be transmitted as a null or empty field.

**Validations:**
- E357 A Patient/Client's Legal Family Name or Given Names are provided but Account Class is not VX (DVA) or TA (TAC) or WC (VWA)
- E358 Account Class is VX (DVA) or TA (TAC) or WC (VWA), but the Patient's Legal Name or Given Names are not provided
Related items: Contact Account Class
Contact Date/Time
Contact Given Name(s)

Administration

Purpose: To facilitate reimbursement by DVA for patients/clients with entitlements. These data are processed differently from other VINAH data to ensure that personal information remains confidential.

Principal users: Department of Veterans’ Affairs

Version history:

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
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<tr>
<td>5</td>
<td>Contact Family Name</td>
<td>2010/07/01</td>
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<tr>
<td>4</td>
<td>Contact/Client Service Event Family Name</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Contact/Client Service Event Family Name</td>
<td>2008/07/01</td>
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<tr>
<td>2</td>
<td>Family Name</td>
<td>2007/07/01</td>
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<td>1</td>
<td>Family Name</td>
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Definition source: Department of Veterans’ Affairs

Value domain source: Not applicable (Consistent with CCDSv2)
Contact Given Name(s)

**Definition:** The given name(s) of the patient/client.

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**Form:** Name

**Layout:** UX (0-14)

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**Transmission protocol:** HL7 Submission

Contact (insert): ADT_A03 (PID\PID.5\XPN.2)
Contact (update): ADT_A08 (PID\PID.5\XPN.2)
Contact (delete): ADT_A13 (PID\PID.5\XPN.2)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Contacts in the current reporting period where, and only where, Account Class is 'VX - Department of Veterans’ Affairs (DVA)' or 'WC - WorkSafe Victoria' or 'TA - Transport Accident Commission (TAC)'.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Report when and only when Contact Account Class = 'VX', 'TA' or 'WC')
- Second and Subsequent Contact Date/Time (Report when and only when Contact Account Class = 'VX', 'TA' or 'WC').

**Value domain:** A person’s name.

**Reporting guide:** The given name(s) of the patient/client.

Permitted characters: A to Z (uppercase), space, apostrophe and hyphen.

The first character must be an alpha character.

Where not required by the value of Account Class, must be left blank.

Note that VINAH requires only 15 characters of the given name to be reported, organisations may collect names longer than 15 characters in full, for their own purposes.

When instructed to leave or report blank, in VINAH this means that the corresponding field in the transmission file must be transmitted as a null or empty field.

**Validations:**

- E357 A Patient/Client’s Legal Family Name or Given Names are provided but Account Class is not VX (DVA) or TA (TAC) or WC (VWA)
- E358 Account Class is VX (DVA) or TA (TAC) or WC (VWA), but the Patient’s Legal Name or Given Names are not provided
**Related items:** Contact Account Class  
Contact Date/Time  
Contact Given Name(s)

**Administration**

**Purpose:** To facilitate reimbursement by DVA for patients/clients with entitlements. These data are processed differently from other VINAH data to ensure that personal information remains confidential.

**Principal users:** Department of Veterans’ Affairs

**Version history:**

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<td>4</td>
<td>Contact/Client Service Event Family Name</td>
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<td>3</td>
<td>Contact/Client Service Event Family Name</td>
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<tr>
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<td>Given Name(s)</td>
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<td>1</td>
<td>Given Name(s)</td>
<td>2005/07/01</td>
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</table>

**Definition source:** Department of Veterans’ Affairs

**Value domain source:** Not applicable (Consistent with CCDSv2)
Contact Group Session Identifier

**Definition:** An identifier, unique to a Group Session within an organisation.

**Repeats:**

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<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>Not applicable</td>
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**Form:** Name

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**Location:**

- **Transmission protocol:** HL7 Submission
  - Contact (insert): ADT_A03 (PV1\PV1.50\CX.1)
  - Contact (update): ADT_A08 (PV1\PV1.50\CX.1)
  - Contact (delete): ADT_A13 (PV1\PV1.50\CX.1)

**Reported by:** Specialist Clinics (Outpatients)

**Reported for:** All contacts where Contact Session Type = '2-Group Session'

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Must be specified of Contact Session Type = '2')
- Second and Subsequent Contact Date/Time (Must be specified of Contact Session Type = '2')

**Value domain:** Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:** This data element is used to determine which patients/clients were present in a given group session. The same value must be reported in this data element for all patients/clients that were present in the same group session.

**Validation**

It is strongly recommended that submitters ensure that the same Contact Professional Group and Contact Date is reported for all group session contacts submitted with the same Contact Group Session Identifier.

**Validations:**

- E365 Contact Session Type = '2-Group session' but Contact Group Session Identifier has not been reported
- E366 A Contact Group Session Identifier has been reported but the Contact Session Type <> '2-Group session'

**Related items:** Contact Date/Time

Contact Session Type

**Administration**

**Purpose:** To enable identification of unique group sessions across different patients/clients.

**Principal users:** Department of Health and Human Services, Commonwealth Government.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
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<tbody>
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<td>Contact Group Session Identifier</td>
<td>2011/07/01</td>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Health services
**Contact Indigenous Status**

**Definition:** Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.

<table>
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<tr>
<th>Repeats:</th>
<th>Min.</th>
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<td>Transmission protocol:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Contact (insert)</td>
<td>ADT_A03 (PID\PID.10\CE.1)</td>
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<td></td>
<td>Contact (delete)</td>
<td>ADT_A13 (PID\PID.10\CE.1)</td>
<td></td>
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</table>

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Optional for patients/clients whose episode opened during the current reporting period; mandatory for patients/clients whose first contact occurred during the current reporting period.

**Reported when:** All Programs, not elsewhere specified
- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - First Contact Date/Time (Mandatory)
  - Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

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<th>Code</th>
<th>Descriptor</th>
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<tr>
<td></td>
<td>2</td>
<td>Indigenous - Torres Strait Islander but not Aboriginal origin</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Indigenous – Both Aboriginal and Torres Strait Islander origin</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Not indigenous – Neither Aboriginal or Torres Strait Islander origin</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Question unable to be answered</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Client refused to answer</td>
</tr>
</tbody>
</table>

**Reporting guide:** This information must be collected. Systems must not be set up to input a default code.

Rather than asking every patient/client about their indigenous status, first ask the patient/client. "Were you born in Australia?"

- If No, the patient/client should be asked, "What country were you born in?"
- If Yes, the patient/client should be asked, "Are you of Aboriginal or Torres Strait Islander origin?"

If the patient/client answers "Yes" to being of Aboriginal or Torres Strait Islander origin, then ask further questions to record correctly the person’s indigenous status.
If the patient/client is a baby or child, the parent or guardian should be asked about the indigenous status of the child's mother or father. If the mother has not identified as being of Aboriginal or Torres Strait Islander descent, staff should not assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of Commonwealth v Tasmania (1983) 46 ALR 625.

"An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives."

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous Status relate to descent and self-identification only.

Validations: General edits only, see Format.

Related items: Contact Date/Time

Administration

Purpose: Required for service planning.

Principal users: Koori Health Unit (Public Health, DHHS).

Version history:

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<thead>
<tr>
<th>Version</th>
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<th>Effective Date</th>
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<tbody>
<tr>
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<td>Contact Indigenous Status</td>
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<td>5</td>
<td>Contact Indigenous Status</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>4</td>
<td>Contact/Client Service Event Indigenous Status</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Contact/Client Service Event Indigenous Status</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Indigenous Status</td>
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</tr>
<tr>
<td>1</td>
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<td>2005/07/01</td>
</tr>
</tbody>
</table>

Definition source: NHDD

Value domain source: NHDD 002009 (DHHS modified) (Consistent with CCDSv2)
**Contact Inpatient Flag**

**Definition:** An indication of whether the patient/client is an inpatient at the time of the contact.

<table>
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**Location:** Transmission protocol: HL7 Submission

- Contact (insert) ADT_A03 (PV1\PV1.2)
- Contact (update) ADT_A08 (PV1\PV1.2)
- Contact (delete) ADT_A13 (PV1\PV1.2)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts where the Contact Client Present Status indicates that the patient/client is present (values 10, 11 and 12).

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Report when Contact Client Present Status = ‘10’, ‘11’ or ‘12’ (patient/client present))
- Second and Subsequent Contact Date/Time (Report when Contact Client Present Status = ‘10’, ‘11’ or ‘12’ (patient/client present))

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>I</td>
<td>Yes (Inpatient/Admitted)</td>
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</tbody>
</table>

**Reporting guide:** This item should be used to indicate whether the patient/client is an inpatient/admitted patient at the time of the contact/client service event. This includes a patient in Hospital in the Home (HITH).

For Specialist Clinics (Outpatients), all services in scope should be reported to this collection. The reporting of Inpatient Flag ‘1’ indicates that the outpatient service has been provided as part of the Inpatient service and therefore will not be funded separately.

Note: AIMS reporting has a different scope to this collection and the same business rules may not apply. Refer to the AIMS Manual or the HDSS Helpdesk for further information.

**Validations:** General edits only, see Format.

**Related items:** Contact Date/Time
Administration

**Purpose:** To allow national reporting requirements to be met and assist with outcome analyses and service planning.

**Principal users:** Department of Health and Human Services

**Version history:**

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<th>Effective Date</th>
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<tr>
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<td>Contact Inpatient Flag</td>
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<tr>
<td>3</td>
<td>Contact Inpatient Flag</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Contact/Client Service Event Inpatient Flag</td>
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</tr>
<tr>
<td>1</td>
<td>Contact/Client Service Event Inpatient Flag</td>
<td>2007/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
Contact Interpreter Required

Definition: The patient's/client's need for an interpreter, as perceived by the patient/client or the person consenting for the patient/client.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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</thead>
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<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PV1\PV1.15)</td>
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<tr>
<td>Contact (update)</td>
<td>ADT_A08 (PV1\PV1.15)</td>
<td></td>
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</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PV1\PV1.15)</td>
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Reported by: Family Choice Program
Hospital Admission Risk Program
Hospital Based Palliative Care Consultancy Team
Post Acute Care
Residential In-Reach
Specialist Clinics (Outpatients)
Sub-acute Ambulatory Care Services
Transition Care Program
Victorian HIV Service
Victorian Respiratory Support Service

Reported for: All contacts completed in the current reporting period.

Reported when: All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
First Contact Date/Time (Mandatory)
Second and Subsequent Contact Date/Time (Mandatory)

Value domain: Enumerated
Table identifier HL70009

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<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>1</td>
<td>Interpreter needed</td>
</tr>
<tr>
<td>2</td>
<td>Interpreter not needed</td>
</tr>
<tr>
<td>3</td>
<td>Not Stated/inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide: Preferred Language is to be asked before Interpreter Required.

If Preferred Language is ‘1201 - English’, Interpreter Required can be assumed to be ‘2 - Interpreter not needed’.

This data element must:
• Be checked for every contact/client service event.
• Not be set up to input a default code on computer systems.
• Be collected at, or as soon as possible after, the contact/client service event.

The standard question is:
[Do you] [Does the person] [Does (name)] require an interpreter?

The question “Do you require an interpreter?” is asked to determine patient/client need for an interpreter, not the capacity of the service to provide an interpreter.

Validations: E360 Contact Preferred Language is ‘1201-English’ but Contact Interpreter Required (<val>) is not ‘2 – Interpreter Not Needed’

Related items: Contact Date/Time
Contact Preferred Language
Administration

**Purpose:**
This information is essential to assist in planning for provision of interpreter services.

**Principal users:**
Department of Health and Human Services

**Version history:**

<table>
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<th>Version</th>
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<tr>
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<td>Contact Interpreter Required</td>
<td>2010/07/01</td>
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<tr>
<td>4</td>
<td>Contact/Client Service Event Interpreter Required</td>
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<td>Contact/Client Service Event Interpreter Required</td>
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<td>1</td>
<td>Interpreter Required</td>
<td>2005/07/01</td>
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</table>

**Definition source:**
Department of Health and Human Services

**Value domain source:**
Consumer Information SCTT (modified) (Consistent with CCDSv2)
Contact Medicare Benefits Schedule Item Number

**Definition:** The Medicare Benefits Schedule Item Numbers charged during this contact, or their uncharged equivalents for non-MBS-funded contacts.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
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**Location:**

- **Transmission protocol:** HL7 Submission
- Contact (insert) ADT_A03 (PR1\PR1.3\CE.1)
- Contact (update) ADT_A08 (PR1\PR1.3\CE.1)
- Contact (delete) ADT_A13 (PR1\PR1.3\CE.1)

**Reported by:** Specialist Clinics (Outpatients)

**Reported for:** Optional where Contact Account Class = "QM".

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Optional if Contact Account Class = 'QM')
- Second and Subsequent Contact Date/Time (Optional if Contact Account Class = 'QM')

**Value domain:** Enumerated

<table>
<thead>
<tr>
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<th>990084</th>
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</table>

**Code** | **Descriptor**
--- | ---

For full code set visit the Australian Government ‘MBS Online’ website.

**Reporting guide:** When reporting this data element for Contacts with Contact Account Class <> "QM", the MBS item numbers for the equivalent service should be reported.

**Validations:** General edits only, see Format.

**Related items:** Contact Date/Time

**Administration**

**Purpose:** To inform cost-weight setting for activity-based funding.

**Principal users:** Department of Health and Human Services

**Version history:**

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<td>1</td>
<td>Contact Medicare Benefits Schedule Item Number</td>
<td>2011/07/01</td>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Medicare Australia
Contact Preferred Care Setting

**Definition:** The setting identified by the patient/client at the time of the contact as their preferred place of care.

**Repeats:**

<table>
<thead>
<tr>
<th>Form</th>
<th>Layout</th>
<th>Size</th>
<th>Min.</th>
<th>Max.</th>
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</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PV1\PV1.42\PL.6)</td>
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</table>

**Reported by:** Palliative Care

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** **All Programs, not elsewhere specified**

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

This value domain is similar to that used for Contact/Client Service Event Delivery Setting (HL70305) but has the additional code 97.

| Table identifier | 990039 |

**Code** | **Descriptor**
---|---
11 | Hospital setting - inpatient setting
12 | Hospital setting - clinic/centre
13 | Hospital setting - emergency department
14 | Hospital setting - other non-inpatient setting
15 | Hospital setting - palliative care unit
21 | Community based health facility
22 | General practice setting
23 | Residential care
24 | Supported accommodation setting
31 | Home
41 | Educational institution setting
97 | Unknown, not stated or question not asked
98 | Not applicable - patient/client not present
99 | Other

**Reporting guide:** Asking a patient/client about their preferred setting of care is a means to gather information about the location of service delivery that best meets the patient's/client's current needs.

**97 - Unknown, not stated or question not asked**

Includes:

- Where it was inappropriate to ask the question
- Where the patient/client did not, or was not able to answer the question
- Where the answer is otherwise unknown
98 - Not applicable - patient/client not present
Report this code when the value of Contact/Client Service Event Client Present Status is not ‘11’ and not ‘12’.

**Validations:**
E363 <Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting > is <‘9-Not applicable – patient/client not present’ |‘5 – Bereavement Phase’ |‘98-Not applicable – patient/client not present’> but Contact Client Present Status is ‘11- Patient/Client present only’, ‘12- Patient/Client present with carer(s)/relative(s)’ or ‘13 - Patient/Client via telehealth’

E364 Where Contact Client Present status is ‘20 - Carer(s)/Relative(s) of the patient/client only’ or ‘31 - Patient/Client/Carer(s)/Relative(s) not present: Indirect Contact’, <Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting > must be ‘9-Not applicable – patient/client not present’ |‘5 – Bereavement Phase’ |‘98-Not applicable – patient/client not present’>

**Related items:**
- Contact Care Model
- Contact Care Phase
- Contact Date/Time
- Contact Preferred Death Place

**Administration**

**Purpose:** To assist with outcome analyses and service planning, and meeting state government reporting requirements.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
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<tr>
<td>2</td>
<td>Contact Preferred Care Setting</td>
<td>2010/07/01</td>
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<tr>
<td>1</td>
<td>Contact/Client Service Event Preferred Setting of Care</td>
<td>2009/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
Contact Preferred Death Place

**Definition:** The place identified by the patient/client at the time of the contact as their preferred place to die.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<td><strong>Layout:</strong></td>
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**Location:** Transmission protocol: HL7 Submission
- Contact (insert): ADT_A03 (PD1\PD1.15\CE.1)
- Contact (update): ADT_A08 (PD1\PD1.15\CE.1)
- Contact (delete): ADT_A13 (PD1\PD1.15\CE.1)

**Reported by:** Palliative Care

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

This value domain is similar to that used for Episode Place of Death (990034) but has the additional codes 97 and 98.

<table>
<thead>
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<th>Code</th>
<th>Descriptor</th>
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<tr>
<td>21</td>
<td>Residential – aged care setting</td>
</tr>
<tr>
<td>22</td>
<td>Residential – other setting</td>
</tr>
<tr>
<td>30</td>
<td>Non-residential setting</td>
</tr>
<tr>
<td>41</td>
<td>Inpatient setting – designated palliative care unit</td>
</tr>
<tr>
<td>42</td>
<td>Inpatient setting – other than designated palliative care unit</td>
</tr>
<tr>
<td>97</td>
<td>Unknown, not stated or question not asked</td>
</tr>
<tr>
<td>98</td>
<td>Not applicable – patient/client not present</td>
</tr>
<tr>
<td>99</td>
<td>Other location</td>
</tr>
</tbody>
</table>

**Reporting guide:** This topic needs to be addressed sensitively as part of a developing relationship of trust between patient/client, family and care provider. While it is expected that this question would be addressed during a service contact, it may be insensitive to broach this topic during early contacts and sometimes at all. In these instances, reporting code 97 is appropriate.

**97 - Unknown, not stated or question not asked**

Includes:
- Where it was inappropriate to ask the question
- Where the patient/client did not, or was not able to answer the question
- Where the answer is otherwise unknown

**98 - Not applicable - patient/client not present**

Report this code when the value of Contact/Client Service Event Client Present Status is not ‘11’ and not ‘12’.
**Validations:**

E363  
<Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting> is <'9-Not applicable – patient/client not present' | '5 – Bereavement Phase' | '98-Not applicable – patient/client not present'> but Contact Client Present Status is ‘11-Patient/Client present only’, ‘12-Patient/Client present with carer(s)/relative(s)’ or ‘13 - Patient/Client via telehealth’

E364  
Where Contact Client Present status is ‘20 - Carer(s)/Relative(s) of the patient/client only’ or ‘31 -Patient/Client/Carer(s)/Relative(s) not present: Indirect Contact’, <Contact Care Phase | Contact Care Model | Contact Preferred Death Place | Contact Preferred Care Setting> must be ‘9-Not applicable – patient/client not present’ | '5 – Bereavement Phase' | '98-Not applicable – patient/client not present'>

**Related items:**

Contact Care Model
Contact Care Phase
Contact Date/Time
Contact Preferred Care Setting

**Administration**

**Purpose:**
To assist with outcome analyses and service planning, and meeting state government reporting requirements.

**Principal users:**
Department of Health and Human Services

**Version history:**

<table>
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<tr>
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<tr>
<td>1</td>
<td>Contact/Client Service Event Preferred Place of Death</td>
<td>2009/07/01</td>
</tr>
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</table>

**Definition source:**
Department of Health and Human Services

**Value domain source:**
Department of Health and Human Services
Contact Preferred Language

**Definition:** The language (including sign language) most preferred by the patient/client for communication during the provision of care. This may be a language other than English even where the person can speak fluent English.

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<th>Duplicate</th>
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**Form:** Code

**Layout:** NNNN

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**Location:** Transmission protocol: HL7 Submission
- Contact (insert) ADT_A03 (PID\PID.15\CE.1)
- Contact (update) ADT_A08 (PID\PID.15\CE.1)
- Contact (delete) ADT_A13 (PID\PID.15\CE.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Patients/clients whose episodes opened during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** See Section 9: Code Sets.

**Reporting guide:**

Four-digit codes as specified in ABS Australian Standard Classification of Languages, (2011) (ABS ASCL (2011) should be used.

One of the supplementary codes should be used where a patient's/client's preferred language is not stated or inadequately described:
- '0000-Inadequately described'
- '0002-Not stated'

This information must be ascertained for each contact.

This information must not be set up to a default code on computer systems.

The standard question is:

"What is [your] [the person's] preferred language?"

**Patient/Client is unable to consent (for example child or cognitively impaired)**

Where a patient/client is not able to consent for themselves then the language of the person who is consenting will be recorded. For example a guardian or someone with enduring power of attorney.
Validations: E360  <Contact Phase of Contact Preferred Language is ‘1201-English’ but Contact Interpreter Required (<val>) is not ‘2 – Interpreter Not Needed’

Related items: Contact Date/Time
Contact Interpreter Required

Administration

Purpose: Required for service planning.

Principal users: Department of Health and Human Services

Version history:

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<th>Effective Date</th>
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<tr>
<td>6</td>
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<tr>
<td>5</td>
<td>Contact Preferred Language</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>4</td>
<td>Contact/Client Service Event Preferred Language</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Contact/Client Service Event Preferred Language</td>
<td>2008/07/01</td>
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<td>2</td>
<td>Preferred Language</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Preferred Language</td>
<td>2005/07/01</td>
</tr>
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</table>

Definition source: NHDD

Value domain source: METeOR: Based on 304128, Person – preferred language (ASCL 2011) code NN{NN} (Consistent with CCDSv2).
Contact Professional Group

**Definition:** The professional group or professional(s) providing services for a contact.

<table>
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<th>Repeats</th>
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<th>Max.</th>
<th>Duplicate</th>
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**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

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2523 Dentist
252311 Dental specialist
252411 Occupational therapist
252511 Physiotherapist
252611 Podiatrist
252711 Audiologist
252712 Speech pathologist/therapist
252900 Allied health assistant
252999 Other allied health
2531 General practitioner (GP)
253211 Anaesthetist
2533 Intern medicine specialist
253311 Specialist physician (general medicine)
253312 Cardiologist
253313 Clinical haematologist
253314 Clinical oncologist
253315 Endocrinologist
253316 Gastroenterologist
253317 Intensive care specialist
253318 Neurologist
253321 Paediatrician
253322 Renal medicine specialist
253323 Rheumatologist
253324 Thoracic medicine specialist
253399 Geneticist
253411 Psychiatrist
253511 Surgeon (general)
253512 Cardiothoracic surgeon
253513 Neurosurgeon
253514 Orthopaedic surgeon
253515 Otorhinolaryngologist
253516 Paediatric surgeon
253517 Plastic and reconstructive surgeon
253518 Urologist
253521 Vascular surgeon
253621 Palliative medicine specialist
253721 Pain medicine specialist
253911 Dermatologist
253912 Emergency medicine specialist
253913 Obstetrician and gynaecologist
253914 Ophthalmologist
253915 Pathologist
253918 Radiation oncologist
253999 Medical specialist NEC
254111 Midwife
254211 Nurse educator
254400 Nurse - Division 1
254411 Nurse practitioner
254412 Clinical nurse specialist
272100 Counsellor
272199 Spiritual carer
272313 Clinical psychologist
272389 Neuropsychologist
272399 Psychologist NEC
272511 Social worker
411311 Diversional therapist
411411 Nurse - Division 2
4115 Indigenous health worker
423312 Nursing support worker
434999 Exercise physiologist
435010 Non-professional healthcare provider

**Reporting guide:** Use as many codes as necessary to report each professional and professional group involved in the contact and client service event, respectively.

For Client Service Events, do not repeat codes. For example, if two physiotherapists are involved in a single client service event, only report the code ‘252511-Physiotherapist’ once. If codes are repeated for Client Service Events they will be removed for reporting purposes.

At the contact level, report one code for each participating clinician.

**099893 - Medical research fellow**
A Medical Research Fellow is a post-graduate medical practitioner in receipt of a recognised Australian or international Research Fellowship. Note that reportable VINAH contacts must be clinically significant in nature and result in a dated entry being made in the patient/client record.

**099894 - Visiting medical officer**
A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis.

**099895 - Registrar**
A Registrar is a medical practitioner admitted to an Australian Medical Council accredited vocational training program leading to a fellowship of a Medical College including those of General Practice and Rural and Remote Medicine.

**099896 - Resident medical practitioner**
A Resident Medical Practitioner is a medical practitioner in the second or subsequent post-graduate year of clinical experience. An RMP must complete 12 months of clinical experience to advance to the next pay point.

**2533 - Intern medicine specialist**
An Intern is a medical practitioner in the first post-graduate year of clinical experience.

**Validations:** General edits only, see Format.

**Related items:** Contact Date/Time
Administration

**Purpose:** To monitor and plan resource utilisation

**Principal users:** Department of Health and Human Services

**Version history:**

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**Definition source:** Department of Health and Human Services

**Value domain source:** ANZSCO 1st Ed (DHHS modified)
Contact Provider

**Definition:** An identifier, unique within the state, for the organisational unit providing services that are reportable to the VINAH MDS, for a particular contact.

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**Location:**

**Transmission protocol:** HL7 Submission

- Contact (insert) ADT_A03 (PV2:PV2.23:XON.10)
- Contact (update) ADT_A08 (PV2:PV2.23:XON.10)
- Contact (delete) ADT_A13 (PV2:PV2.23:XON.10)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Refer to Section 9: Code Lists

Table identifier 990012

**For full code set see Section 9.**

**Reporting guide:** The Contact Provider identifies the specific unit providing the care for a particular contact.

The Contact Provider may be, for example, a hospital campus (including the Emergency Department), Community Health Service, CRC or some other organisational unit providing HARP services or SACS.

If a contact:
- Occurs in a patient's/client's home or some other location, this item should indicate the unit from which the health care professional/s originate.
- Is provided through a brokered service, this item should be reported as 'BROKER'

It must be distinguished from the Local Identifier Assigning Authority, which indicates the facility responsible for assigning an identifier to the patient/client. For example, a particular stand-alone CRC is the Contact Provider when it delivers a contact to a patient/client. That patient's/client’s identifier may have been assigned by a hospital campus within the same Health Service, and the Local Identifier Assigning Authority would identify that hospital campus.

Where leading zeros are specified as part of a Contact Provider code they must be transmitted.

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Validations: General edits only, see Format.

Related items: Contact Date/Time

Administration

Purpose: To monitor and plan resource utilisation.

Principal users: Department of Health and Human Services

Version history:

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Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
Contact Purpose

**Definition:** The purpose of the service provided within the contact.

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**Location:**

- Transmission protocol: HL7 Submission
  - Contact (insert) ADT_A03 (PR1\PR1.3\CE.1)
  - Contact (update) ADT_A08 (PR1\PR1.3\CE.1)
  - Contact (delete) ADT_A13 (PR1\PR1.3\CE.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
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- Palliative Care
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**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

- Table identifier: HL70230

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*HBPCCT 29 Formal family meeting

*HBPCCT, PC 31 Terminal care

*HBPCCT, PC 32 Respite

41 Case conference

42 Case management and/or Care co-ordination

*OP 61 Research/Medical trial

71 Follow up/Monitoring/Evaluation/Review

*OP 72 New patient consultation

99 Other
Reporting guide: Where there is more than one service provided in a single contact, choose as the main purpose the value that was most significant. (Except Specialist Clinics - see below).

More than one purpose may be optionally reported. The main purpose must be reported with a Procedure Sequence Number of ‘1’, additional purposes reported with values of ‘2’, ‘3’, ‘4’… and so on.

For Specialist Clinics (Outpatients), one of 71-Follow Up/Monitoring/Evaluation/Review or 72-New Patient Consultation must be reported for each Contact. Other appropriate codes may also be reported.

11 - Initial Needs Identification (INI)
The healthcare provider delivers the service in the physical presence of the patient (i.e., in the same room).

Initial needs identification is an initial screening for risk and service requirements. The practitioner undertaking initial needs identification looks beyond the presenting issue to what underlying issues may exist. Initial needs identification is not a diagnostic process but is a determination of the patient's/client's risk, eligibility and priority for service.

Includes:
• Service Coordination Template Tool (SCTT)
• Other tools incorporating initial needs identification principles

12 - Comprehensive assessment
Comprehensive Assessment involves the most intense level of inquiry, and incorporates an advanced dimension of history taking, examination, observation and measurement/testing about medical, physical, social, cultural and psychological dimensions of need.

Includes:
• Tools (or combination of tools) used to support the comprehensive assessment process
• Common assessment

For Palliative Care, this will usually be the admission visit.

13 - Specialist assessment
The means by which services determine the patient's/client's particular service requirement and adapt their service provision to the patients'clients' assessed need. It must be undertaken by a provider who has specialist skills knowledge and expertise.

For example, in palliative care this could include the initial bereavement risk assessment and assessment of a single and specific symptom, such as nausea.

Excludes:
• Specialist Clinics (Outpatients) contacts where the clinician is seeing a new patient for initial assessment or treatment. (Use code 72).

21 - Education/Self-management
Education and feedback provided to the patient/client. This can include self-management education where education and empowerment are the main intent.

Includes:
• Health coaching
• Motivational interviewing
• Development of self-management skills
• Decision-based counselling

Excludes staff training.
This could also include:

- Education regarding the role of Palliative Care and services provided
- Education regarding the disease process and/or treatment/symptom variants
- Education regarding the interventions/prescribed medications
- Education regarding the use of domiciliary oxygen
- Education regarding other supports/services in the community
- Education regarding medication side-effects and how they work
- Education regarding transferring, using and caring for equipment such as shower aids
- Education regarding bowel management
- Education regarding depression/anxiety

22 - Therapy/Clinical intervention not further specified

This could include the following:

- Wound care/dressing
- Bowel management/ enemas/ suppositories
- Catheter care/ insertion
- Care of naso-gastric tube
- Oedema/lymphoeoeema management/ bandaging
- Pathology specimen collection
- Parenteral medications other than for symptom management, for example, Clexane
- Initiation of webster packs/dosette
- Pressure care
- PICC flush
- Subcutaneous fluids
- Stomal care
- Counselling
- Care at time of death
- Accessing port
- Cleaning of and caring for the body of a deceased person
- Music therapy

Excludes:

- Bereavement (26)
- Personal care (25)
- Social support (27)
- Spiritual care (24)
- Symptom control/pain management (23)

23 - Symptom control/Pain management

Where medications relate to pain management or symptom control, this could also include the following:

- Monitor medication regimens/ monitor effectiveness of interventions/ alteration of doses
- Administer parenteral medications
- Domiciliary oxygen/nebulised medications
- Insertion of delivery system for a syringe driver, for example, saf-t-intima
- Filling of syringe driver
- Instigation of new medications or altering medications
24 - Spiritual care
This could also include:
- Discussions relating to death and dying
- Discussions relating to religion / beliefs / spirituality
- Contact with religious ministers on behalf of the client
- Discussions relating to funerals/special rites
- Discussions relating to the meaning of life and death

25 - Personal care
Refers to assistance with daily self-care tasks such as eating, bathing, toileting and grooming.
Includes:
- Hygiene - bathing / showering / sponge
- Teeth / hair / shaving
- Personal Care Assistance
- Mouth care
- Ambulation
- Assist with food / fluids
- Toileting
- Assistance with or training in meal preparation

26 - Bereavement support
Includes:
- Grief and bereavement support for patients/clients not yet deceased
- Ongoing bereavement risk assessment
- If appropriate, attendance at funeral
- Bereavement follow-up visits
- Phone call with carer post-death
- Support to family pre- and post-death
- Pre- and post-death contacts by counsellor for the purpose of bereavement support

27 - Social support
Intervention to offer support for a patient's/client's participation and functioning in their community.
Includes:
- Emotional / psychosocial support for patients and caregivers
- Biography service
- Social work visits / contacts
- Centrelink contacts if not administrative, for example, assisting clients with disability payments or carer allowance application paperwork
- Talking / reading / sharing a game / watching TV / shopping / home maintenance / respite
- Provision of childcare
- Purchase or provision of meals

28 - Supported accommodation
Provision of housing, with staff on-site for:
- Clients with high care needs and complex health and psychosocial issues who would otherwise require admission to an acute hospital due to lack of other more appropriate options.
- Continuity of care from acute hospital services to the community for clients with complex issues who would otherwise remain in acute care.
- Social and carer respite, to provide a break for clients because of health or psychosocial stressors, or when their carer requires respite from their caring responsibility.
• People from rural and regional Victoria accessing HIV specialist medical care in Melbourne,
• Clients who are homeless, while emergency accommodation is secured.
• Clients who are homeless with complex health and psychosocial issues, while longer term sustainable accommodation is secured.

29 - Formal family meeting
This code reportable by Hospital Based Palliative Care Consultancy Team only.
Formal Family meetings take place between the patient, their family and health care professionals for multiple purposes, including: the sharing of information and concerns, clarifying the goals of care, discussing diagnosis, treatment, prognosis and developing a plan of care for the patient and family carers.

31- Terminal care
Care in the hours or days immediately preceding death that is focussed on emotional and spiritual issues as a prelude to bereavement.

32- Respite
Short term care of the client to provide client and/or carer support.

41 - Case conference
An inclusive process for making decisions about the care of a patient/client. Assessment findings and options for ongoing care and support are presented or other practitioners/clinicians, who can be from the same or different organisations. The presentation includes conclusions of the assessment that are supported by a range of information sources. Case Conferences are often multi-disciplinary and incorporate the views and preferences of the patient/client and their carers.

For Palliative Care this could include:
• Family meetings/conferences
• Liaison with other health professionals/multi-disciplinary team meetings / palliative care physician/GPs/LMOs/inpatient service liaison
• Client review
• Handover

42 - Case management and/or Care co-ordination
Care Coordination: The range of services required by the patient/client is coordinated so that they are delivered in the most efficient and effective way to meet individual patient's/client's needs. Care co-ordination enables continuity of care, avoids duplication of services and ensures that meeting patient/client needs is paramount over the needs of individual service providers and is not hampered unnecessarily by program boundaries.

Case Management: The activities undertaken by one central person who assumes overall responsibility for the care plan, in order to streamline the interface between the service system and the patient/client and carer.
The terms ‘care co-ordination’ and ‘case management’ may be used interchangeably in some services.

Excludes Case Conference (41)

This could include:
• Liaison with other health professionals
• Referrals to other agencies e.g. home help/respite/HACC
• Organising provision and delivery of equipment
• Medication organisation/request for scripts to be written and sent to pharmacy
• Liaison with nursing services
• Contact with GPs, specialists, community services or PC nurse liaison
• Funding application for equipment / services
• Referrals within service to other professional groups, such as volunteers
• Team discussion and care plan determination
• Goal setting
• Exploration of service options
• Facilitated service linkage (with patient present)

61 - Research/Medical trial
Report this code when the contact occurs due to the patient's/client's participation in a research/trial.

Only in scope for Specialist Clinics (Outpatients).
Includes:
• Testing of a drug or other intervention
• Assessment or testing associated with research/medical trial

71 - Follow up/Monitoring/Evaluation/Review
For Specialist Clinics (Outpatients): Report this code if the appointment has the primary purpose of reviewing the patient following a previous outpatient appointment or treatment as an inpatient or day surgery patient.

Includes:
• Post-operative review
• Routine review of chronic condition
• Monitoring results of interventions
• Evaluation of action plans
• Re-assessing client needs are being met

72 - New patient consultation
Report this code if the clinician is seeing a new patient for initial assessment or treatment.

Only in scope for Specialist Clinics (Outpatients).

Validation:
E367 The Episode Program/Stream is Specialist Clinics (Outpatients) but a Contact Purpose of either '71-Follow up/Monitoring/Evaluation/Review' or '72-New Patient Consultation' has not been reported.

Related items:
Contact Date/Time
Contact Medicare Benefits Schedule Item Number

Administration

Purpose: To allow national reporting requirements to be met and to monitor and plan resource utilisation.

Principal users: Department of Health and Human Services

Version history:

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Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
Contact Session Type

**Definition:** The type of session in which the contact was provided to the patient/client.

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- Contact (update): ADT_A08 (PR1\PR1.6)
- Contact (delete): ADT_A13 (PR1\PR1.6)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
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**Value domain:** Enumerated

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**Reporting guide:** Group – group program

A ‘Group – group program’ is defined as two or more patients/clients receiving the same services on the same date from the same clinician/s at the same location. For example, a movement class or a chronic disease education class, where all participants are following the same intervention at the same time and/or where the group nature of the activity is conceived as part of the benefit to the patient/client.

Group – individual program

A ‘Group – individual program’ is defined as two or more patient/clients receiving their own personalised program (for example, in a physio gym in a CRC), from the same clinician/s at the same location and same date. Each of these clients should be coded as having a Contact Session Type of ‘4 - Group - individual program’ as the services provided to each patient/client are not the ‘same’ but rather individualised programs.
Note that providing care to a patient/client can encompass the provision of services (for example, counselling, education) to the patient/client's carer(s) and family, whether or not the patient/client is present when these services are delivered. The carer/family member is not, in these situations, considered to be a patient/client in their own right.

Thus, for example, if a single patient/client and several members of their family were the only attendees at a centre-based contact, the Contact Session Type coded for that contact would still be '1 - Individual'.

**Only one Contact Session Type can be reported for a single contact.** Should a patient/client receive care in both individual and group settings within a single attendance, this must be reported as two separate contacts. E.g. One contact for ‘Group – group program’ and one contact for ‘Group – individual program’. **Multiple session types cannot be reported within a single contact.**

**Validations:**
- E365 Contact Session Type = '2-Group session' but Contact Group Session Identifier has not been reported.
- E366 A Contact Group Session Identifier has been reported but the Contact Session Type <> '2-Group session'.

**Related items:**
- Contact Date/Time
- Contact Group Session Identifier

**Administration**

**Purpose:** To monitor and plan resource utilisation, and for reporting to the Australian Government.

**Principal users:** Department of Health and Human Services

**Version history:**

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<tr>
<td>4</td>
<td>Contact Session Type</td>
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**Definition source:** NHDD

**Value domain source:** NHDD 000235 (DHHS modified)
Contact Specialist Palliative Care Provider

**Definition:** Indicates if the person providing the contact is a specialist palliative care provider.

**Repeats:**

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**Location:**

**Transmission protocol:** HL7 Submission
- Contact (insert): ADT_A03 (PV1\PV1.7\XCN.1)
- Contact (update): ADT_A08 (PV1\PV1.7\XCN.1)
- Contact (delete): ADT_A13 (PV1\PV1.7\XCN.1)

**Reported by:** Palliative Care

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)

**Value domain:** Enumerated

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**Reporting guide:** This item should be used to indicate whether or not during their case a patient/client is receiving specialist palliative care. A specialist palliative care provider is a provider who has completed training or has qualifications in providing care specifically to palliative care clients.

Professionals who are not specialist palliative care providers should be coded as ‘2-No’.

**Validations:** General edits only, see Format.

**Related items:** Contact Date/Time

**Administration**

**Purpose:** To assist with outcome analyses and service planning, and to meet national reporting requirements.

**Principal users:** Department of Health and Human Services

**Version history:**

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</tr>
<tr>
<td>1</td>
<td>Contact/Client Service Event Specialist Palliative Care Provider</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Proposed Pall Care NMDS

**Value domain source:** Proposed Pall Care NMDS
Contact TAC Claim Number

**Definition:** The Transport Accident Commission Claim Number of the patient/client, relating to this contact.

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<th>Max.</th>
<th>Duplicate</th>
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<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PID\PID.3\CX.1)</td>
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</tbody>
</table>

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Contacts in the current reporting period where, and only where, Contact Account Class is 'TA - Transport Accident Commission (TAC)'.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- First Contact Date/Time (Report when and only when Account Contact Class = 'TA')
- Second and Subsequent Contact Date/Time (Report when and only when Account Contact Class = 'TA')

**Value domain:** A valid TAC Claim Number.

**Reporting guide:**

Patient/client includes carer and/or relative, except where the patient/client and carer and/or relative have a different delivery mode, in which case the delivery mode of the patient/client should be reported.

**Layout**

- Characters 1-2: Financial year of claim acceptance.
- Characters 3-7: Numeric characters allocated by TAC.
- Characters C-U: Claim number unavailable. Reported where a TAC Claim Number is not known by the Health Service.

Where a TAC Claim Number is not applicable, leave the field blank.

Note that when instructed to leave or report blank, in VINAH this means that the corresponding field in the transmission file must be transmitted as a null or empty field.

**Examples**

9812345, 5412345, C-U

Organisations wishing to obtain TAC Claim Numbers can contact TAC on: 1300 654 329 (Choose option 2: Service Provider to a TAC Customer).
Validations: E356 Contact is Compensable (<AccountClass>) but there is no client identifier provided relevant to this compensable agency

Related items: Contact Account Class
Contact Client Medicare Number
Contact Date/Time
Contact VWA File Number
Patient/Client DVA File Number
Patient/Client Identifier

Administration

Purpose: To facilitate payment by TAC for TAC patients.

Principal users: Transport Accident Commission.

Version history:

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<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>5</td>
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<td>4</td>
<td>Contact TAC Claim Number</td>
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<tr>
<td>3</td>
<td>Contact/Client Service Event TAC Claim Number</td>
<td>2009/07/01</td>
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<td>2</td>
<td>Contact/Client Service Event TAC Claim Number</td>
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</tr>
<tr>
<td>1</td>
<td>TAC Claim Number</td>
<td>2007/07/01</td>
</tr>
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</table>

Definition source: Transport Accident Commission

Value domain source: Transport Accident Commission (Consistent with CCDSv2)
**Contact VWA File Number**

**Definition:** The WorkSafe Victoria (Victorian WorkCover Authority) file number applicable to the patient/client. Unique identifier for a claim.

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<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
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**Location:**
- Transmission protocol: HL7 Submission
- Contact (insert) ADT_A03 (PID\PID.3\CX.1)
- Contact (update) ADT_A08 (PID\PID.3\CX.1)
- Contact (delete) ADT_A13 (PID\PID.3\CX.1)

** Reported by:**
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:**
- Contacts in the current reporting period where, and only where, Contact Account Class is 'WC - WorkSafe Victoria'.

**Reported when:**
- **All Programs, not elsewhere specified**
- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - First Contact Date/Time (Report when and only when Account Contact Class = 'WC')
  - Second and Subsequent Contact Date/Time (Report when and only when Account Contact Class = 'WC')

**Value domain:** A valid VWA file number (see reporting guide).

**Reporting guide:**
- This number must be recorded at each contact/client service event where a service is provided to a person who holds the entitlement for reimbursement purposes.
- The VWA file number is obtained from the patient/client.

**Layout**
- Part 1: Two digit claim agent code Layout: XX
- Part 2: Two digit year Layout: YY
- Part 3: Seven digit field with the unique ID Layout: XXXXXXX

**Valid format**
- Only numeric characters are permitted:
- Made up of a two digit claim agent code
- Two digit year
- Then a seven digit field with the unique ID
- Characters C-U: Reported where a VWA File number is not known by the Health service
Examples

‘12078706489’ ‘08060087098’ C-U

Where a VWA File Number is not applicable, leave the field blank
Note that when instructed to leave or report blank, in VINAH this means that the corresponding field in the transmission file must be transmitted as a null or empty field

Validations: E356 Contact is Compensable (&lt;AccountClass&gt;) but there is no client identifier provided relevant to this compensable agency

Related items: Contact Account Class
Contact Client Medicare Number
Contact Date/Time
Contact VWA File Number
Patient/Client DVA File Number
Patient/Client Identifier

Administration

Purpose: To facilitate reimbursement by VWA for patients/clients with entitlements. These data are processed differently from other VINAH data to ensure that personal information remains confidential.

Principal users: Victorian Work Cover.

Version history:

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<tr>
<td>1</td>
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<td>2007/07/01</td>
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</table>

Definition source: Victorian Work Cover

Value domain source: Victorian Work Cover (Consistent with CCDSv2)
**Episode Advance Care Plan Documented Date**

**Definition:** The date of documentation that an advance care plan has been initiated or updated.

**Repeats:**

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<tr>
<th></th>
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**Location:**

- Transmission protocol: HL7 Submission
  - Episode (insert) PPP_PCB (PTH:PTH.4)
  - Episode (update) PPP_PCC (PTH:PTH.4)
  - Episode (delete) PPP_PCD (PTH:PTH.4)

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Episodes opened during the current reporting period.

**Reported when:** **All Programs, not elsewhere specified**

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Must be specified if an advance care plan was documented previously or during the course of the Episode)
- Episode End Date (Must be specified if an advance care plan was documented previously or during the course of the Episode)

**Value domain:** Valid date.

**Reporting guide:** 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 members 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.

An ACP Date should not be recorded if the topic of ACP is introduced but no information to guide future decision making is gained.

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 of the advance care plan is unknown then the day prior to the episode start date should be recorded.

**Transmission binding data element**
When this data element is transmitted via HL7, the value “ACPD” must be transmitted in Episode Pathway Type.

**Validations**: General edits only, see Format.

**Related items**: Contact Date/Time
Episode Care Plan Documented Date
Episode End Date
Episode First Appointment Booked Date
Episode Hospital Discharge Date
Episode Patient/Client Notified of First Appointment Date
Episode Start Date
Episode TCP Bed-Based Care Transition Date
Episode TCP Home-Based Care Transition Date

**Administration**

**Purpose**: To assist in service planning.

**Principal users**: Department of Health and Human Services

**Version history**:  

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<td>Episode Advance Care Plan Documented Date</td>
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**Definition source**: Department of Health and Human Services

**Value domain source**: ISO8601:2000
Episode Assessment - Barthel Index - Date/Time

**Definition:** The date (and optionally, time) that the Episode Assessment Score - Barthel Index was determined for a given patient/client.

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<th>Repeats:</th>
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<td>Episode (update)</td>
<td>PPP_PCC (OBX\OBX.14\TS.1)</td>
</tr>
<tr>
<td>Episode (delete)</td>
<td>PPP_PCD (OBX\OBX.14\TS.1)</td>
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</table>

**Reported by:** Transition Care Program

**Reported for:** All episodes reported in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- Episode End Date (Mandatory)

**Value domain:** Valid date and optional time.

**Reporting guide:** The century component of this data element must begin with a ‘20’.

This data element must be reported with each Episode Assessment Score - Barthel Index that is reported during an Episode.

**Validations:**

| E260 | Episode Assessment Score has been provided but no Episode Assessment Date/Time has been provided |

**Related items:**

- Episode Assessment Score - Barthel Index
- Episode End Date
- Episode Start Date Observation
- Sequence Number

**Administration**

**Purpose:** To assist in service planning.

**Principal users:** Department of Health and Human Services

**Version history:**

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<th>Version</th>
<th>Previous Name</th>
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**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
Episode Assessment - FIM Score - Date/Time

**Definition:** The date (and optionally, time) that the Episode Assessment Score - FIM Score was determined for a given patient/client.

<table>
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<th>Repeats</th>
<th>Min.</th>
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**Size:** Min. | Max. |

**Location:** Transmission protocol: HL7 Submission

- Episode (insert) | PPP_PCB (OBX\OBX.14\TS.1)
- Episode (update) | PPP_PCC (OBX\OBX.14\TS.1)
- Episode (delete) | PPP_PCD (OBX\OBX.14\TS.1)

**Reported by:** Not reportable

**Reported for:** All episodes reported in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- Episode End Date (Mandatory)

**Value domain:** Valid date and optional time.

**Reporting guide:** The century component of this data element must begin with a ‘20’.

This data element must be reported with each Episode Assessment Score – FIM Score that is reported during an Episode.

**Validations:** E260 Episode Assessment Score has been provided but no Episode Assessment Date/Time has been provided

**Related items:**
- Episode Assessment – Barthel Index - Date/Time
- Episode Assessment Score - Barthel Index
- Episode Assessment Score - FIM Score
- Episode End Date
- Episode Start Date Observation
- Sequence Number

**Administration**

**Purpose:** To assist in service planning.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
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<tbody>
<tr>
<td>1</td>
<td>Episode Assessment – FIM Score - Date/Time</td>
<td>2010/07/01</td>
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**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
Episode Assessment Score - Barthel Index

**Definition:** A score that is the outcome of a Barthel Index assessment made on a patient/client.

**Repeats:**

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**Form:** Repeatable Integer

**Layout:** N[NN]

**Size:**

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**Location:**

**Transmission protocol:** HL7 Submission

- Episode (insert): PPP_PCB (OBX:OBX.3:CE.1)
- Episode (update): PPP_PCC (OBX:OBX.3:CE.1)
- Episode (delete): PPP_PCD (OBX:OBX.3:CE.1)

**Reported by:** Transition Care Program

**Reported for:** All episodes reported in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- Episode End Date (Mandatory)

**Value domain:** The Barthel Index has a valid value domain that ranges from 0 through to 100; any values outside this range are invalid.

**Reporting guide:** Assessments must be reported in chronological order within their assessment type. For example, the Barthel Score assessed at the start of the episode must appear before (and have a lower Observation Sequence Number than) the Barthel Score assessed at the end of the episode.

It is permissible to interleave assessment scores and other data elements that use the OBX segment for reporting, as long as the above sequencing requirement is met.

Each assessment score must be reported with the date that the assessment was taken (see Episode Assessment - Barthel Index - Date/Time data element).

**Transmission binding data element**

When this data element is transmitted via HL7, the value "BARTHEL" must be transmitted in Observation Bound Data Element.

**Assessment frequency**

The Barthel assessment is to be carried out at the start of a patient's/client's Episode and at the end of the Episode for all patients/clients receiving services on the TCP Program/Stream. Both Barthel start and end of episode results must be reported at/by the Episode End Date.

The Barthel assessment may also be carried out when the Contact Account Class changes from 'QT' – Commonwealth Funded TCP to 'MP' – Public Eligible.

Leading zeros are optional.

**Reporting the Barthel index**

Add the appropriate scores against each of the assessment items based on the patient's/client's level of function to calculate a score from 0 to 100.

**Modified Barthel index for the Transition Care Program (TCP)**

The assessment mechanism used to calculate Barthel index for episodes reportable under the Transition Care Program are as per the Modified Barthel index specification developed by the Department of Health and Ageing.
This specification is available from the following internet site:  http://www.health.gov.au
• For Health Professionals
• Services
• Aged & Community Care
• The Claim & Advance Payment Cycle - Information for The Transition Care Program 2006

**Validations:**

- **E259** Episode has an End Date but does not have an Episode Assessment Score
- **E260** Episode Assessment Score has been provided but no Episode Assessment Date/Time has been provided
- **E262** Episode has an Episode End Date but does not have two Episode Assessment Score - Barthel Index data elements reported

**Related items:**

- Episode Assessment – Barthel Index - Date/Time
- Episode End Date
- Episode Health Conditions
- Episode Malignancy Flag
- Episode Other Factors Affecting Health
- Episode Start Date
- Observation Bound Data Element
- Observation Sequence Number

**Administration**

**Purpose:** To assist in service planning.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
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<tbody>
<tr>
<td>1</td>
<td>Episode Assessment Score – Barthel Index</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Barthel Index
Episode Assessment Score - FIM Score

**Definition:** A score that is the outcome of a FIM assessment made on a patient/client.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
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**Repeats:**

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- Max.
- Duplicate

**Form:** Repeatable Structured Code

**Layout:** N(18)

**Size:**

- Min.
- Max.

**Location:**

**Transmission protocol:** HL7 Submission

- Episode (insert): PPP_PCB (OBX\OBX.3\CE.1)
- Episode (update): PPP_PCC (OBX\OBX.3\CE.1)
- Episode (delete): PPP_PCD (OBX\OBX.3\CE.1)

**Reported by:** Not reportable

**Reported for:** All episodes reported in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - Episode Start Date (Optional)
  - Episode End Date (Mandatory)

**Value domain:** The FIM Score has a valid value domain that ranges from 1 through to 7 for each individual component of the 18 items.

**Reporting guide:** Assessments must be reported in chronological order within their assessment type. For example, the FIM Score assessed at the start of the episode must appear before (and have a lower Observation Sequence Number than) the FIM Score assessed at the end of the episode.

- It is permissible to interleave assessment scores and other data elements that use the OBX segment for reporting, as long as the above sequencing requirement is met.

- Each assessment score must be reported with the date that the assessment was taken (see Episode Assessment - FIM Score - Date/Time data element).

**Transmission binding data element**

When this data element is transmitted via HL7, the value "FIM" must be transmitted in Observation Bound Data Element.

**Assessment frequency**

The FIM assessment is to be carried out at the start of a patient's/client's Episode and at the end of the Episode for all patients/clients receiving services on the TCP Program/Stream. Both FIM start and end of episode results must be reported at/by the Episode End Date.

The FIM assessment may also be carried out when the Contact Account Class changes from ‘QT’ – Commonwealth Funded TCP to ‘MP’ – Public Eligible.

**Reporting the FIM score**

Report a score for each item, that is, a 1 digit score for 18 items.

**FIM Scores**

- **No Helper**
  - 7 = Complete Independence
  - 6 = Modified Independence

- **Helper**
  - 5 = Supervision or setup
  - 4 = Minimal assistance
  - 3 = Moderate assistance
  - 2 = Maximal assistance
  - 1 = Total assistance
FIM Assessment Items
(Motor Subscale)
Score sequence 1: Eating
Score sequence 2: Grooming
Score sequence 3: Bathing
Score sequence 4: Dressing upper body
Score sequence 5: Dressing lower body
Score sequence 6: Toileting
Score sequence 7: Bladder Management
Score sequence 8: Bowel Management
Score sequence 9: Transfers - Bed/Chair/Wheelchair
Score sequence 10: Transfers - Toilet
Score sequence 11: Transfers - Bath/Shower
Score sequence 12: Walk/Wheelchair
Score sequence 13: Stairs
(Cognitive Subscale)
Score sequence 14: Comprehension
Score sequence 15: Expression
Score sequence 16: Social Interaction
Score sequence 17: Problem Solving
Score sequence 18: Memory

Validations:
E259 Episode has an End Date but does not have an Episode Assessment Score
E260 Episode Assessment Score has been provided but no Episode Assessment Date/Time has been provided

Related items:
Episode Assessment – Barthel Index - Date/Time
Episode Assessment – Barthel Index - Date/Time
Episode Assessment Score – Barthel Index
Episode End Date
Episode Health Conditions
Episode Malignancy Flag
Episode Other Factors Affecting Health
Episode Start Date
Observation Bound Data Element
Observation Sequence Number

Administration

Purpose: To assist in service planning.

Principal users: Department of Health and Human Services

Version history: Version Previous Name Effective Date
1 Episode Assessment Score – FIM Score 2010/07/01

Definition source: Department of Health and Human Services

Value domain source: FIM
**Episode Campus Code**

**Definition:** A code that specifies the hospital campus responsible for the delivery of a service to a patient/client during an episode.

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<th>Max.</th>
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<td>Transmission protocol:</td>
<td>HL7 Submission</td>
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<td>PPP_PCC (PV1\PV1.39\IS.1)</td>
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Value domain: Refer to Section 9: Code Lists

Table identifier: HL70115

For full code set see Section 9.

**Reported by:** All programs, dependent on transmission protocol

Family Choice Program
Hospital Admission Risk Program
Hospital Based Palliative Care Consultancy Team
Medi-Hotel
Palliative Care
Post Acute Care
Residential In-Reach
Specialist Clinics (Outpatients)
Sub-acute Ambulatory Care Services
Transition Care Program
Victorian HIV Service
Victorian Respiratory Support Service

**Reported for:** All Episode messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Episode Start Date (Mandatory)

**Reporting guide:** Report the campus of the organisation responsible for the provision of services to a patient/client within the episode. The actual service may be delivered by another organisation or party, the identifier of which is reported in the Contact Provider Identifier.

Where a service is provided at the responsible campus, both the Campus Identifier and the Contact Provider Identifier will indicate the same entity (although the code values may be different).

For reporting organisations with only one campus, a single Campus Identifier for the organisation has been issued.

**Validations:** E265 This Organisation (\<OrganisationIdentifier\>) is not approved to report Episodes under this campus (\<EpisodeCampusIdentifier\>)

**Related items:** Episode Start Date
Administration

**Purpose:** To fulfil DHHS reporting obligations.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
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<th>Version</th>
<th>Previous Name</th>
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<tr>
<td>1</td>
<td>Episode Campus Code</td>
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**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**Episode Care Plan Documented Date**

**Definition:** The date of documentation that an interdisciplinary care plan was first agreed.

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<thead>
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<th>Max.</th>
<th>Duplicate</th>
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**Location:** Transmission protocol: HL7 Submission
- Episode (insert): PPP_PCB (PTH:PTH.4)
- Episode (update): PPP_PCC (PTH:PTH.4)
- Episode (delete): PPP_PCD (PTH:PTH.4)

** Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Post Acute Care
- Residential In-Reach
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Episodes with a documented care plan and where Episode End Date falls within the current reporting period.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Episode Care Plan Documented Date (Optional)
- Episode End Date (Must be specified if a care plan was documented during the course of the Episode)

**Value domain:** Valid date

**Reporting guide:** The century component of the year must begin with '20'.

The outcome of a patient's/client's entry assessment should be the development of a goal-oriented care plan that has been negotiated with the patient/client and discussed with the patient's/client's carer and/or family. This item should be used to report the date that it is documented that the care plan has been first agreed with the patient/client and/or their carer.

For further guidance on what the care plan should include, refer to the appropriate guidelines.

If the care plan has not yet been documented, do not report this item.

**Transmission binding data element**
When this item is transmitted via HL7, the value "CPD" should also be transmitted in Episode Pathway Type. However, for backward compatibility if that item is left null it will be assumed to mean a Care Plan Documented Date.

**Validations:** General edits only, see Format.
**Related items:**
- Episode Advance Care Plan Documented Date
- Episode Care Plan Documented Date
- Episode End Date
- Episode First Appointment Booked Date
- Episode Hospital Discharge Date
- Episode Patient/Client Notified of First Appointment Date
- Episode TCP Bed-Based Care Transition Date
- Episode TCP Home-Based Care Transition Date

**Administration**

**Purpose:**
To monitor and plan resource utilisation. Required for accountability reporting regarding SACS to the Victorian Government and Australian Government. This item is used to determine the proportion of sub-acute ambulatory care service patients/clients for whom there is no documented established multidisciplinary care plan within the first three visits.

Used for service planning and quality analysis for both HARP-CDM and SACS services.

**Principal users:**
Victorian and Australian Governments

**Version history:**

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<th>Effective Date</th>
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<tr>
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<td>Episode Care Plan Documented Date</td>
<td>2010/07/01</td>
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<tr>
<td>4</td>
<td>Episode Care Plan Documented Date</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Episode Care Plan Documented Date</td>
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<tr>
<td>2</td>
<td>Date Care Plan Documented</td>
<td>2007/07/01</td>
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<tr>
<td>1</td>
<td>Date Care Plan Documented</td>
<td>2005/07/01</td>
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**Definition source:**
Department of Health and Human Services

**Value domain source:**
ISO8601:2000
**Episode End Date**

**Definition:**
The date when a patient/client no longer meets the criteria for a program/stream, and they cease to be a patient/client of the program/stream.

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<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
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**Size:**
Min. Max.

**Location:**
Transmission protocol:
- HL7 Submission
  - Episode (insert): PPP_PCB (PV1\PV1.45\TS.1)
  - Episode (update): PPP_PCC (PV1\PV1.45\TS.1)
  - Episode (delete): PPP_PCD (PV1\PV1.45\TS.1)

**Reported by:**
- All programs, dependent on transmission protocol
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:**
- All contacts completed in the current reporting period.

**Reported when:**
**All Programs, not elsewhere specified**
The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode End Date (Mandatory)

**Value domain:**
Valid date

**Reporting guide:**
The date on which a patient/client formally ceases receiving ongoing services from the program/stream. The criteria for this may differ between programs/streams.

An episode should not be closed simply because there is a waiting period for the specific service a patient/client requires.

For all programs except Palliative Care if a patient/client with an open episode dies the Episode End Date should be recorded as the date of death. Where the date of death is unknown, report the date that the program/stream found out that the patient/client was deceased. For Palliative Care, the usual criteria for ending an episode applies irrespective of the patient's death, that is, if the family or carers are still in need of services the episode should be kept open.

If a patient/client returns after the Episode End Date requiring further assessment or care, a new episode should be opened.

Where a patient/client receives a time-limited period of therapy or assessment with the understanding that there will need to be further periods of assessment in the future (for example, patients/clients with degenerative diseases), it is appropriate to start and end an episode for each period of therapy or assessment.
Validations: E020  <SucceedingEvent> (<SucceedingEventValue>) is before <Preceding Event> (<PrecedingEventValue>)

Related items: Contact Date/Time
Episode End Date
Episode End Reason
Episode First Appointment Booked Date
Episode Patient/Client Notified of First Appointment Date
Episode Proposed Treatment Plan Completion
Episode Start Date
Patient/Client Birth Date
Referral In Clinical Referral Date
Referral In Receipt Acknowledgment Date
Referral In Received Date
Referral Out Date

Administration

Purpose: To allow calculation of the period for which a person is a patient/client of a program/stream.

Principal users: Victorian and Australian Governments.

Version history:

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<th>Version</th>
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<th>Effective Date</th>
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<td>1</td>
<td>Episode End Date</td>
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Definition source: NHDD

Value domain source: NHDD
Episode End Reason

**Definition:** The reason the palliative care episode ended.

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- **Location:**
  - **Transmission protocol:** HL7 Submission
    - Episode (insert): PPP_PCB (PV1\PV1.36)
    - Episode (update): PPP_PCC (PV1\PV1.36)
    - Episode (delete): PPP_PCD (PV1\PV1.36)

- **Reported by:** Hospital Based Palliative Care Consultancy Team
  Palliative Care

- **Reported for:** Episodes closed during the current reporting period.

- **Reported when:** **All Programs, not elsewhere specified**
  The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - Episode End Date (Mandatory)

- **Value domain:** Enumerated
  - Table identifier: HL70112
  - **Code**
    - **Descriptor**
      - 1: Patient/client death or bereavement phase end
      - 2: Discharged to speciality palliative care provider
      - 3: Discharged to other health care provider
      - 4: Other reason

- **Reporting guide:** Leave blank if an episode of care has not ended.

- **Related items:** Episode End Date

**Administration**

- **Purpose:** To assist with outcome analyses and service planning, and meeting national reporting requirements.

- **Principal users:** Department of Health and Human Services

- **Version history:**
  - **Version**
    - 2: Episode End Reason
    - 1: Reason for Ending Episode
  - **Effective Date**
    - 2008/07/01
    - 2007/07/01

- **Definition source:** Proposed Pall Care NMDS

- **Value domain source:** Proposed Pall Care NMDS
**Episode First Appointment Booked Date**

**Definition:** The date of the patient's/client's first appointment booking.

**Repeats:**
- **Min.:** 1
- **Max.:** 1
- **Duplicate:** Not applicable

**Form:** Date

**Layout:** YYYYMMDD

**Location:**
- **Transmission protocol:** HL7 Submission
  - Episode (insert) PPP_PCB (PTH:PTH.4)
  - Episode (update) PPP_PCC (PTH:PTH.4)
  - Episode (delete) PPP_PCD (PTH:PTH.4)

**Reported by:** Specialist Clinics (Outpatients)

**Reported for:** Episodes where the patient/client was first notified of the date of their first appointment.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Patient/Client Notified of First Appointment Date (Mandatory)

**Value domain:** Valid date

**Reporting guide:** Record the first booking date for the first appointment. This is not the date on which that booking was entered into the booking system. Subsequent changes to the date of the first appointment date must not be submitted.

**Transmission binding data element**

When this data element is transmitted via HL7, the value “AB1” must be transmitted in Episode Pathway Type.

**Validations:**
- E020: `<SucceedingEvent> (<SucceedingEventValue>)` is before `<Preceding Event> (<PrecedingEventValue>)`

**Related items:**
- Contact Date/Time
- Episode End Date
- Episode End Reason
- Episode First Appointment Booked Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Proposed Treatment Plan Completion
- Episode Start Date
- Patient/Client Birth Date
- Referral In Clinical Referral Date
- Referral In Receipt Acknowledgment Date
- Referral In Received Date
- Referral Out Date

**Administration**

**Purpose:** To assist in measuring access to Specialist Clinic (Outpatients) services.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
<thead>
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<th>Version</th>
<th>Previous Name</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Episode First Appointment Booked Date</td>
<td>2011/07/01</td>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
**Episode Health Conditions**

**Definition:** An indication of the health condition or diagnosis contributing to the reason for providing a program/stream, and any additional health condition(s) that impact on the episode.

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<td>Episode (update)</td>
<td>PPP_PCC (OBX\OBX.3:CE.1)</td>
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<tr>
<td>Episode (delete)</td>
<td>PPP_PCD (OBX\OBX.3:CE.1)</td>
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**Reported by:** All programs, dependent on transmission protocol
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Optional for episodes open during the current reporting period. Must be reported for episodes where Episode End Date falls within the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Episode Start Date (Optional)
- Episode Care Plan Documented Date (Optional)
- Episode End Date (Mandatory)

**Value domain:** Enumerated

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<tr>
<td>0015</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>0080</td>
<td>Poliomyelitis</td>
</tr>
<tr>
<td>0081</td>
<td>Viral infection of nervous system</td>
</tr>
<tr>
<td>0100</td>
<td>Measles, varicella, shingles</td>
</tr>
<tr>
<td>0115</td>
<td>Acute hepatitis A</td>
</tr>
<tr>
<td>0116</td>
<td>Acute hepatitis B</td>
</tr>
<tr>
<td>0117</td>
<td>Other acute viral hepatitis</td>
</tr>
<tr>
<td>0118</td>
<td>Other chronic viral hepatitis</td>
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<tr>
<td>0119</td>
<td>Unspecified viral hepatitis</td>
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<td>HIV</td>
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<td>AIDS</td>
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<td>0125</td>
<td>Meningococcal infection</td>
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<tr>
<td>0191</td>
<td>Sequelae of poliomyelitis</td>
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<tr>
<td>0199</td>
<td>Other infectious diseases</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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</tr>
<tr>
<td>0200</td>
<td>Head and neck cancer</td>
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<tr>
<td>0215</td>
<td>Upper gastrointestinal cancer</td>
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<tr>
<td>0218</td>
<td>Colorectal cancer</td>
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<td>0222</td>
<td>Endocrine and thyroid cancer</td>
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<td>Lung cancer</td>
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<td>0240</td>
<td>Bone and articular cartilage cancer</td>
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<td>0243</td>
<td>Skin cancer</td>
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<td>0245</td>
<td>Soft tissue cancer</td>
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<tr>
<td>0250</td>
<td>Breast cancer</td>
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<td>0251</td>
<td>Gynaecological cancer</td>
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<td>Genitourinary cancer</td>
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<td>0269</td>
<td>Central nervous system cancer</td>
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<td>0276</td>
<td>Other malignant tumours</td>
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<td>0279</td>
<td>Metastatic (secondary) malignancy</td>
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<tr>
<td>0280</td>
<td>Secondary of unknown primary</td>
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<tr>
<td>0281</td>
<td>Hodgkin's disease</td>
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<tr>
<td>0282</td>
<td>Non-Hodgkin's lymphoma</td>
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<td>0290</td>
<td>Leukaemia</td>
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<td>0299</td>
<td>Rare cancer</td>
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<td>0310</td>
<td>Other benign tumour</td>
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<tr>
<td>0350</td>
<td>Anaemia</td>
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<td>0366</td>
<td>Haemophilia</td>
</tr>
<tr>
<td>0370</td>
<td>Other diseases of blood</td>
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<td>Immunodeficiency disorder</td>
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<td>Disorders of the thyroid gland</td>
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<td>Nutritional deficiencies</td>
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<td>Obesity</td>
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<td>High cholesterol</td>
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<td>Cystic fibrosis</td>
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<td>Dehydration</td>
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<tr>
<td>0490</td>
<td>Other endocrine, nutritional and metabolic disorders</td>
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<tr>
<td>0491</td>
<td>Diabetes with peripheral vascular disease</td>
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<td>0493</td>
<td>Diabetes with other complication</td>
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<td>Drug and/or alcohol use causing mental and behavioural disorders</td>
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<td>Diseases of the gallbladder, biliary tract and pancreas</td>
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1340 Other diseases of the genitourinary system
1377 Gynaecological issues, not otherwise specified
1400 Pregnancy with abortive outcome
1460 Preterm labour with preterm delivery
1461 Complications of labour and delivery
1480 Birth without complication
1482 Birth by caesarean section
1485 Birth with complications
1505 Prematurity
1521 Birth asphyxia
1600 Congenital malformations of the nervous system
1604 Other congenital malformations of the brain
1605 Spina bifida
1610 Congenital malformations of eye, ear, face and neck
1620 Congenital malformations of the circulatory system
1630 Congenital malformations of the respiratory system
1665 Congenital malformations and deformations of the musculoskeletal system
1680 Other congenital malformations
1713 Dysphagia
1715 Bowel/faecal incontinence
1718 Ascites
1741 Disorientation
1742 Dizziness
1745 Symptoms and signs involving emotional state
1751 Headache
1752 Pain, not elsewhere classified
1753 Malaise and fatigue
1755 Malaise and fatigue
1756 Convulsions
1758 Haemorrhage
1760 Oedema
1769 Unknown and unspecified causes of morbidity
1800 Injuries to the head
1802 Fracture of skull
1806 Intracranial injury
1808 Amputation of part of head
1810 Injuries to the neck
1812 Fracture of neck
1816 Injury of muscle and tendon at neck level
1820 Injuries to the thorax, abdomen, lower back, lumbar spine and pelvis
1822 Fracture in thoracic region
1823 Dislocation, sprain of joints of thorax
1826 Injury of heart
1832 Fracture of lumbar spine and pelvis
1833 Dislocation, sprain of joint of lumbar spine and pelvis
1836 Injury of intra-abdominal organs
1840 Injuries to the shoulder and upper arm
1842 Fracture of shoulder and upper arm
1848 Amputation of shoulder and upper arm
1850 Injuries to the elbow, forearm, wrist and hand
1852 Fracture of elbow, forearm, wrist and hand
1858 Amputation of elbow, forearm, wrist and hand
1870 Injuries of the hip and thigh
1872 Fracture of femur
1878 Amputation of hip and thigh
1880  Injuries to the knee, lower leg, ankle and foot  
1882  Fracture of knee, lower leg, ankle and foot  
1888  Amputation of lower leg, foot  
1899  Spinal cord injury  
1905  Amputation involving multiple limbs  
1920  Burns  
1982  Mechanical complication of other cardiac and vascular devices and implants  
2219  Unspecified fall  
9998  Diagnosis unclear  
9999  No impairment  
A33  Polyneuropathy  
A38  Other cognitive impairment  
A41  Paraplegia incomplete  
A42  Paraplegia complete  
A43  Quadriplegia incomplete C1-4  
A44  Quadriplegia incomplete C5-8  
A45  Quadriplegia complete C1-4  
A46  Quadriplegia complete C5-8  
A55  Amputation - double lower extremity above knee  
A56  Amputation - double lower extremity above/below knee  
A57  Amputation - double lower extremity below knee  
A62  Osteoarthritis  
A71  Neck pain  
A72  Back pain  
A73  Extremity pain  
A81  Post hip fracture  
A82  Post femur (shaft) fracture  
A83  Post pelvic fracture  
A84  Post major multiple fracture  
A85  Post hip replacement  
A86  Post knee replacement  
A87  Post upper limb fracture  
A89  Other orthopaedic  
A99  Other cardiovascular  
A101  Chronic obstructive pulmonary disease  
A104  Pulmonary fibrosis  
A131  Diabetic foot disease  
A132  Diabetes without complication  
A134  Post-operative (non-orthopaedic)  
A135  Cancer  
A139  Other disabling impairment  
A141  Brain and spinal cord trauma  
A142  Brain and multiple fracture/amputation  
A143  Spinal cord and multiple fracture/amputation  
A149  Other major multiple trauma  
A160  Debility  
A173  Urinary and faecal incontinence  
A174  Voiding dysfunction  
A179  Other continence issues  
A189  Other mental health  
A191  Venous leg ulcers  
A192  Arterial leg ulcers  
A199  Other wounds  
A200  Other geriatric management
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**Reporting guide:** More than one health condition can be reported, but the first health condition must be the main health condition to which the services provided within a particular episode of care relate.

Where there is more than one health condition reported, the main health condition should be the first reported; in technical terms this means it should have an Observation Sequence Number of 1 (see Transmission data elements).

A main health condition should be reported as soon as it is determined, preferably immediately after the first contact/client service event has been delivered.

However, where the patient/client is receiving care primarily to receive a specialist assessment, a diagnosis may not be confirmed until a later point in the episode. If a main health condition has not been determined for an episode opened during the reporting period, do not report this item.

At least one health condition must be reported in order for an episode to be ended (note that this may be ‘9998-Diagnosis unclear’ or ‘9999-No impairment’).

**Validations:** General edits only, see Format.

**Related items:**
- Episode Assessment Score – Barthel Index
- Episode Care Plan Documented Date
- Episode End Date
- Episode Malignancy Flag
- Episode Other Factors Affecting Health
- Episode Start Date

**Administration**

**Purpose:** To support analysis for service planning.

**Principal users:** Department of Health and Human Services

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**Definition source:** Department of Health and Human Services

**Value domain source:** Australian Rehabilitation Outcomes Centre (modified)
**Episode Hospital Discharge Date**

**Definition:** The date the patient/client was separated from hospital, including departure from ED prior to the start of their VINAH episode.

**Repeats:**

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**Form:** Date  
**Layout:** YYYYMMDD  
**Size:** Min. Max.

**Location:** Transmission protocol: HL7 Submission  
Episode (insert) PPP_PCB (PTH\PTH.4)  
Episode (update) PPP_PCC (PTH\PTH.4)  
Episode (delete) PPP_PCD (PTH\PTH.4)

**Reported by:** Post Acute Care  
Residential In-Reach  
Sub-acute Ambulatory Care Services  
Transition Care Program

**Reported for:** Episodes opened during the current reporting period. Optional for PAC and TCP, SACS and RIR programs.

**Reported when:** All Programs, not elsewhere specified  
The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- Episode End Date (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** The century component of the year must begin with ‘20’.

This item should be reported for all VINAH episodes associated with an admitted episode of care or ED presentation. This will frequently occur prior to the VINAH episode, especially for the PAC and TCP programs.

**Transmission binding data element**

When this data element is transmitted via HL7, the value “HD” must be transmitted in Episode Pathway Type.

**Validations:** General edits only, see Format.

**Related items:**  
Episode Advance Care Plan Documented Date  
Episode Care Plan Documented Date  
Episode End Date  
Episode First Appointment Booked Date  
Episode Patient/Client Notified of First Appointment Date  
Episode Start Date  
Episode TCP Bed-Based Care Transition Date  
Episode TCP Home-Based Care Transition Date

**Administration**

**Purpose:** To support analysis for service planning.

**Principal users:** Department of Health and Human Services

**Version history:**

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**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
**Episode Malignancy Flag**

**Definition:** Whether the patient’s/client’s principal diagnosis is a malignant condition.

**Repeats:**

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**Reported by:** Hospital Based Palliative Care Consultancy Team Palliative Care

**Reported for:** Optional for patients/clients whose episode opened during the current reporting period; mandatory for patients/clients whose first contact occurred during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- First Contact Date/Time (Mandatory)

**Value domain:** Enumerated

Table identifier 990033

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**Reporting guide:** If the principal diagnosis is not a malignant condition, report '2-No'.

**Validations:** Nil.

**Related items:**

- Episode Assessment Score – Barthel Index
- Episode Health Conditions
- Episode Other Factors Affecting Health
- Episode Start Date
- Patient/Client Birth Country
- Patient/Client Carer Availability
- Patient/Client Living Arrangement
- Patient/Client Usual Accommodation Type

**Administration**

**Purpose:** To assist with outcome analyses and service planning, and meeting national reporting requirements.

**Principal users:** Department of Health and Human Services

**Version history:**

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**Definition source:** Proposed Pall Care NMDS

**Value domain source:** Department of Health and Human Services
Episode Other Factors Affecting Health

Definition: An indication of the other factors affecting health to accurately reflect the complexity of patients/clients.

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Reported by: Family Choice Program
Hospital Admission Risk Program
Post Acute Care
Residential In-Reach
Sub-acute Ambulatory Care Services
Transition Care Program
Victorian HIV Service
Victorian Respiratory Support Service

Reported for: Mandatory for episodes with HARP Program/Stream closed during the current reporting period. Optional for all other episodes opened or closed during the current reporting period.

Reported when: All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- Episode Care Plan Documented Date (Optional)
- Episode End Date (Must be specified for HARP programs, optional for all others)

Value domain: Enumerated

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</table>
2406 Tenancy issues
2407 Unsuitable accommodation
2408 Other housing issue
2409 Immigration issue
2408 Immunisation required
2700 Isolation issue
2800 Issue due to other misadventure
2801 Issue due to falling
2802 Issues due to medication
2900 Learning issue
3000 Legal issue
3100 Maltreatment issue
3200 Negligence/Adverse result issue
3300 Nutrition & eating issue
3500 Promotion/Prevention required
3600 Public safety issue
3700 Sexuality issue
3800 Spiritual/Religious issue
3900 Verbal communication issue
4001 Other psychosocial issue
4100 Palliative
4101 Non-weight bearing
4102 Functional decline
4103 Presence of PEG
*RIR 4104 Presence of catheter
*RIR 4105 Presence of stoma
4106* Presence of PEG
9998 Not stated/inadequately described
9999 No issue identified

**Reporting guide:** 2800 - Issue due to other misadventure
Excludes:
- Falling
- Medication issues

**Validations:** General edits only, see Format.

**Related items:**
- Episode Assessment Score – Barthel Index
- Episode Care Plan Documented Date
- Episode End Date
- Episode Health Conditions
- Episode Malignancy Flag
- Episode Start Date

**Administration**

**Purpose:** To facilitate service planning.

**Principal users:** Multiple internal and external research users.

**Version history:**

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<td>4</td>
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<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Episode Other Factors Affecting Health</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Episode Other Factors Affecting Health</td>
<td>2008/07/01</td>
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<td>1</td>
<td>Client Service Event Delivery Mode</td>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** CATCH (Issue Type: DHHS modified across hierarchies)
Episode Patient/Client Notified of First Appointment Date

**Definition:** The date the patient/client was first advised of their first appointment booking.

**Repeats:**

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**Layout:** YYYYMMDD

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**Location:**

- **Transmission protocol:** HL7 Submission
- Episode (insert) PPP_PCB (PTH:PTH.4)
- Episode (update) PPP_PCC (PTH:PTH.4)
- Episode (delete) PPP_PCD (PTH:PTH.4)

**Reported by:** Specialist Clinics (Outpatients)

**Reported for:** Episodes where the patient/client was first notified of the date of their first appointment.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Patient/Client Notified of First Appointment Date (Optional)

**Value domain:** A valid date.

**Reporting guide:** Record the date on which the patient was first notified of the first booking date for the first appointment. The dates of notification of any subsequent changes to the date of the first appointment must not be submitted.

**Transmission binding data element**
When this data element is transmitted via HL7, the value “PNAB1” must be transmitted in Episode Pathway Type.

**Validations:** E020 <SucceedingEvent> (<SucceedingEventValue>) is before <Preceding Event> (<PrecedingEventValue>)

**Related items:**

- Contact Date/Time
- Episode Advance Care Plan Documented Date
- Episode Care Plan Documented Date
- Episode End Date
- Episode First Appointment Booked Date
- Episode Hospital Discharge Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Start Date
- Episode TCP Bed-Based Care Transition Date
- Episode TCP Home-Based Care Transition Date
- Patient/Client Birth Date
- Referral In Clinical Referral Date
- Referral In Receipt Acknowledgment Date
- Referral In Received Date
- Referral Out Date

**Administration**

**Purpose:** To assist in measuring access to Specialist Clinics (Outpatients) services.

**Principal users:** Department of Health and Human Services

**Version history:**

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</table>

**Effective Date:** 2011/07/01

**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
**Episode Program/Stream**

**Definition:** The program/stream to which the patient’s/client’s episode relates

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**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All episodes started during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

**Episode Start Date (Mandatory)**

**Value domain:** Enumerated

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**Code** | **Descriptor**

**Sub-Acute Ambulatory Care Services (SACS)**

- 1 Rehabilitation
- 2 Specialist continence
- 3 Specialist cognitive
- 4 Specialist pain management
- 5 Specialist falls
- 6 Specialist wound management
- 7 Younger adult/transition
- 8 Specialist paediatric rehabilitation
- 9 Specialist polio
- 11 Specialist movement disorders
- 19 Specialist other

**Hospital Admission Risk Program (HARP)**

- 27 HARP – HIV
- 28 HARP – Complex care

**Post Acute Care (PAC)**

- 31 Post Acute Care
<table>
<thead>
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<td>Family Choice Program (FCP)</td>
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<td>Family Choice Program</td>
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<td>Victorian HIV Service (VHS)</td>
<td>61</td>
<td>Victorian HIV consultancy</td>
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<td></td>
<td>62</td>
<td>Victorian HIV mental health service</td>
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<td>63</td>
<td>HIV outreach ambulatory care</td>
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<td>HIV CALD service</td>
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<td>65</td>
<td>Horizon place</td>
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<td></td>
<td>66</td>
<td>Chronic viral illness program</td>
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<td>67</td>
<td>Victorian NPEP service</td>
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<td>68</td>
<td>HIV outreach allied health</td>
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<td></td>
<td>69</td>
<td>Sexual health and wellbeing service</td>
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<tr>
<td>Victorian Respiratory Support Service (VRSS)</td>
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<td>Medi-Hotel</td>
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<td>Endocrinology, includes Diabetes</td>
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<td></td>
<td>201</td>
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<td></td>
<td>205</td>
<td>Ear, nose and throat</td>
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<tr>
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<td>206</td>
<td>Plastic surgery</td>
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<td>310</td>
<td>Orthopaedics/musculoskeletal</td>
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<td>311</td>
<td>Orthopaedic applications</td>
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<td></td>
<td>312</td>
<td>Wound care</td>
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<tr>
<td></td>
<td>313</td>
<td>Allied Health - stand-alone</td>
</tr>
<tr>
<td></td>
<td>350</td>
<td>Psychiatry and behavioural disorders, includes Alcohol and drug</td>
</tr>
</tbody>
</table>
402 Obstetrics
403 Gynaecology
406 Reproductive medicine and family planning

Transition Care Program (TCP)
1101 Transition Care Program

Residential In-reach (RIR)
1201 Residential In-reach

Hospital Based Palliative Care Consultancy Team (HBPCCT)
1300 Hospital Based Palliative Care Consultancy Team
1301 Symptom control/Pain management
1302 Discharge planning
1303 Psychosocial support/Advocacy
1304 Assessment
1305 Terminal (end of life) care
1306 Symptom control/Pain management/Discharge planning
1307 Symptom control/Pain management/Psychosocial support
1308 Symptom control/Pain management/Assessment
1309 Symptom control/Pain management/Terminal (end of life) care
1310 Discharge planning/Psychosocial support/Advocacy
1311 Discharge planning/Assessment
1312 Discharge planning/Terminal (end of life) care
1313 Psychosocial support/Advocacy/Assessment
1314 Psychosocial support/Advocacy/Terminal (end of life) care
1315 Assessment/Terminal (end of life) care

Reporting guide: The value of this data element cannot be changed after the episode has been opened. See Section 5 for more information.

The value domain is similar to Referral In Program/Stream. The difference is that in this value domain there are no generic codes for:
- SACS, HARP, Specialist Clinics (Outpatients) and Victorian HIV Service programs.

Report the program/stream to which the patient/client has been accepted, not the intervention they are to receive. For example, do not report ‘313-Allied Health - Stand-alone’ unless the referral is to an Allied Health Clinic. Patients/clients can access allied health in other programs/streams.

The program/stream to which the patient/client is referred may not be the same as the program/stream for which the patient/client is accepted. For example, a patient/client may be referred to rehabilitation (code ‘1’), but after assessment it is decided that the patient/client be seen by the specialist falls clinic (code ‘5’); in this instance report ‘5-Specialist Falls’.

Code 1-19
Includes the SACS Program/Streams.

Code 21-29
Includes the HARP Program/Streams.

Code 61-69
Includes the Victorian HIV Program/Streams.

Code 101-406
Includes the Specialist Clinics (Outpatients) Program/Streams.
313 Allied Health - Stand-alone
This code should only be used when the entire episode for the patient/client is constituted of one or more Allied Health contacts. Where the patient/client is receiving services which fall under another Program/Stream but is also receiving Allied Health services, the episode should be reported with the other Program/Stream, not code 313.

Code 1300-1315
Includes the Hospital-Based Palliative Care Consultancy Team Program/Streams.
Choose the most appropriate Episode Program/Stream based on the service expected to be delivered. Code 1300 is available for reporting non-specific services.

Validations: E258 This organisation (<OrganisationIdentifier>) is not approved to report Episodes under this program/stream (<Episode Program/Stream>)

Related items: Episode Start Date

Administration

Purpose: To allow national reporting requirements to be met and assist with service planning and monitoring.

Principal users: Department of Health and Human Services

Version history:

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<td>8</td>
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<td>Episode Program/Stream</td>
<td>2014/07/01</td>
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<td>6</td>
<td>Episode Program/Stream</td>
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<td>5</td>
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Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
Episode Proposed Treatment Plan Completion

**Definition:** An indicator of whether the patient/client completed the proposed treatment/assessment program, and, if not, whether this was for medical or non-medical reasons, as determined by clinician.

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**Location:** Transmission protocol: HL7 Submission
- Episode (insert) PPP_PCB (PV2\PV2.24)
- Episode (update) PPP_PCC (PV2\PV2.24)
- Episode (delete) PPP_PCD (PV2\PV2.24)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Post Acute Care
- Residential In-Reach
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Episodes where Episode End Date falls within the current reporting period.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Episode End Date (Mandatory)

**Value domain:** Enumerated

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<tbody>
<tr>
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<td>Completed</td>
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</tbody>
</table>

**Completed**
- Care plan/proposed treatment completed

**Did not complete for medical reasons**
- 21 Unplanned patient/client admission to hospital
- 22 Planned patient/client admission to hospital
- 25 Alteration in patient/client medical condition without hospital admission
- 27 Patient/client died

**Did not complete for non-medical reasons**
- 31 Patient/client has declined further services
- 33 Patient/client has moved from area
- 35 Patient/client is unable to be contacted
- 41 Patient/client has been referred to another service
- 43 No measurable benefit from continuing the service
- 51 Patient/client not complying with program
- 53 Risk to client or staff prevents service provision

**Reporting guide:** These values align with the Health Independence Program guidelines.

**Related items:** Episode End Date
Administration

**Purpose:** Required for outcome analyses.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
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<td>Episode Proposed Treatment Plan Completion</td>
<td>2010/07/01</td>
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<tr>
<td>4</td>
<td>Episode Completion of Proposed Plan of Treatment</td>
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<td>Episode Completion of Proposed Plan of Treatment</td>
<td>2008/07/01</td>
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<td>2</td>
<td>Completion of Proposed Plan of Treatment</td>
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<td>Completion of Proposed Program of Treatment</td>
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</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** DHHS, based on HIP Guidelines 2008
Episode Start Date

**Definition:** When a program/stream first accepts a patient/client. This occurs in response to a referral, when a referral is accepted.

**Repeats:**
- Min.: 1
- Max.: 1
- Duplicate: Not applicable

**Form:** Date

**Layout:** YYYYMMDD

**Size:** Min. Max.

**Location:**
- **Transmission protocol:** HL7 Submission
  - Episode (insert): PPP_PCB (PV1\PV1.44\TS.1)
  - Episode (update): PPP_PCC (PV1\PV1.44\TS.1)
  - Episode (delete): PPP_PCD (PV1\PV1.44\TS.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Episodes opened in the current reporting period.

**Reported when:** **All Programs, not elsewhere specified**

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** The Episode Start Date is the date that it is determined that the Referral In Outcome is ‘1-Referral Accepted’.

For Palliative Care, where the foetus (in utero) has been classed as terminal, the Episode Start Date can occur prior to date of birth.

**Validations:**
- E020 <SucceedingEvent> (<SucceedingEventValue>) is before <Preceding Event> (<PrecedingEventValue>)
- E151 Client Age (<n>) is greater than 120 years.
- E206 Open episode sent for a referral specified as not accepted (<ref_details>)

**Related items:**
- Contact Date/Time
- Episode End Date
- Episode First Appointment Booked Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Start Date
- Patient/Client Birth Date
- Referral Identifier
- Referral In Clinical Referral Date
- Referral In Receipt Acknowledgment Date
- Referral In Received Date
- Referral Out Date
Administration

**Purpose:** To allow calculation of the period for which a person is a patient/client of a program/stream.

**Principal users:** Victorian and Australian Governments

**Version history:**

<table>
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<th>Version</th>
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<th>Effective Date</th>
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</thead>
<tbody>
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<tr>
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</tr>
<tr>
<td>1</td>
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<td>2007/07/01</td>
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**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
Episode TCP Bed-Based Care Transition Date

**Definition:** The date(s) on which a patient/client transitioned to bed-based care.

**Repeats:** Min. Max. Duplicate

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**Location:** Transmission protocol: HL7 Submission

- Episode (insert) PPP_PCB (PTH\PTH.4)
- Episode (update) PPP_PCC (PTH\PTH.4)
- Episode (delete) PPP_PCD (PTH\PTH.4)

**Reported by:** Transition Care Program

**Reported for:** All TCP episodes.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Either Episode TCP Bed-Based Care Transition Date or Episode TCP Home-Based Care Transition Date must be reported)
- Episode TCP Bed-Based Care Transition Date (Mandatory)

**Value domain:** A valid date.

**Reporting guide:** If a patient/client begins a TCP episode in bed-based care this date must be reported at episode start and the first value must be equal to Episode Start Date.

This date must be reported at each subsequent transition of a patient/client in the TCP program to bed-based care.

**Transmission binding data element**

When this item is transmitted via HL7, the value "TCPTB" must also be transmitted in Episode Pathway Type.

**Validations:** General edits only, see Format.

**Related items:**
- Episode Advanced Care Plan Documented Date
- Episode Care Plan Documented Date
- Episode First Appointment Booked Date
- Episode Hospital Discharge Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Start Date
- Episode TCP Bed-Based Care Transition Date
- Episode TCP Home-Based Care Transition Date

**Administration**

**Purpose:** To enable accurate counts of bed- and home-based care for the TCP program and Commonwealth reporting.

**Principal users:** Department of Health and Human Services, Commonwealth government.

**Version history:**

<table>
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<td>2010/07/01</td>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
Episode TCP Home-Based Care Transition Date

Definition: The date(s) on which a patient/client transitioned to home-based care.

<table>
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Location: Transmission protocol: HL7 Submission
- Episode (insert): PPP_PCB (PTH\PTH.4)
- Episode (update): PPP_PCC (PTH\PTH.4)
- Episode (delete): PPP_PCD (PTH\PTH.4)

Reported by: Transition Care Program

Reported for: All TCP episodes.

Reported when: All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Episode Start Date (Either Episode TCP Bed-Based Care Transition Date or Episode TCP Home-Based Care Transition Date must be reported)
- Episode TCP Home-Based Care Transition Date (Mandatory)

Value domain: A valid date.

Reporting guide: If a patient/client begins a TCP episode in home-based care this date must be reported at episode start and the first value must be equal to Episode Start Date.

This date must be reported at each subsequent transition of a patient/client in the TCP program to home-based care.

Transmission binding data element
When this item is transmitted via HL7, the value "TCPH" must also be transmitted in Episode Pathway Type.

Validations: General edits only, see Format.

Related items:
- Episode Advance Care Plan Documented Date
- Episode Care Plan Documented Date
- Episode First Appointment Booked Date
- Episode Hospital Discharge Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Start Date
- Episode TCP Bed-Based Care Transition Date
- Episode TCP Home-Based Care Transition Date

Administration

Purpose: To enable accurate counts of bed- and home-based care for the TCP program and Commonwealth reporting.

Principal users: Department of Health and Human Services, Commonwealth government.

Version history:

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<th>Effective Date</th>
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<tr>
<td>1</td>
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<td>2010/07/01</td>
</tr>
</tbody>
</table>

Definition source: Department of Health and Human Services

Value domain source: ISO8601:2000
**Patient/Client Birth Country**

**Definition:** The country in which the person was born.

**Repeats:**

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<th>Form</th>
<th>Min.</th>
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<th>Duplicate</th>
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<tbody>
<tr>
<td>Code</td>
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**Location:**

**Transmission protocol:** HL7 Submission

- Patient/Client (insert) ADT_A04 (PID:PID.23)
- Patient/Client (update) ADT_A08 (PID:PID.23)
- Patient/Client (merge) ADT_A40 (PID:PID.23)

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:**

Optional for patients/clients whose episode opened during the current reporting period; mandatory for patients/clients whose first contact occurred during the current reporting period.

**Reported when:** *All Programs, not elsewhere specified*

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- First Contact Date/Time (Mandatory)

**Value domain:** Refer to Section 9: Country of Birth.

**Reporting guide:** Select the code which describes the patient’s Country of Birth as precisely as possible.

The code set used is Standard Australian Classification of Countries 2011 (SACC). Australian Bureau of Statistics Cat. no. 1269.0 (2nd Edition, Revision 1).

**Validations:** E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date

**Related items:**

- Contact Clinic Identifier
- Contact Date/Time
- Episode Malignancy Flag
- Episode Start Date
- Patient/Client Carer Availability
- Patient/Client Death Place
- Patient/Client Living Arrangement
- Patient/Client Main Carer's Relationship to the Patient
- Patient/Client Usual Accommodation Type
- Patient/Client Usual Residence Locality Name
- Patient/Client Usual Residence Postcode
Administration

**Purpose:** To facilitate epidemiological studies.

**Principal users:** Multiple internal and external users.

**Version history:**

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<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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<tbody>
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<td>8</td>
<td>Patient/Client Birth Country</td>
<td>2014/07/01</td>
</tr>
<tr>
<td>7</td>
<td>Patient/Client Birth Country</td>
<td>2012/07/01</td>
</tr>
<tr>
<td>6</td>
<td>Patient/Client Birth Country</td>
<td>2009/11/01</td>
</tr>
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<td>5</td>
<td>Patient/Client Birth Country</td>
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<td>3</td>
<td>Patient/Client Birth Country</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Country of Birth</td>
<td>2007/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** NHDD

**Value domain source:** NHDD
**Patient/Client Birth Date**

**Definition:** The date of birth of the patient/client.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tbody>
<tr>
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<td>Max.</td>
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</table>

**Location:**

- **Transmission protocol:** HL7 Submission
- **Patient/Client (insert)**: ADT_A04 (PID\PID.7\TS.1)
- **Patient/Client (update)**: ADT_A08 (PID\PID.7\TS.1)
- **Patient/Client (merge)**: ADT_A40 (PID\PID.7\TS.1)

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Patients/clients whose episode was opened during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- **Episode Start Date** (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** The date of birth must be on or before Episode Start Date.

The century component of the year must begin with '18', '19' or '20'.

Where the patient's/client's date of birth is unknown it should be estimated as accurately as possible and the reliability of the estimate reported in the Date of Birth Accuracy Code data element. Components of the date marked in the Date of Birth Accuracy Code as 'U-Unknown', as opposed to 'A-Accurate' or 'E-Estimated', will be ignored by VINAH.

Patient/Client Birth Date may be reported with lower precision, as specified in Section 5, but these components of the date must be assigned a Patient/Client Birth Date Accuracy of 'U-Unknown'.

**Validations:**

- E020 <SucceedingEvent> (<SucceedingEventValue>) is before <PrecedingEvent> (<PrecedingEventValue>)
- E151 Client Age (<n>) is greater than 120 years.
**Related items:**
- Contact Date/Time
- Episode End Date
- Episode First Appointment Booked Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Start Date
- Referral In Clinical Referral Date
- Referral In Receipt Acknowledgment Date
- Referral In Received Date
- Referral Out Date

**Administration**

**Purpose:** A code representing the accuracy of the components of a date - year, month, day.

**Principal users:** Multiple internal and external research users.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
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<td>Patient/Client Birth Date</td>
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</tr>
<tr>
<td>5</td>
<td>Patient/Client Birth Date</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>4</td>
<td>Patient/Client Birth Date</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Date of Birth</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Date of Birth</td>
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</tr>
<tr>
<td>1</td>
<td>Date of Birth</td>
<td>2005/07/01</td>
</tr>
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</table>

**Definition source:** NHDD

**Value domain source:** ISO8601:2000 (Consistent with CCDSv2)
Patient/Client Birth Date Accuracy

**Definition:** The mode of provision of the service during the contact.

**Repeats:**

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<tr>
<th>Item</th>
<th>Min.</th>
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<th>Duplicate</th>
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<tr>
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**Reported by:**
Family Choice Program
Hospital Admission Risk Program
Medi-Hotel
Palliative Care
Post Acute Care
Residential In-Reach
Specialist Clinics (Outpatients)
Sub-acute Ambulatory Care Services
Transition Care Program
Victorian HIV Service
Victorian Respiratory Support Service

**Reported for:** Patients/clients whose episode was opened during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Mandatory)

**Value domain:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Accurate Year, Accurate Month, Accurate Day</td>
</tr>
<tr>
<td>AAE</td>
<td>Accurate Year, Accurate Month, Estimated Day</td>
</tr>
<tr>
<td>AAU</td>
<td>Accurate Year, Accurate Month, Unknown Day</td>
</tr>
<tr>
<td>AEA</td>
<td>Accurate Year, Estimated Month, Accurate Day</td>
</tr>
<tr>
<td>AEE</td>
<td>Accurate Year, Estimated Month, Estimated Day</td>
</tr>
<tr>
<td>AEU</td>
<td>Accurate Year, Estimated Month, Unknown Day</td>
</tr>
<tr>
<td>AUA</td>
<td>Accurate Year, Unknown Month, Accurate Day</td>
</tr>
<tr>
<td>AUE</td>
<td>Accurate Year, Unknown Month, Estimated Day</td>
</tr>
<tr>
<td>AUU</td>
<td>Accurate Year, Unknown Month, Unknown Day</td>
</tr>
<tr>
<td>EAA</td>
<td>Estimated Year, Accurate Month, Accurate Day</td>
</tr>
<tr>
<td>EAE</td>
<td>Estimated Year, Accurate Month, Estimated Day</td>
</tr>
<tr>
<td>EAU</td>
<td>Estimated Year, Accurate Month, Unknown Day</td>
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<td>EEA</td>
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<td>EEE</td>
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<tr>
<td>EEU</td>
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</tr>
<tr>
<td>EUA</td>
<td>Estimated Year, Unknown Month, Accurate Day</td>
</tr>
<tr>
<td>EUE</td>
<td>Estimated Year, Unknown Month, Estimated Day</td>
</tr>
<tr>
<td>EUU</td>
<td>Estimated Year, Unknown Month, Unknown Day</td>
</tr>
</tbody>
</table>
**Reporting guide:** This data element's value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:

- **A** - The referred date component is accurate.
- **E** - The referred date component is not known but is estimated.
- **U** - The referred date component is not known and not estimated.

This data element contains three positional components (YMD) that reflect the order of the date components in the format (YYYYMMDD) of the reported Date of Birth.

1st - **Y** - Refers to the accuracy of the year component.
2nd - **M** - Refers to the accuracy of the month component.
3rd - **D** - Refers to the accuracy of the day component.

Report: Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

Example 1: A date has been sourced from a reliable source and is known as accurate then the date accuracy indicator should be informed as 'AAA'.

Example 2: If only the age of the person is known and there is no certainty of the accuracy of this, then the date accuracy indicator should be informed as 'EUU'. That is the day and month are unknown and the year is estimated.

VINAH does not accept a Year component value of 'U-Unknown'.

Where this element is not reported for VINAH-SACS sites prior to 01 January 2007, it will be assumed to be 'AAA'.

**Validations:** General edits only, see Format.

**Related items:**
- Episode Start Date
- Patient/Client Death Date Accuracy

**Administration**

**Purpose:** Required to derive age for demographic analyses and for analysis by age at a point of time.

**Principal users:** Multiple internal and external research users.

**Version history:**

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<th>Version</th>
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<td>Patient/Client Birth Date Accuracy</td>
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<td>2008/07/01</td>
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</tr>
<tr>
<td>1</td>
<td>Date of Birth Accuracy Code</td>
<td>2006/07/01</td>
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</table>

**Definition source:** NHDD (DHHS modified)

**Value domain source:** NHDD 94429 (DHHS modified) (Consistent with CCDSv2)
Patient/Client Carer Availability

**Definition:** A record of whether a person, such as a family member, friend or neighbour, has been identified as providing regular and sustained informal care and assistance to the person requiring care.

**Repeats:**

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<tbody>
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**Form:**
Code

**Layout:**
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**Size:**

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**Location:**

**Transmission protocol:** HL7 Submission

- Patient/Client (insert) ADT_A04 (NK1\NK1.7\CE.1)
- Patient/Client (update) ADT_A08 (NK1\NK1.7\CE.1)
- Patient/Client (merge) ADT_A40 (NK1\NK1.7\CE.1)

**Reported by:**
Family Choice Program
Hospital Admission Risk Program
Palliative Care
Post Acute Care
Residential In-Reach
Sub-acute Ambulatory Care Services
Transition Care Program
Victorian HIV Service
Victorian Respiratory Support Service

**Reported for:** Optional for patients/clients whose episode opened during the current reporting period; mandatory for patients/clients whose first contact occurred during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- Episode Contact Date/Time (Mandatory)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>1</td>
<td>Has a carer</td>
</tr>
<tr>
<td>2</td>
<td>Has no carer</td>
</tr>
<tr>
<td>9</td>
<td>Not stated/inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide:**

Carers include those people who receive a pension or benefit for their caring role but the definition does not include paid or volunteer carers organised by formal services. It also excludes funded group housing or similar situations.

A carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the patient/client does not have to live with the patient/client in order to be called a carer.

The availability of a carer should also be distinguished from living with someone else. Although in many instances a co-resident will also be a carer, this is not necessarily the case. The data element Living Arrangement is designed to record information about person(s) with whom the patient/client may live.

This data element is purely descriptive of a patient's/client's circumstances. It is not intended to reflect whether the carer is considered by the service...
provider to be capable of undertaking the caring role and is also not intended to reflect whether the service provider considers that a carer is needed by the patient/client. In line with this, the expressed views of the patient/client and/or their carer should be used as the basis for determining whether the patient/client is recorded as having a carer or not.

1 - Has a carer
Excludes:
• Patients/Clients whose potential carers are children under eight years of age.
• Patients/Clients who is living in supported accommodation or other care facility that will provide the formal care required.

Includes:
• Patients/Clients who are in the care of a foster family/person/s or similar temporary family role.

2 - Has no carer
Patient/Client does not have an informal carer willing and/or able to assist with care on an arranged and regular basis.

9 - Not stated/inadequately described
Insufficient information to determine carer availability.

Validations:

E152 Carer Availability is 'Has a carer' (<ca>) but Carer Residency Status (<crs>) is not compatible
E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date
E254 Patient/client must have a Main Carer's Relationship to the Patient when Carer Availability is '1 - Has a carer'

Related items:
Contact Clinic Identifier
Contact Date/Time
Episode Start Date
Patient/Client Birth Country
Patient/Client Carer Residency Status
Patient/Client Death Place
Patient/Client Living Arrangement
Patient/Client Main Carer’s Relationship to the Patient
Patient/Client Usual Accommodation Type
Patient/Client Usual Residence Locality Name
Patient/Client Usual Residence Postcode

Administration

Purpose: To enable monitoring of the impact of carer availability on exit timing and use of ambulatory services, to support policy development and planning.

Principal users: Department of Health and Human Services

Version history:

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<thead>
<tr>
<th>Version</th>
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<tbody>
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<td>Patient/Client Carer Availability</td>
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<td>4</td>
<td>Patient/Client Carer Availability</td>
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<tr>
<td>3</td>
<td>Patient/Client Carer Availability</td>
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<tr>
<td>2</td>
<td>Carer Availability</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Carer Availability</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

Definition source: NHDD

Value domain source: NHDD 002003 (Consistent with CCDSv2)
Patient/Client Carer Residency Status

**Definition:** Whether or not a carer lives with the patient/client for whom they care.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min</th>
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<th>Duplicate</th>
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**Location:**

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<tr>
<th>Transmission protocol:</th>
<th>HL7 Submission</th>
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</thead>
<tbody>
<tr>
<td>Patient/Client (insert)</td>
<td>ADT_A04 (NK1\NK1.21)</td>
</tr>
<tr>
<td>Patient/Client (update)</td>
<td>ADT_A08 (NK1\NK1.21)</td>
</tr>
<tr>
<td>Patient/Client (merge)</td>
<td>ADT_A40 (NK1\NK1.21)</td>
</tr>
</tbody>
</table>

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All patients/clients where the Carer Availability is reported as 1 - Has a carer.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Report when Patient/Client Carer Availability = ‘1’)
- First Contact Date/Time (Report when Patient/Client Carer Availability = ‘1’)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Table identifier</th>
<th>990014</th>
</tr>
</thead>
</table>

**Code** | **Descriptor**
---|---
1 | Co-resident carer
2 | Non-resident carer
9 | Not stated/inadequately described

**Reporting guide:** Used to record residency status of the person who provides most care to the patient/client.

If a patient/client has both a co-resident (for example a spouse) and a visiting carer (for example a daughter or son), the response should be related to the carer who provides the most significant care and assistance related to the patient's/client's capacity to remain living at home. The expressed views of the patient/client and/or their carer(s) or significant other should be used as the basis for determining this.

1 - Co-resident carer
A co-resident carer is a person who provides care and assistance on a regular and sustained basis to a person who lives in the same household.

2 - Non-resident carer
A non-resident or visiting carer is a person who provides care and assistance on a regular and sustained basis to someone who lives in a different household.

9 - Not stated/inadequately described
Insufficient information to determine carer residency status.
Validations: E152 Carer Availability is ‘Has a carer’ (<ca>) but Carer Residency Status (<crs>) is not compatible

Related items: Contact Clinic Identifier
Episode Start Date
Patient/Client Carer Availability

Administration

Purpose: To enable monitoring of the impact of carer availability and residency status on exit timing and use of ambulatory services, to support policy development and planning.

Principal users: Department of Health and Human Services

Version history:

<table>
<thead>
<tr>
<th>Version</th>
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<th>Effective Date</th>
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<tbody>
<tr>
<td>5</td>
<td>Patient/Client Carer Residency Status</td>
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<tr>
<td>4</td>
<td>Patient/Client Carer Residency Status</td>
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</tr>
<tr>
<td>3</td>
<td>Patient/Client Carer Residency Status</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Carer Residency Status</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Carer Residency Status</td>
<td>2005/07/01</td>
</tr>
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</table>

Definition source: NCSDD

Value domain source: NCSDD 000553 (Consistent with CCDScv2)
Patient/Client Death Date

Definition: The date of death of the patient/client.

Repeats: Min. 1 Max. 1 Duplicate Not applicable

Form: Date

Layout: YYYYMMDD Size: Min. Max.

Location: Transmission protocol: HL7 Submission

Patient/Client (insert) ADT_A04 (PID\PID.29\TS.1)
Patient/Client (update) ADT_A08 (PID\PID.29\TS.1)
Patient/Client (merge) ADT_A40 (PID\PID.29\TS.1)

Reported by: Family Choice Program
Hospital Admission Risk Program
Palliative Care
Post Acute Care
Residential In-Reach
Sub-acute Ambulatory Care Services
Transition Care Program
Victorian HIV Service
Victorian Respiratory Support Service

Reported for: Patients/clients who died during the current reporting period.

Reported when: All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Episode End Date (Must be reported if Episode Proposed Treatment Plan Completion = ‘27’ or Program is Palliative Care or HBPCCT)
Patient/Client Death Date (Mandatory)

Value domain: Valid date.

Reporting guide: The century component of the year must begin with ‘20’.

Where the patient’s/client’s date of death is unknown it should be estimated as accurately as possible and the reliability of the estimate reported in the Death Date Accuracy data element. Components of the date marked in the Date of Death Accuracy Code as ‘U-Unknown’, as opposed to ‘A-Accurate’ or ‘E-Estimated’, will be ignored by VINAH.

The patient’s/client’s death date is required where the Episode Completion of Proposed Plan of Treatment is code 27 – Patient/Client died and for Palliative Care and HBPCCT, when the patient dies within the Episode. This data element is Mandatory only when the patient's death occurs within the episode.

Validations: E154 Where a Date of Death is reported, a Date of Death Accuracy Code and Place of Death must be provided
E361 Contact Date (<ccsedate>) is after Date of Death (<dod>), but Client Present Status (<val>) is not ‘20 - Carer(s)/Relative(s) of the patient/client only’ or ‘31 - Patient/Client/Carer(s)/Relative(s) not present: Indirect Contact’

Related items: Contact Client Present Status
Contact Date/Time
Episode End Date
Patient/Client Death Date
Patient/Client Death Date Accuracy
Patient/Client Death Place
Administration

**Purpose:** Required for commonwealth reporting.

**Principal users:** Multiple internal and external research users.

**Version history:**

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<tr>
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<th>Effective Date</th>
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<tbody>
<tr>
<td>4</td>
<td>Patient/Client Death Date</td>
<td>2014/07/01</td>
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<tr>
<td>3</td>
<td>Patient/Client Death Date</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Patient/Client Death Date</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Date of Death</td>
<td>2007/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** METeOR 287305

**Value domain source:** METeOR 287305 (Consistent with CCDSv2)
### Patient/Client Death Date Accuracy

**Definition:** A code representing the accuracy of the components of a date - year, month, day.

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<thead>
<tr>
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<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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**Location:**

- **Transmission protocol:** HL7 Submission
- Patient/Client (insert) ADT_A04 (PID\PID.32\TS.1)
- Patient/Client (update) ADT_A08 (PID\PID.32\TS.1)
- Patient/Client (merge) ADT_A40 (PID\PID.32\TS.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Patients/clients who died during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Episode End Date (Must be reported if Episode Proposed Treatment Plan Completion = '27' or Program is Palliative Care or HBPCCT)
- Patient/Client Death Date (Mandatory)

**Value domain:** Table identifier HL70445

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Accurate Year, Accurate Month, Accurate Day</td>
</tr>
<tr>
<td>AAE</td>
<td>Accurate Year, Accurate Month, Estimated Day</td>
</tr>
<tr>
<td>AAU</td>
<td>Accurate Year, Accurate Month, Unknown Day</td>
</tr>
<tr>
<td>AEA</td>
<td>Accurate Year, Estimated Month, Accurate Day</td>
</tr>
<tr>
<td>AEE</td>
<td>Accurate Year, Estimated Month, Estimated Day</td>
</tr>
<tr>
<td>AEU</td>
<td>Accurate Year, Estimated Month, Unknown Day</td>
</tr>
<tr>
<td>AUA</td>
<td>Accurate Year, Unknown Month, Accurate Day</td>
</tr>
<tr>
<td>AUE</td>
<td>Accurate Year, Unknown Month, Estimated Day</td>
</tr>
<tr>
<td>AUU</td>
<td>Accurate Year, Unknown Month, Unknown Day</td>
</tr>
<tr>
<td>EAA</td>
<td>Estimated Year, Accurate Month, Accurate Day</td>
</tr>
<tr>
<td>EAE</td>
<td>Estimated Year, Accurate Month, Estimated Day</td>
</tr>
<tr>
<td>EAU</td>
<td>Estimated Year, Accurate Month, Unknown Day</td>
</tr>
<tr>
<td>EEA</td>
<td>Estimated Year, Estimated Month, Accurate Day</td>
</tr>
<tr>
<td>EEE</td>
<td>Estimated Year, Estimated Month, Estimated Day</td>
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<tr>
<td>EEU</td>
<td>Estimated Year, Estimated Month, Unknown Day</td>
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<tr>
<td>EUA</td>
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</tr>
<tr>
<td>EUE</td>
<td>Estimated Year, Unknown Month, Estimated Day</td>
</tr>
<tr>
<td>EUU</td>
<td>Estimated Year, Unknown Month, Unknown Day</td>
</tr>
</tbody>
</table>
**Reporting guide:** This data element's value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:

- **A** - The referred date component is accurate.
- **E** - The referred date component is not known but is estimated.
- **U** - The referred date component is not known and not estimated.

This data element contains three positional components (YMD) that reflect the order of the date components in the format (YYYYMMDD) of the reported Date of Birth.

1st - **Y** - Refers to the accuracy of the year component.
2nd - **M** - Refers to the accuracy of the month component.
3rd - **D** - Refers to the accuracy of the day component.

Report: Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

Example 1: A date has been sourced from a reliable source and is known as accurate then the date accuracy indicator should be informed as 'AAA'.

Example 2: If only the age of the person is known and there is no certainty of the accuracy of this, then the date accuracy indicator should be informed as 'EUU'. That is the day and month are unknown and the year is estimated.

VINAH does not accept a Year component value of 'U-Unknown'.

Report this data element when reporting Patient/Client Death Date.

**Validations:** E154 Where a Date of Death is reported, a Date of Death Accuracy Code and Place of Death must be provided

**Related items:** Episode End Date
Patient/Client Birth Date Accuracy
Patient/Client Death Date
Patient/Client Death Place

**Administration**

**Purpose:** For national reporting requirements.

**Principal users:** Multiple internal and external research users.

**Version history:**

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<tr>
<th>Version</th>
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<th>Effective Date</th>
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<tbody>
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<td>Patient/Client Death Date Accuracy</td>
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<tr>
<td>3</td>
<td>Patient/Client Death Date Accuracy</td>
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<td>2</td>
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<td>2008/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Date of Death Accuracy Code</td>
<td>2007/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** METeOR 294429

**Value domain source:** METeOR 294429 (Consistent with CCDSv2)
Patient/Client Death Place

**Definition:** The type of setting in which the patient/client died.

**Repeats:** Min. Max. Duplicate
Form: Code 1 1 Not applicable
Layout: NN Size: Min. Max. 2 2

**Location:**
Transmission protocol: HL7 Submission
Patient/Client (insert) ADT_A04 (PDA\PDA.2\PL.6)
Patient/Client (update) ADT_A08 (PDA\PDA.2\PL.6)

**Reported by:** Palliative Care
**Reported for:** Patients/clients who died in the current reporting period.
**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
Date of Death (Mandatory)
Patient/Client Death Date (Mandatory)

**Value domain:** Enumerated
Table identifier 990034

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>10</td>
<td>Private residence</td>
</tr>
<tr>
<td>21</td>
<td>Residential – aged care setting</td>
</tr>
<tr>
<td>22</td>
<td>Residential – other setting</td>
</tr>
<tr>
<td>30</td>
<td>Non-residential setting</td>
</tr>
<tr>
<td>41</td>
<td>Inpatient setting – designated palliative care unit</td>
</tr>
<tr>
<td>42</td>
<td>Inpatient setting – other than designated palliative care unit</td>
</tr>
<tr>
<td>99</td>
<td>Other location</td>
</tr>
</tbody>
</table>

**Reporting guide:** This item should be coded to reflect the delivery location from the patient's/client’s perspective, not the location of the health service professional(s).

**10 - Private residence**
Includes:
- Caravans
- Houseboats
- Mobile homes
- Units in a retirement village.

**21 - Residential – aged care setting**
Includes high and low care residential aged care facilities
Excludes patients living in a retirement village

**22 - Residential – other setting**
Includes Residential facilities other than aged care facilities for example:
- Prison
- Community living environment including a group home
Excludes patients in an inpatient setting for example hospital and hospices

**30 - Non-residential setting**
Includes:
- Day respite centres
- Day centres
- Palliative care day centres
• Community health centres
• Outpatient departments (hospitals/hospices)

41 - Inpatient setting – designated palliative care unit
A dedicated ward or unit that receives identified funding for palliative care and/or primarily delivers palliative care. The unit may be a standalone unit.

42 - Inpatient setting – other than designated palliative care unit
Includes all beds not designated for palliative care, usually located in acute hospital wards.
Excludes patients in designated palliative care units.

99 - Other location
Includes but is not limited to, an accident and emergency department (casually department) prior to the patient being admitted.

Validations:
E154 Where a Date of Death is reported, a Date of Death Accuracy Code and Place of Death must be provided
E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date

Related items:
Contact Clinic Identifier
Date of Death
Patient/Client Birth Country
Patient/Client Carer Availability
Patient/Client Death Date
Patient/Client Death Date Accuracy
Patient/Client Living Arrangement
Patient/Client Main Carer’s Relationship to the Patient
Patient/Client Usual Accommodation Type
Patient/Client Usual Residence Locality Name
Patient/Client Usual Residence Postcode

Administration

Purpose: To assist with service planning and monitoring, and to meet national reporting requirements.

Principal users: Department of Health and Human Services

Version history:

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<th>Effective Date</th>
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<tr>
<td>3</td>
<td>Patient/Client Death Place</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Patient/Client Place of Death</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Place of Death</td>
<td>2007/07/01</td>
</tr>
</tbody>
</table>

Definition source: Proposed Pall Care NMDS

Value domain source: Proposed Pall Care NMDS
Patient/Client DVA File Number

**Definition:** The Department of Veterans’ Affairs file number applicable to the patient/client.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<td>Location:</td>
<td>Transmission protocol: HL7 Submission</td>
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<tr>
<td></td>
<td>Contact (insert)</td>
<td>ADT_A03 (PID:PID.3\CX.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact (update)</td>
<td>ADT_A08 (PID:PID.3\CX.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact (delete)</td>
<td>ADT_A40 (PID:PID.3\CX.1)</td>
<td></td>
</tr>
</tbody>
</table>

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Contacts in the current reporting period where, and only where, Contact Account Class is ‘VX - Department of Veterans’ Affairs (DVA)’.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

First Contact Date/Time (Report when and only when Contact Account Class = 'VX')

Second and Subsequent Contact Date/Time (Report when and only when Contact Account Class = 'VX')

**Value domain:** A valid DVA file number (see reporting guide).

**Reporting guide:**
This number must be recorded at each contact/client service event where a service is provided to a person who holds the entitlement for reimbursement purposes.

The DVA file number is obtained from the patient/client. It is recorded on the DVA card, held by those eligible for DVA benefits.

The file number used is the one stated on the DVA gold card or white card, reported as it appears on the card. The number used is the one immediately below the patient’s/client’s name. The file number will be 8 or 9 characters that may be letters or numbers.

**Layout**

Part 1: State identifier

| Layout: | A |
| Valid codes: | Q, N, V, T, S or W. |
| ACT is included in N (NSW) and NT with S (SA). |
| May be 1 character in length. |

Part 2: War Group Code

| Layout: | [XXX] |
| May be 0 to 3 alphanumeric characters in length. A list of valid War Group Codes may be downloaded from the HDSS web site at:

Part 3: Serial Number
Layout: NN[NNNN]
May be 2 to 6 numeric characters in length.

Part 4: Spouse or Dependent Identifier
Layout: [X]
May be 0 to 1 characters in length.

**Valid format**

- Only alpha, numeric and spaces are permitted.
- Alpha characters must be uppercase.
- A maximum of six numeric characters is permitted.
- Trailing spaces (to the right) are permitted.

**Examples**

'N123456', 'VX123456', 'WXX123A' or 'QXXX1B'.

**Validations:**

E356  Contact is Compensable (<AccountClass>) but there is no client identifier provided relevant to this compensable agency

**Related items:**

- Contact Account Class
- Contact Client Medicare Number
- Contact Date/Time
- Contact TAC Claim Number
- Contact VWA File Number
- Patient/Client Identifier

**Administration**

**Purpose:** To facilitate reimbursement by DVA for patients/clients with entitlements. These data are processed differently from other VINAH data to ensure that personal information remains confidential.

**Principal users:** Department of Veterans’ Affairs.

**Version history:**

<table>
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<th>Version</th>
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<tbody>
<tr>
<td>5</td>
<td>Patient/Client DVA File Number</td>
<td>2010/07/01</td>
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<td>4</td>
<td>Patient/Client DVA File Number</td>
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<tr>
<td>3</td>
<td>Patient/Client DVA File Number</td>
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<td>1</td>
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<td>2005/07/01</td>
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**Definition source:** NHDD

**Value domain source:** DVA (Consistent with CCDSv2)
### Patient/Client Identifier

**Definition:**
An identifier unique to a person.

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<tr>
<th>Repeats:</th>
<th>Min.</th>
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**Location:**

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<th>HL7 Submission</th>
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<tbody>
<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PID\PID.3\CX.1)</td>
</tr>
<tr>
<td>Patient/Client (insert)</td>
<td>ADT_A04 (PID\PID.3\CX.1)</td>
</tr>
<tr>
<td>Contact (update)</td>
<td>ADT_A08 (PID\PID.3\CX.1)</td>
</tr>
<tr>
<td>Patient/Client (update)</td>
<td>ADT_A08 (PID\PID.3\CX.1)</td>
</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PID\PID.3\CX.1)</td>
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<tr>
<td>Patient/Client (merge)</td>
<td>ADT_A40 (PID\PID.3\CX.1)</td>
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<td>Episode (update)</td>
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<td>Referral Out (insert)</td>
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<td>Referral Out (update)</td>
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<tr>
<td>Referral In (delete)</td>
<td>RRI_I14 (PID\PID.3\CX.1)</td>
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</table>

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:**

All messages.

**Reported when:**

**All Programs, not elsewhere specified**

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Referral In Received Date (Mandatory)
- Referral In Received Date (Mandatory)
- Referral In Receipt Acknowledgment Date (Mandatory)
- Episode Start Date (Mandatory)
- Episode Care Plan Documented Date (Mandatory)
- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)
- Episode End Date (Mandatory)
- Patient/Client Death Date (Mandatory)
- Patient/Client Death Date (Mandatory)

**Value domain:**

Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.
**Reporting guide:** Organisations may use patient/client's unit record number where the number is unique across campuses for the organisation. Where this is not possible an identifier unique across HARP-CDM, Specialist Clinics (Outpatients), PAC, Palliative Care, SACS services in scope should be provided. For example, if linkage number or universal identifier is used this may be provided.

It is understood that during the transition period while the VINAH is first implemented, some organisations may not be able to provide a Patient/Client Identifier that fully adheres to this definition by providing a unique identification for a HARP-CDM, Specialist Clinics (Outpatients), PAC, Palliative Care, SACS patient/client across the entire organisation. Organisations in this position are requested to use a Patient/Client Identifier with as broad a scope as possible.

This item will be used in conjunction with the Local Identifier Assigning Authority and the Identifier Type item to determine the scope of the unique identification of the patient/client.

It is permissible to utilise upper case or lower case ASCII alpha characters, digits 0 to 9, dashes, spaces or apostrophes. That is, ASCII hexadecimal values 20, 27, 2D, 41 through 5A inclusive, 61 through 7A inclusive. Identifiers are case-sensitive.

It is recommended that if this data is converted from a numeric value with less than 15 places it be right justified and zero filled.

**Use in Referral In Messages**
Patient/Client Identifier and the associated values of Identifier Type and Local Identifier Assigning Authority may be left null in Referral In messages. However, if transmitted, they must identify a registered patient or client.

**Validations:**

- **E050** Field `<element_name> (<Location>)` has no value but is part of the primary key for the `<structure>` record.
- **E051** Cannot insert record, same Primary Key for data structure "<structure>" already exists (<conflict_location>). Key fields: `<pk_expanded_val>`
- **E052** A `<pk_structure>` message (<hl7_message>) has been sent containing a reference to a "<fk_structure>" record that has not been previously received and accepted. Key fields: `<fk_expanded>`
- **E061** A `<pk_structure>` message (<hl7_message_type>) was sent to either update or delete a record that has not been previously received and accepted. Key fields: `<key_expanded>`

**Related items:**
- Contact Client Medicare Number
- Contact Date/Time
- Contact Identifier
- Contact TAC Claim Number
- Contact VWA File Number
- Episode Care Plan Documented Date
- Episode End Date
- Episode Identifier
- Episode Start Date
- Identifier Type
- Local Identifier Assigning Authority
- Patient/Client Death Date
- Patient/Client DVA File Number
- Referral Identifier
- Referral In Receipt Acknowledgment Date
- Referral In Received Date
Administration

**Purpose:** To enable analysis of data for utilisation patterns.

**Principal users:** Department of Health and Human Services

**Version history:**

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<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>5</td>
<td>Patient/Client Identifier</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>4</td>
<td>Patient/Client Identifier</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Patient/Client Identifier</td>
<td>2008/07/01</td>
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<tr>
<td>2</td>
<td>Person Identifier</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Person Identifier</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** VINAH contributing organisation (Consistent with CCDSv2)
Patient/Client Living Arrangement

**Definition:** Whether a patient/client usually resides alone or with others.

**Repeats:**

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<tr>
<th>Form</th>
<th>Layout</th>
<th>Size</th>
<th>Min.</th>
<th>Max.</th>
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</table>

**Location:**

- **Transmission protocol:** HL7 Submission
  - Patient/Client (insert) ADT_A04 (PD1\PD1.2)
  - Patient/Client (update) ADT_A08 (PD1\PD1.2)

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Optional for patients/clients whose episode opened during the current reporting period; mandatory for patients/clients whose first contact occurred during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Optional)
- First Contact Date/Time Mandatory

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>1</td>
<td>Lives alone</td>
</tr>
<tr>
<td>2</td>
<td>Lives with family</td>
</tr>
<tr>
<td>3</td>
<td>Lives with others</td>
</tr>
<tr>
<td>9</td>
<td>Not stated/Inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide:**

It is recognised that living arrangements may change during the course of an episode. This item should record the situation at the time when the episode is opened.

On occasion, difficulties can arise in deciding the living arrangement of a person due to their type of accommodation (for example boarding houses, hostels, group homes, retirement villages, residential aged care facilities). In these circumstances the person should be regarded as living alone, except in those instances in which they are sharing their own private space/room within the premises with a significant other (for example partner, sibling, close friend).

- **2 - Lives with family**
  
  If the person's household includes both family and non-family members, the person should be recorded as living with family. 'Living with family' should be considered to include defacto and same sex relationships.

- **9 - Not stated/inadequately described**
  
  Insufficient information to determine Living Arrangement.
Validations: E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date

Related items: Contact Clinic Identifier
Contact Date/Time
Episode Malignancy Code
Episode Start Date
Patient/Client Birth Country
Patient/Client Carer Availability
Patient/Client Death Place
Patient/Client Living Arrangement
Patient/Client Main Carer’s Relationship to the Patient
Patient/Client Usual Accommodation Type
Patient/Client Usual Residence Locality Name
Patient/Client Usual Residence Postcode

Administration

Purpose: To enable monitoring of the impact of living arrangements (in conjunction with carer availability and residency status) on exit timing and use of ambulatory services, to support policy development and planning.

Principal users: Department of Health and Human Services

Version history:

<table>
<thead>
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<th>Version</th>
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<th>Effective Date</th>
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<td>5</td>
<td>Patient/Client Living Arrangement</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>4</td>
<td>Patient/Client Living Arrangement</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Patient/Client Living Arrangement</td>
<td>2008/07/01</td>
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<tr>
<td>2</td>
<td>Living Arrangement</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Living Arrangement</td>
<td>2005/07/01</td>
</tr>
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</table>

Definition source: NHDD

Value domain source: NCSDD 000527 (Consistent with CCDSv2)
Patient/Client Main Carer’s Relationship to the Patient

**Definition:** The relationship of the patient's/client’s carer to the patient/client.

**Repeats:**

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<tr>
<th>Form</th>
<th>Code</th>
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<th>Max.</th>
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**Location:** Transmission protocol: HL7 Submission
- Patient/Client (insert) ADT_A04 (NK1\NK1.3\CE.1)
- Patient/Client (update) ADT_A08 (NK1\NK1.3\CE.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Patients/clients where Patient/Client Carer Availability is ‘1-Has a Carer’.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Episode Start Date (Optional)
- First Contact Date/Time (Report when Patient/Client Carer Availability = ‘1’)

**Value domain:** Enumerated

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<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>10</td>
<td>Spouse/partner</td>
</tr>
<tr>
<td>20</td>
<td>Parent</td>
</tr>
<tr>
<td>30</td>
<td>Child</td>
</tr>
<tr>
<td>40</td>
<td>Child-in-law</td>
</tr>
<tr>
<td>50</td>
<td>Other relative</td>
</tr>
<tr>
<td>60</td>
<td>Friend/neighbour</td>
</tr>
<tr>
<td>70</td>
<td>Foster carer</td>
</tr>
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</table>

**Value domain:**

**Table identifier** HL70063

**Reporting guide:**

This data element should always be used to record the relationship of the carer to the person for whom they care, regardless of whether the patient/client of the agency is the carer or the person for whom they care.

For example, if a woman was caring for her frail aged mother-in-law, the agency would record that the carer is the daughter-in-law of the care recipient (that is code ‘40’). Similarly, if a man were caring for his disabled son, then the agency would record that the carer is the father of the care recipient (that is code ‘20’).

If a person has more than one carer (for example a spouse and a son), the coding response to relationship of carer to care recipient should relate to the carer who provides the most significant care and assistance related to the person's capacity to remain living at home. The expressed views of the patient/client and/or their carer or significant other should be used as the basis for determining which carer should be considered to be the primary or principal carer in this regard.
Validations:  E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date
          E254 Patient/client must have a Main Carer's Relationship to the Patient when Carer Availability is ‘1 - Has a carer’

Related items:  Contact Clinic Identifier
                Contact Date/Time
                Episode Start Date
                Patient/Client Birth Country
                Patient/Client Carer Availability
                Patient/Client Carer Residency Status
                Patient/Client Death Place
                Patient/Client Living Arrangement
                Patient/Client Usual Accommodation Type
                Patient/Client Usual Residence Locality Name
                Patient/Client Usual Residence Postcode

Administration

Purpose:  To assist with outcome analyses and service planning, and meeting national reporting requirements.

Principal users:  Department of Health and Human Services

Version history:

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<th>Version</th>
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<tr>
<td>4</td>
<td>Patient/Client Main Carer’s Relationship to the Patient</td>
<td>2010/07/01</td>
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<td>Patient/Client Main Carer’s Relationship to the Patient</td>
<td>2009/07/01</td>
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<td>2</td>
<td>Patient/Client Main Carer’s Relationship to the Patient</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Main Carer’s Relationship to the Patient</td>
<td>2007/07/01</td>
</tr>
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</table>

Definition source:  METeOR 270012 (also proposed Pall Care NMDS)

Value domain source:  METeOR 270012 (Consistent with CCDS v2)
Patient/Client Sex

**Definition:** The sex of the person.

**Repeats:**

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<th>Code</th>
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<th>Max.</th>
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<tr>
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<td>HL7 Submission</td>
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<tr>
<td>Patient/Client (insert)</td>
<td>ADT_A04 (PID\PID.8)</td>
<td></td>
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<tr>
<td>Patient/Client (update)</td>
<td>ADT_A08 (PID\PID.8)</td>
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**Size:**

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**Location:**

<table>
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<tr>
<th>Reported by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Choice Program</td>
</tr>
<tr>
<td>Hospital Admission Risk Program</td>
</tr>
<tr>
<td>Hospital Based Palliative Care Consultancy Team</td>
</tr>
<tr>
<td>Medi-Hotel</td>
</tr>
<tr>
<td>Palliative Care</td>
</tr>
<tr>
<td>Post Acute Care</td>
</tr>
<tr>
<td>Residential In-Reach</td>
</tr>
<tr>
<td>Specialist Clinics (Outpatients)</td>
</tr>
<tr>
<td>Sub-acute Ambulatory Care Services</td>
</tr>
<tr>
<td>Transition Care Program</td>
</tr>
<tr>
<td>Victorian HIV Service</td>
</tr>
<tr>
<td>Victorian Respiratory Support Service</td>
</tr>
</tbody>
</table>

**Reported for:** Patients/clients whose episode was opened during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Mandatory)

**Value domain:** Enumerated

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<tbody>
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<td>Code</td>
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<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>4</td>
<td>Intersex</td>
</tr>
</tbody>
</table>

**Reporting guide:**

Patient/Client Sex should be inferred or accepted as reported by the respondent, as at the time of patient/client registration. That is, it is usually unnecessary and may be inappropriate or even offensive to ask a person their sex. Patient/Client Sex may be inferred from other cues such as observation, relationship to respondent, or first name.

A person’s sex may change during their lifetime as a result of procedures known variously as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, Patient/Client Sex could be recorded as either Male or Female.
4 - Intersex
The term 'intersex' refers to a person, who:

- because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female and who identifies as being neither male nor female; OR
- Identifies as being neither male nor female.

Excludes: transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female).

**Validations:**
General edits only, see Format.

**Related items:**
Episode Start Date

**Administration**

**Purpose:**
To enable analyses of service utilisation, need for services and epidemiological studies.

**Principal users:**
Multiple internal and external users.

**Version history:**

<table>
<thead>
<tr>
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<th>Previous Name</th>
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<tbody>
<tr>
<td>5</td>
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<td>2010/07/01</td>
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<tr>
<td>4</td>
<td>Patient/Client Sex</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Patient/Client Sex</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Sex</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Sex</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:**
ABS

**Value domain source:**
NHDD (DHHS modified VAED) Consistent with CCDSv2
Patient/Client Usual Accommodation Type

**Definition:** The type of accommodation in which the patient/client usually lives.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tbody>
<tr>
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</table>

**Form:** Code

**Location:** Transmission protocol: HL7 Submission
- Patient/Client (insert) ADT_A04 (PV1:PV1.6:PL.6)
- Patient/Client (update) ADT_A08 (PV1:PV1.6:PL.6)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Post Acute Care
- Residential In-Reach
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Optional for patients/clients whose episode opened during the current reporting period; mandatory for patients/clients whose first contact occurred during the current reporting period.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Episode Start Date (Optional)
- First Contact Date/Time (Mandatory)

**Value domain:** Enumerated
- Table identifier: 990027

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>1000</td>
<td>Independent Living</td>
</tr>
<tr>
<td>2100</td>
<td>Short term crisis, emergency or transitional accommodation facility</td>
</tr>
<tr>
<td>2200</td>
<td>Outreach (no on-site support)</td>
</tr>
<tr>
<td>2300</td>
<td>Supported community accommodation facility</td>
</tr>
<tr>
<td>2402</td>
<td>Supported residential service</td>
</tr>
<tr>
<td>3101</td>
<td>Community-based residential supported accommodation</td>
</tr>
<tr>
<td>3203</td>
<td>Residential aged care facility</td>
</tr>
<tr>
<td>3400</td>
<td>Other institutional setting</td>
</tr>
<tr>
<td>4100</td>
<td>None/homeless/public place</td>
</tr>
<tr>
<td>9999</td>
<td>Not stated/inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide:** 'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to presentation.
In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation.

**1000 - Independent Living**
Includes private residence/accommodation, independent living within a retirement village, community housing.

**2100 - Short term crisis, emergency or transitional accommodation facility**
Includes night shelters, refuges, and hostels for the homeless.
2200 - Outreach (no on-site support)
Includes group living arrangements such as group homes for people with disabilities.

2300 - Supported community accommodation facility
Includes community living settings or accommodation facilities in which people are provided with support in some way by staff or volunteers.

2402 - Supported residential service
Includes private businesses that provide accommodation and personal care.

3101 - Community-based residential supported accommodation
Includes permanent residents of residential aged care services (formerly nursing homes and aged care hostels), who receive high level care.

3203 - Residential aged care facility
Includes permanent residents of residential aged care services (formally known as nursing homes and aged care hostels).

3400 - Other institutional setting
Includes other institutional settings which provide care and accommodation services, such as hospices and long-stay residential psychiatric institutions.

4100 - None/homeless/public place
Includes public places such as streets and parks, as well as temporary shelters such as bus shelters or camps and accommodation outside legal tenure.

Validations: E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date

Related items: Contact Clinic Identifier
Contact Date/Time
Episode Malignancy Flag
Episode Start Date
Patient/Client Birth Country
Patient/Client Carer Availability
Patient/Client Death Place
Patient/Client Living Arrangement
Patient/Client Main Carer’s Relationship to the Patient
Patient/Client Usual Accommodation Type
Patient/Client Usual Residence Locality Name
Patient/Client Usual Residence Postcode

Administration

Purpose: To support analyses of service provision by delivery setting

Principal users: Department of Health and Human Services

Version history:

<table>
<thead>
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<th>Version</th>
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<tr>
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<td>Patient/Client Usual Accommodation Type</td>
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<td>Patient/Client Type of Usual Accommodation</td>
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<td>Type of Usual Accommodation</td>
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</tr>
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</table>

Definition source: Department of Health and Human Services

Value domain source: Consistent with CCDSv2, subset across hierarchies
Patient/Client Usual Residence Locality Name

**Definition:**
The name of the geographic location (suburb/town/locality for Australian residents, country for overseas residents) of usual residence of the person (not the postal address).

**Repeats:**

<table>
<thead>
<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Form:</td>
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<td>Location:</td>
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<tr>
<td>Transmission protocol:</td>
<td>HL7 Submission</td>
<td></td>
<td></td>
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<tr>
<td>Patient/Client (insert)</td>
<td>ADT_A04 (PID\PID.11\XAD.3)</td>
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</tr>
<tr>
<td>Patient/Client (update)</td>
<td>ADT_A08 (PID\PID.11\XAD.3)</td>
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<td>Patient/Client (merge)</td>
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**Size:**

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**Location:**

Patient/Client (insert) ADT_A04 (PID\PID.11\XAD.3)
Patient/Client (update) ADT_A08 (PID\PID.11\XAD.3)
Patient/Client (merge) ADT_A40 (PID\PID.11\XAD.3)

**Reported by:**
Family Choice Program
Hospital Admission Risk Program
Hospital Based Palliative Care Consultancy Team
Medi-Hotel
Palliative Care
Post Acute Care
Residential In-Reach
Specialist Clinics (Outpatients)
Sub-acute Ambulatory Care Services
Transition Care Program
Victorian HIV Service
Victorian Respiratory Support Service

**Reported for:**
Patients/clients whose episode opened during the current reporting period.

**Reported when:**
All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
Episode Start Date (Mandatory)
Episode End Date (Mandatory)

**Value domain:**
Locality name as maintained in the HDSS reference file which can be downloaded from:
Table identifier 990025

**Reporting guide:**
The DHHS file excludes non-residential postcodes listed in the Australia Post file. Common variations of locality spellings, as used in Melway references and the Australian Bureau of Statistics National Locality Index (Cat. No. 1252), are included in the DHHS file.

If Patient/Client Usual Residence Postcode is ‘1000’ (No Fixed Abode) or ‘9988’ (Unknown) do not report this item. Where the locality is overseas, report the country code.

**Validations:**
E153 Invalid combination of Postcode (<value1>) and Locality (<value2>)
E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date
**Related items:**
- Contact Clinic Identifier
- Episode Start Date
- Patient/Client Birth Country
- Patient/Client Carer Availability
- Patient/Client Death Place
- Patient/Client Living Arrangement
- Patient/Client Main Carer’s Relationship to the Patient
- Patient/Client Usual Accommodation Type
- Patient/Client Usual Residence Postcode

**Administration**

**Purpose:** To enable calculation (with Client Usual Residence Postcode) of the patient’s/client’s Statistical Local Area (SLA) of residence which enables:
- Analysis of service utilisation and need for services.
- Identification of patients/clients living outside Victoria for purposes of cross-border funding.
- Identification of patients/clients living outside Australia for the Reciprocal Health Care Agreement (RHCA).

**Principal users:** Metropolitan Health and Aged Care Services Division, DHHS. Multiple internal and external users.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
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<tbody>
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<td>4</td>
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<td>2009/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Patient/Client Usual Residence Locality Name</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Client Usual Residence Locality Name</td>
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</tr>
<tr>
<td>1</td>
<td>Client Usual Residence Locality Name</td>
<td>2005/07/01</td>
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</table>

**Definition source:** Department of Health and Human Services (VAED)

**Value domain source:** ABS National Locality Index (Cat. No. 1252) (DHHS modified) (Consistent with CCDSv2, with modification)
Patient/Client Usual Residence Postcode

**Definition:** The postcode of the locality in which the person usually resides (not postal address).

**Repeats:** Min. | Max. | Duplicate
---|---|---
1 | 1 | Not applicable

**Form:** List

**Layout:** NNNN

**Size:** Min. | Max.
---|---
4 | 4

**Location:** Transmission protocol: HL7 Submission

- Patient/Client (insert) ADT_A04 (PID\PID.11\XAD.5)
- Patient/Client (update) ADT_A08 (PID\PID.11\XAD.5)
- Patient/Client (merge) ADT_A40 (PID\PID.11\XAD.5)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Patients/clients whose episode opened during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Episode Start Date (Mandatory)

**Value domain:** Locality name as maintained in the HDSS reference file which can be downloaded from:

- Table identifier 990025

**Reporting guide:** From the Australia Post list, non-residential postcodes are excluded and common variations of locality spellings, as used in Melway references and the Australian Bureau of Statistics National Locality Index (Cat. No. 1252), are included.

The organisation may collect the patient's/client's postal address for its own purposes. However, for transmission to VINAH, the postcode must represent the patient's/client's residential address. Non-residential postcodes (such as mail delivery centres) will be rejected.

Where the patient usually resides overseas, report '8888' as the Postcode and the Country Code in the Patient/Client Usual Residence Locality.

**Validations:**
- E153 Invalid combination of Postcode (<value1>) and Locality (<value2>)
- E159 Code (<CodeSupplied>) for Data Element (<FieldName>) is not valid as the Contact Date
**Related items:**
- Contact Clinic Identifier
- Episode Start Date
- Patient/Client Birth Country
- Patient/Client Carer Availability
- Patient/Client Death Place
- Patient/Client Living Arrangement
- Patient/Client Main Carer’s Relationship to the Patient
- Patient/Client Usual Accommodation Type
- Patient/Client Usual Residence Postcode

**Administration**

**Purpose:**
To enable analysis of data for utilisation patterns, to link data across different sections of care. To enable calculation (with Client Usual Residence Locality Name) of the patient’s/client’s Statistical Local Area (SLA) of residence which enables:
- Analysis of service utilisation and need for services.
- Identification of patients/clients living outside Victoria for purposes of cross-border funding.
- Identification of patients/clients living outside Australia for the Reciprocal Health Care Agreement (RHCA).

**Principal users:**
Multiple internal and external users.

**Version history:**

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<tr>
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<td>3</td>
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</tr>
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<td>2</td>
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<tr>
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<td>Client Usual Residence Postcode</td>
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**Definition source:**
Department of Health and Human Services (VAED)

**Value domain source:**
Australia Post (DHHS modified) (Consistent with CCDSv2, with modification)
Referral In Clinical Referral Date

**Definition:** The date on the referral as entered by the referring clinician.

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**Location:**
- Transmission protocol: HL7 Submission
  - Referral In (insert): RRI_I12 (RF1.9\TS.1)
  - Referral In (update): RRI_I13 (RF1.9\TS.1)
  - Referral In (delete): RRI_I14 (RF1.9\TS.1)

**Reported by:** Specialist Clinics (Outpatients)

**Reported for:** Referrals received during the current reporting period.

**Reported when:** All Programs, not elsewhere specified
- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - Referral In Received Date (Mandatory)

**Value domain:**
- Valid date or 'NP' if date is unavailable.

**Reporting guide:**
- Report the date the clinician has entered onto, or dated, the referral. If no date has been provided, report 'NP'-'Not present'.
- If the referral is updated or renewed, this date should not be changed and should reflect the original referral Clinical Referral Date.

**Validations:**
- E002: The field '<FieldName>' (<Location>) is mandatory for this Program/Stream <Program/Stream>, but no value was supplied
- E020: `<SucceedingEvent> (<SucceedingEventValue>) is before <Preceding Event> (<PrecedingEventValue>)`

**Related items:**
- Contact Date/Time
- Episode End Date
- Episode First Appointment Booked Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Start Date
- Patient/Client Birth Date
- Referral In Outcome
- Referral In Receipt Acknowledgment Date
- Referral In Received Date
- Referral In Service Type
- Referral Out Date
- Referral Out Service Type

**Administration**

**Purpose:** To calculate waiting times from the patient's perspective.

**Principal users:** Department of Health and Human Services

**Version history:**
- Version 1: Referral In Clinical Referral Date 2012/07/01

**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
Referral In Clinical Urgency Category

**Definition:**
A categorisation of the urgency with which a patient needs to be seen in a Specialist Clinic (Outpatients).

**Repeats:**

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**Form:**
Code

**Layout:**

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**Location:**

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<td>RRI_I12 (RF1.2\CE.1)</td>
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<td>Referral In (update)</td>
<td>RRI_I13 (RF1.2\CE.1)</td>
</tr>
<tr>
<td>Referral In (delete)</td>
<td>RRI_I14 (RF1.2\CE.1)</td>
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**Reported by:**
Specialist Clinics (Outpatients)

**Reported for:**
Referrals received during the current reporting period.

**Reported when:**
All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Not linked to a date data element (Mandatory for Specialist Clinics (Outpatients) when Referral In Outcome is reported, and is not ‘98’ or ‘99’.)

**Value domain:**
Enumerated

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<td>Urgent</td>
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<td></td>
<td>2</td>
<td>Routine</td>
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</table>

**Reporting guide:**
Report the Referral In Clinical Urgency Category after the triage process is completed and a Referral In Outcome code other than ‘98 – Referral awaiting additional information for referrer’ and ‘99 - Referral process In progress’ has been reported.

1 - Urgent
A referral is urgent if the patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly. Use when a clinician determines that the patient should be seen in a Specialist Clinic (Outpatients) within 30 days of the receipt of the referral.

2 - Routine
Use when a clinician determines that the patient does not need to be seen in a Specialist Clinic (Outpatients) within 30 days of the receipt of the referral.

**Validations:**
E453  Referral Outcome is not ‘98-Referral awaiting additional information for referrer’ or ‘99-Referral process In progress’ but Referral In Clinical Urgency Category is not provided.

**Related items:**
Referral In Outcome

**Administration**

**Purpose:**
To calculate waiting times categorised by the urgency of the referral.

**Principal users:**
Department of Health and Human Services

**Version history:**

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<td>Referral In Clinical Urgency Category</td>
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**Definition source:**
Department of Health and Human Services

**Value domain source:**
Department of Health and Human Services
Referral In Outcome

**Definition:** The outcome of a referral.

**Repeats:**

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**Form:**

- Code

**Location:**

- Transmission protocol: HL7 Submission
  - Referral In (insert) RRI_I12 (RF1.1\CE.1)
  - Referral In (update) RRI_I13 (RF1.1\CE.1)
  - Referral In (delete) RRI_I14 (RF1.1\CE.1)

**Reported by:**

- Family Choice Program
- Hospital Admission Risk Program
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:**

- All referrals resolved during the reporting period.

**Reported when:**

- All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

**Value domain:**

- Enumerated

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<th>Code</th>
<th>Descriptor</th>
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<td>*OP 010</td>
<td>Referral accepted – New appointment</td>
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<tr>
<td>*OP 020</td>
<td>Referral accepted – Review appointment</td>
</tr>
<tr>
<td>Not OP 1</td>
<td>Referral accepted</td>
</tr>
<tr>
<td>3</td>
<td>Referral accepted - Renewed referral</td>
</tr>
</tbody>
</table>

**Patient related reason - Medical**

- 21 Patient/client died
- 22 Patient/client safety issue
- 23 Patient/client not medically fit
- 36 Recommended to present to ED for medical reasons

**Patient related reason - Non-medical**

- 24 Patient/client not contactable
- 25 Services declined or not required

**Service provider related reason**

- 30 Patient/client out of catchment area for program
- 31 Clinician safety issue
- 32 More appropriate program/service identified
- 33 Patient/client does not meet the program/service criteria
- 34 Required services not available
- 35 No program/service capacity
Other reasons
40 Other reason for cancellation
41 Referral withdrawn by referrer

Referral process not complete
98 Referral awaiting additional information from referrer
99 Referral processing in progress

Reporting guide: Record the main referral in outcome.

010 – Referral accepted – New appointment
Report this code if the patient has been referred to the health service for initial assessment or treatment.

020 – Referral accepted – Review appointment
Report this code if the patient has been referred for the purpose of review following a previous outpatient appointment, treatment as an inpatient or day surgery patient.

1 - Referral accepted
Includes patients/clients who are accepted into a program and have been placed on a waiting list to receive services.

3 - Referral accepted - Renewed referral
This code is only required to be reported when services use Medicare Australia’s ECLIPSE system which requires referrals to be closed when renewed.

98- Referral awaiting additional information from referrer
Report this code when the referral is unintelligible, missing demographic or other required information and is sent back to the referrer.

99 - Referral processing in progress
Report this code when the referral has not been finalised. This may be because the referral is undergoing triage or further information is required from the patient.

Validations: E002 The field '<FieldName>' (<Location>) is mandatory for this Program/Stream <Program/Stream>, but no value was supplied

Related items: Episode Start Date
Referral Identifier
Referral In Clinical Referral Date
Referral In Received Date
Referral In Service Type
Referral Out Service Type

Administration

Purpose: To support analyses of service provision by delivery setting.

Principal users: Department of Health and Human Services

Version history:

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<td>Referral In Outcome</td>
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<td>Referral In Outcome</td>
<td>2013/07/01</td>
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<td>2012/07/01</td>
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<td>2009/07/01</td>
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<td>Referral In Outcome</td>
<td>2008/07/01</td>
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<tr>
<td>1</td>
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<td>2007/07/01</td>
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Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
Referral In Program/Stream

**Definition:** The program/stream to which the patient/client is referred.

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<th><strong>Repeats:</strong></th>
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<th><strong>Max.</strong></th>
<th><strong>Duplicate</strong></th>
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**Location:**
- **Transmission protocol:** HL7 Submission
- Referral In (insert) RRI_I12 (PV1.10)
- Referral In (update) RRI_I13 (PV1.10)
- Referral In (delete) RRI_I14 (PV1.10)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All referrals resolved during the reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Referral In Received Date (Mandatory)

**Value domain:** Enumerated

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<tr>
<td>4</td>
<td>Specialist pain management</td>
</tr>
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<td>5</td>
<td>Specialist falls</td>
</tr>
<tr>
<td>6</td>
<td>Specialist wound management</td>
</tr>
<tr>
<td>7</td>
<td>Younger adult/transition</td>
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<td>Specialist paediatric rehabilitation</td>
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<td>Specialist polio</td>
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<td>Specialist movement disorders</td>
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<td>19</td>
<td>Specialist other</td>
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<td>27</td>
<td>HARP - HIV</td>
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<tr>
<td>28</td>
<td>HARP – Complex care</td>
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<tr>
<td>31</td>
<td>Post acute care</td>
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</table>

*Sub-Acute Ambulatory Care Services (SACS)*

*Hospital Admission Risk Program – (HARP)*

*Post Acute Care (PAC)*
Palliative Care (PC)
41 Community palliative care

Family Choice Program (FCP)
51 Family choice program

Victorian HIV Service (VHS)
61 Victorian HIV consultancy
62 Victorian HIV mental health service
63 HIV outreach ambulatory care
64 HIV CALD service
65 Horizon place
66 Chronic viral illness program
67 Victorian NPEP service
68 HIV outreach allied health
69 Sexual health and wellbeing service

Victorian Respiratory Support Service (VRSS)
81 Victorian respiratory support service

Medi-Hotel
91 Medi-hotel

Specialist Clinics (Outpatients)
101 General medicine
103 Cardiology
106 Gastroenterology
107 Haematology
108 Nephrology
109 Neurology
110 Oncology
111 Respiratory
112 Rheumatology
113 Dermatology
114 Infectious diseases
116 Immunology, includes Allergy
117 Endocrinology, includes Diabetes
118 Hepatobiliary and pancreas
119 Burns
201 General surgery
202 Cardiothoracic surgery
203 Neurosurgery
204 Ophthalmology
205 Ear, nose and throat
206 Plastic surgery
207 Urology
208 Vascular
209 Pre admission
301 Dental
310 Orthopaedics/Musculoskeletal
311 Orthopaedics applications
312 Wound care
313 Allied health – Stand-alone
350 Psychiatry and behavioural disorders, includes Alcohol and drug
402 Obstetrics
403 Gynaecology
406 Reproductive medicine and family planning

Transition Care Program (TCP)
1101 Transition care program

Residential In-Reach (RIR)
1201 Residential In-reach

Hospital Based Palliative Care Consultancy Team (HBPCCT)
1300 Hospital based palliative care consultancy team
1301 Symptom control/Pain management
1302 Discharge planning
1303 Psychosocial support/Advocacy
1304 Assessment
1305 Terminal (end of life) care
1306 Symptom control/Pain management/Discharge planning
1307 Symptom control/Pain management/Psychosocial support
1308 Symptom control/Pain management/Assessment
1309 Symptom control/Pain management/Terminal (end of life) care
1310 Discharge planning/Psychosocial support/Advocacy
1311 Discharge planning/Assessment
1312 Discharge planning/Terminal (end of life) care
1313 Psychosocial support/Advocacy/Assessment
1314 Psychosocial support/Advocacy/Terminal (end of life) care
1315 Assessment/Terminal (end of life) care
1400 Palliative care day hospice
1600 State-wide palliative care service

Reporting guide: Report the program/stream to which the patient/client has been referred, not the intervention they are to receive. For example, do not report ‘313-Allied Health - Stand-alone’ unless the referral is to an Allied Health Clinic. Patients/clients can access allied health in other programs/streams.

The program/stream that the patient/client is referred to may not be the same as the program/stream that the patient/client is accepted for. For example, a patient/client may be referred to Rehabilitation (code ‘1’), but after assessment it is decided that the patient/client be seen by the Specialist Falls Clinics (code ‘5’); in this instance report code ‘1’.

Code 1-19
Includes the SACS Program/Streams.

Code 27, 28
Includes the HARP Program/Streams.

Code 60-69
Includes the Victorian HIV Service Program/Streams.

Code 101-406
Includes the Specialist Clinics (Outpatients) Program/Streams.

313 Allied Health - Stand-alone
This code should only be used when the entire episode for the patient/client is constituted of one or more Allied Health contacts. Where the patient/client is receiving services which fall under another Program/Stream but is also receiving Allied Health services, the episode should be reported with the other Program/Stream, not code 313.
Code 1300-1315
Includes the Hospital-Based Palliative Care Consultancy Team Program/Streams. This code cannot be reported for the Specialist (Outpatient) Clinics program.

Validations: E452 This organisation (<OrganisationIdentifier>) is not approved to report Referrals In under this program/stream (<Referral In Program/Stream>)

Related items: Episode Program/Stream Referral In Received Date

Administration

Purpose: To allow national reporting requirements to be met and assist with service planning and monitoring.

Principal users: Department of Health and Human Services

Version history:

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Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
Referral In Receipt Acknowledgment Date

**Definition:** The date of initial contact with the patient/client or carer to acknowledge receipt of referral. For Specialist Clinics (Outpatients), this is the date of initial contact with the referrer.

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**Form:** Date

**Layout:** YYYYMMDD

**Location:**
- **Transmission protocol:** HL7 Submission
  - Referral In (insert) RRI_I12 (RF1.9\TS.1)
  - Referral In (update) RRI_I13 (RF1.9\TS.1)
  - Referral In (delete) RRI_I14 (RF1.9\TS.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Referrals acknowledged during the current reporting period.

**Reported when:** **All Programs, not elsewhere specified**

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Referral In Receipt Acknowledgment Date (Mandatory)

**Value domain:** Valid date.

**Reporting guide:**

The century component of the year must begin with ‘19’ or ‘20’.

Each Health Service should maintain a single point of entry for all HARP, PAC, SACS services where an intake process is conducted. Contacting the patient/client to acknowledge receipt of the referral would constitute part of this intake process. Health Services can also use this contact to further progress the intake process.

For Specialist Clinics (Outpatients), the Referral In Receipt Acknowledgement Date is the date the referrer was contacted to acknowledge receipt of the referral.

This contact may be in the form of a letter or email, a telephone contact or in person.

This contact does not constitute a contact/client service event.

This item should be reported for all referrals received, even though the intake process may determine that some people referred are not appropriate patients/clients for the service, and therefore not all referrals nor referrals acknowledged need result in an episode being started. As noted elsewhere, an Episode starts when a referral is accepted.
Validations: E002 The field '<FieldName>' (<Location>) is mandatory for this Program/Stream <Program/Stream>, but no value was supplied

E020 <SucceedingEvent> (<SucceedingEventValue>) is before <Preceding Event> (<PrecedingEventValue>)

Related items: Contact Date/Time
Episode End Date
Episode First Appointment Booked Date
Episode Patient/Client Notified of First Appointment Date
Episode Start Date
Patient/Client Birth Date
Referral In Clinical Referral Date
Referral In Receipt Acknowledgment Date
Referral In Received Date
Referral Out Date

Administration

Purpose: Required for SACS accountability reporting to the Victorian Government. This item is used together with Referral Received Date to determine the percentage of SACS patients/clients contacted within three working days of referral.


Version history:

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<td>Referral In Receipt Acknowledgment Date</td>
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<td>2</td>
<td>Date of Referral Receipt Acknowledgment</td>
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<td>1</td>
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Definition source: Department of Health and Human Services

Value domain source: ISO8601:2000
Referral In Received Date

**Definition:** The date that a referral, either written or verbal, is received. For Specialist Clinics (Outpatients), this could be a request for a booking, where the referral will be provided at the first contact.

<table>
<thead>
<tr>
<th><strong>Repeats:</strong></th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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</thead>
</table>

**Form:** Date

**Layout:** YYYYMMDD

**Location:**
- Transmission protocol: HL7 Submission
  - Referral In (insert): RRI_I12 (RF1.7\TS.1)
  - Referral In (update): RRI_I13 (RF1.7\TS.1)
  - Referral In (delete): RRI_I14 (RF1.7\TS.1)

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All referrals received during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Referral In Received Date (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** The century component of the year must begin with ‘20’.

For Specialist Clinics (Outpatients), a patient or medical professional may contact the hospital and request a booking and provide the written referral at the first appointment. In this case, the request for booking should be reported as the Referral In Received Date.

Referrals for Specialist Clinics (Outpatients) must be reported for the period during which they were received, regardless of whether an episode has been opened or any activity has occurred.

Each Health Service should maintain a single point of entry for all SACS and HARP services where an intake process is conducted. Receiving the referral would constitute part of this intake process.

This item should be reported for all referrals received, even though the intake process may determine that some people referred are not appropriate patients/clients for the service, and therefore not all referrals need to result in an episode being started.

In the instance where a patient/client is identified as requiring services from a case finding process, the date of identification should be reported as the Referral In Received Date.
If the referral is updated or renewed, this date should not be changed and should reflect the original referral received date.

**Validations:** E020 \( <\text{SucceedingEvent}> <\text{SucceedingEventValue}> \) is before \( <\text{Preceding Event}> <\text{PrecedingEventValue}> \)

**Related items:**
- Contact Date/Time
- Episode End Date
- Episode First Appointment Booked Date
- Episode Patient/Client Notified of First Appointment Date
- Episode Start Date
- Patient/Client Birth Date
- Referral In Clinical Referral Date
- Referral In Program/Stream
- Referral In Receipt Acknowledgment Date
- Referral In Received Date
- Referral In Service Type
- Referral Out Date

**Administration**

**Purpose:** Multiple internal and external users.

**Principal users:** Multiple internal and external users.

**Version history:**

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<td>5</td>
<td>Referral In Received Date</td>
<td>2010/07/01</td>
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<td>4</td>
<td>Referral In Received Date</td>
<td>2009/07/01</td>
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<td>Referral In Received Date</td>
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**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
Referral In Service Type

**Definition:** The person who, or service which, referred the patient/client.

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<th>Duplicate</th>
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<td>Transmission protocol:</td>
<td>HL7 Submission</td>
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<td>RRI_I12 (PRD.1:CE.4)</td>
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<tr>
<td>Referral In (update)</td>
<td>RRI_I13 (PRD.1:CE.4)</td>
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</tr>
<tr>
<td>Referral In (delete)</td>
<td>RRI_I14 (PRD.1:CE.4)</td>
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</table>

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Referrals In during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Referral In Received Date (Mandatory)

**Value domain:** Enumerated

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<th>Code</th>
<th>Descriptor</th>
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<tr>
<td>12</td>
<td>Relative</td>
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<td>13</td>
<td>Friend</td>
</tr>
<tr>
<td>14</td>
<td>Carer</td>
</tr>
<tr>
<td>19</td>
<td>Other person (includes neighbour, etc.)</td>
</tr>
</tbody>
</table>

**External Referrals - Self/Other Non-Professional**

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<th>Descriptor</th>
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<tbody>
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<td>Friend</td>
</tr>
<tr>
<td>14</td>
<td>Carer</td>
</tr>
<tr>
<td>19</td>
<td>Other person (includes neighbour, etc.)</td>
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**External Referrals - Medical/Professional Service**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>201</td>
<td>GP</td>
</tr>
<tr>
<td>202</td>
<td>Specialist</td>
</tr>
<tr>
<td>206</td>
<td>Ambulance officer/Paramedic</td>
</tr>
<tr>
<td>297</td>
<td>Other health practitioner</td>
</tr>
<tr>
<td>298</td>
<td>Other medical/health service (Government)</td>
</tr>
<tr>
<td>299</td>
<td>Other medical/health service (Non-Government)</td>
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**External Referrals - Mental Health Professional/Service**

<table>
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<th>Code</th>
<th>Descriptor</th>
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<tr>
<td>30</td>
<td>Mental health professional/service</td>
</tr>
<tr>
<td>301</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>302</td>
<td>Private psychiatrist</td>
</tr>
<tr>
<td>399</td>
<td>Other mental health staff</td>
</tr>
</tbody>
</table>
Hospital-based service

*Not OP 403 Outpatients
*Not OP 404 Emergency department
*Not OP 405 Hospital, acute service (public)
*Not OP 406 Hospital, acute service (private)
*Not OP 407 Hospital, sub-acute service
*Not OP 408 Hospital, palliative care service
*Not OP 498 Other hospital department/staff (this hospital/campus)
*Not OP 499 Other hospital department/staff (another hospital/campus)

Internal Referrals - Hospital-Based Service (this health service)

*OP 701 Emergency department
*OP 702 Specialist/Outpatients – same program/stream
*OP 703 Specialist/Outpatients – different program/stream
*OP 704 Other department/staff (e.g. inpatient ward) – same program/stream
*OP 705 Other department/staff (e.g. inpatient ward) – different program/stream

External Referrals - Hospital-Based Service (another health service)

*OP 801 Emergency department
*OP 802 Specialist/Outpatients – same program/stream
*OP 803 Specialist/Outpatients – different program/stream
*OP 804 Other department/staff (e.g. inpatient ward) – same program/stream
*OP 805 Other department/staff (e.g. inpatient ward) – different program/stream

Correctional / Justice

50 Correctional/Justice
51 Police (Referral In only)
52 Correctional officer (Referral In only)
53 Juvenile justice (Referral In only)

Community-Based Service/Agency

601 Post-acute care program services
602 Community rehabilitation centre
603 Community palliative care support
604 Community mental health services
605 Psychiatric disability support service
607 Home & Community Care (HACC)
610 Residential aged care facility (Government)
611 Residential aged care facility (Non-Government)
612 Home nursing service (includes District Nursing)
613 Domiciliary postnatal care
615 Transition care program
616 Aged care assessment service
618 Aboriginal and Torres Strait Islander (ATSI) service
619 Child protection services
636 Carelink centre
637 Other community-based medical/health service (Government)
638 Other community-based agency/service (Non-Government)
639 Other community-based agency/service (Government)
640 Victorian HIV/AIDS service

*PC 650 Paediatric hospice
661 Level 2 home care package
662 Level 4 home care package
Supplementary Values

OTH  Other
NA   Not applicable
UNK  Unknown

Reporting guide:  206 - Ambulance Officer / Paramedic
Report when Ambulance Victoria makes a referral directly to the service. Includes:
• Clients using the telephone triaging service with a member of Ambulance Victoria being present.
Excludes:
• Ambulance Victoria making a recommendation but where the referral is made by another person/provider.

30 - Mental Health Professional/Service
Report the code appropriate for the referring service where known. Code 30 may be reported if a further level of detail is unknown.

Validations:  E002  The field '<FieldName>' (<Location>) is mandatory for this Program/Stream <Program/Stream>, but no value was supplied

Related items:  Referral In Clinical Referral Date
Referral In Outcome
Referral In Received Date
Referral Out Service Type

Administration

Purpose:  To assist in the analysis of patient/client flow and service planning.

Principal users:  Department of Health and Human Services

Version history:  Version  Previous Name  Effective Date
5  Referral In Service Type  2015/07/01
4  Referral In Service Type  2014/07/01
3  Referral In Service Type  2013/07/01
2  Referral In Service Type  2012/07/01
1  Referral In Service Type  2010/07/01

Definition source:  Department of Health and Human Services

Value domain source:  Department of Health and Human Services
**Referral Out Date**

*Definition:* The date that a Referral Out was made.

- **Repeats:** Min. 1 Max. 1 Duplicate Not applicable
- **Form:** Date
- **Layout:** YYYYMMDD
- **Size:** Min. Max.
- **Location:** Transmission protocol: HL7 Submission
  - Referral Out (insert) RRI_I12 (RF1.7\TS.1)
  - Referral Out (update) RRI_I13 (RF1.7\TS.1)
  - Referral Out (delete) RRI_I14 (RF1.7\TS.1)
- **Reported by:**
  - Family Choice Program
  - Hospital Admission Risk Program
  - Post Acute Care
  - Residential In-Reach
  - Specialist Clinics (Outpatients)
  - Sub-acute Ambulatory Care Services
  - Transition Care Program
  - Victorian HIV Service
  - Victorian Respiratory Support Service
- **Reported for:** All Referrals Out made during the current reporting period.
- **Reported when:** All Programs, not elsewhere specified
  - The current reporting period for this item is the calendar month in which the following events or data elements fall:
    - Referral Out Date (Mandatory)
  - **Value domain:** Valid date.
  - **Reporting guide:** The Referral Out Date must fall within the start and end dates of the Episode from which the Referral Out originated. Referrals Out can occur at any time during the episode.
  - **Validations:** E020 <SucceedingEvent> (<SucceedingEventValue>) is before <PrecedingEvent> (<PrecedingEventValue>)
- **Related items:**
  - Contact Date/Time
  - Episode End Date
  - Episode First Appointment Booked Date
  - Episode Patient/Client Notified of First Appointment Date
  - Episode Start Date
  - Patient/Client Birth Date
  - Referral In Clinical Referral Date
  - Referral In Receipt Acknowledgment Date
  - Referral In Received Date
  - Referral Out Date

**Administration**

- **Purpose:** To assist in service planning.
- **Principal users:** Department of Health and Human Services
- **Version history:**
  - **Version** | **Previous Name** | **Effective Date**
  - 3 | Referral Out Date | 2010/07/01
  - 2 | Referral Out Date | 2010/07/01
  - 1 | Referral Out Date | 2009/07/01
- **Definition source:** Department of Health and Human Services
- **Value domain source:** ISO8601:2000
Referral Out Place

**Definition:** Describes the location of the patient/client on completion of the program.

<table>
<thead>
<tr>
<th><strong>Repeats:</strong></th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<td><strong>Form:</strong></td>
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<td><strong>Location:</strong></td>
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<td>RRI_I12 (PRD.4\PL.5)</td>
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<tr>
<td>Referral Out (update)</td>
<td>RRI_I13 (PRD.4\PL.5)</td>
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<tr>
<td>Referral Out (delete)</td>
<td>RRI_I14 (PRD.4\PL.5)</td>
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<td></td>
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</tbody>
</table>

**Reported by:** Transition Care Program

**Reported for:** Referrals Out during the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Referral Out Date (Mandatory)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td><strong>Residential facility</strong></td>
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</tr>
<tr>
<td>24</td>
<td>Mental health residential facility</td>
</tr>
<tr>
<td>25</td>
<td>Psychogeriatric nursing home</td>
</tr>
<tr>
<td>26</td>
<td>Supported residential facility</td>
</tr>
<tr>
<td>27</td>
<td>Residential care facility: low level respite</td>
</tr>
<tr>
<td>28</td>
<td>Residential care facility: high level respite</td>
</tr>
<tr>
<td>29</td>
<td>Aged care facility</td>
</tr>
</tbody>
</table>

**External Referrals - Medical/Professional Service**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Another hospital/campus: admitted</td>
</tr>
<tr>
<td>32</td>
<td>Another hospital/campus: non-admitted</td>
</tr>
<tr>
<td>33</td>
<td>Another hospital/campus: MH inpatient service</td>
</tr>
<tr>
<td>34</td>
<td>Inpatient rehabilitation (VINAH only)</td>
</tr>
<tr>
<td>35</td>
<td>Inpatient palliative care (VINAH only)</td>
</tr>
<tr>
<td>39</td>
<td>Another hospital/campus: Unknown admitted or non-admitted status</td>
</tr>
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</table>

**Private residence/Accommodation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>41</td>
<td>Private residence/accommodation</td>
</tr>
<tr>
<td>42</td>
<td>Independent living unit</td>
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</table>

**Correctional/Custodial facility**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>61</td>
<td>Correctional/Custodial facility</td>
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**Supplementary Values**

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<thead>
<tr>
<th>Code</th>
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<tr>
<td>OTH</td>
<td>Other</td>
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<tr>
<td>UNK</td>
<td>Unknown</td>
</tr>
<tr>
<td>NA</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Reporting guide:** Referral Out Place relates to the physical location of the patient immediately after receiving a service under the reporting Program/Stream. It is reported once per episode. (At this time, this element is only mandatory for the TCP program).
26 - Supported residential facility
To be used when a patient/client is going to a non-aged care supported residential care facility (either private or public). Use this code if no other more specific code describes the facility to which the patient/client is being referred.

29 – Aged care facility
To be used when a patient/client is going to a residential aged care facility.

Codes 30-39 - Another hospital/campus
To be used when a patient/client is going to a hospital (either private or public) and will be treated as an admitted or non-admitted patient/client.

42 - Independent living unit
To be used when a patient when a patient/client is going to an independent living unit (either private or public).

Validations: General edits only, see Format.
Related items: Referral Out Date

Administration
Purpose: To assist in the analysis of patient/client flow and service planning.
Principal users: Department of Health and Human Services

Version history:

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<td>Referral Out Place</td>
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</tr>
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Definition source: Department of Health and Human Services
Value domain source: Department of Health and Human Services
Referral Out Service Type

**Definition:** The person or services to which the patient/client is referred for ongoing care at the episode end.

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<th>Duplicate</th>
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<td>Hospital Admission Risk Program</td>
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<td>Post Acute Care</td>
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<td></td>
<td>Residential In-Reach</td>
<td></td>
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<tr>
<td></td>
<td>Specialist Clinics (Outpatients)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Sub-acute Ambulatory Care Services</td>
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<td></td>
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<tr>
<td></td>
<td>Transition Care Program</td>
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<td></td>
<td>Victorian HIV Service</td>
<td></td>
<td></td>
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<td>Victorian Respiratory Support Service</td>
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<td>Referrals Out during the current reporting period.</td>
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**External Referrals - Self/Other Non-Professional**
- 11 No support services
- 12 Relative
- 13 Friend
- 14 Carer
- 19 Other person (includes neighbour, etc.)

**External Referrals - Medical/Professional Service**
- 201 GP
- 202 Specialist
- 297 Other health practitioner
- 298 Other medical/health service (Government)
- 299 Other medical/health service (Non-Government)

**External Referrals - Mental Health Professional/Service**
- 30 Mental health professional/service
- 301 Psychiatrist
- 302 Private psychiatrist
- 399 Other mental health staff
**Hospital-based service**

*Not OP 403*  
Outpatients

*Not OP 404*  
Emergency department

*Not OP 405*  
Hospital, acute service (public)

*Not OP 406*  
Hospital, acute service (private)

*Not OP 407*  
Hospital, sub-acute service

*Not OP 408*  
Hospital, palliative care service

*Not OP 498*  
Other hospital department/staff (this hospital/campus)

*Not OP 499*  
Other hospital department/staff (another hospital/campus)

**Internal Referrals - Hospital-Based Service (this health service)**

*OP 701*  
Emergency department

*OP 702*  
Specialist/Outpatients – same program/stream

*OP 703*  
Specialist/Outpatients – different program/stream

*OP 704*  
Other department/staff (e.g. inpatient ward) – same program/stream

*OP 705*  
Other department/staff (e.g. inpatient ward) – different program/stream

**External Referrals - Hospital-Based Service (another health service)**

*OP 801*  
Emergency department

*OP 802*  
Specialist/Outpatients – same program/stream

*OP 803*  
Specialist/Outpatients – different program/stream

*OP 804*  
Other department/staff (e.g. inpatient ward) – same program/stream

*OP 805*  
Other department/staff (e.g. inpatient ward) – different program/stream

**Correctional/Justice**

50  
Correctional/Justice

51  
Police (Referral In only)

52  
Correctional officer (Referral In only)

53  
Juvenile justice (Referral In only)

**Community-Based Service/Agency**

601  
Post-acute care program services

602  
Community rehabilitation centre

603  
Community palliative care support

604  
Community mental health services

605  
Psychiatric disability support service

607  
Home & Community Care (HACC)

610  
Residential aged care facility (Government)

611  
Residential aged care facility (Non-Government)

612  
Home nursing service (includes District Nursing)

613  
Domiciliary postnatal care

615  
Transition care program

616  
Aged care assessment service

618  
Aboriginal and Torres Strait Islander (ATSI) service

619  
Child protection services

626  
Accommodation service

636  
Carelink centre

637  
Other community-based medical/health service (Government)

638  
Other community-based agency/service (Non-Government)

639  
Other community-based agency/service (Government)

640  
Victorian HIV/AIDS service

641  
Other infectious disease clinic
642 HIV community health service
643 HIV support service
644 HIV community nursing
645 CALD services
661 Level 2 home care package
662 Level 4 home care package

**Supplementary Values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTH</td>
<td>Other</td>
</tr>
<tr>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>UNK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Reporting guide:** Referral Out Service Type indicates the type of clinical care and support services the program/stream has initiated, to meet the patient's/client's ongoing health care needs during or at the end of an episode. Whilst the referral out can be made at any point in time during the episode, it refers to services that are required after episode end to continue to meet the client's identified care needs.

Where an episode is reported with an Episode End Reason = 1 Patient/client death or bereavement phase end, Referral Out – Service Type must be reported as NA Not applicable.

**30 - Mental Health Professional/Service**

Report the code appropriate for the referral service where known. Code 30 may be reported if a further level of detail is unknown.

**Validations:**

E002 The field '<FieldName>' (<Location>) is mandatory for this Program/Stream <Program/Stream>, but no value was supplied

**Related items:**

- Referral In Clinical Referral Date
- Referral In Outcome
- Referral In Service Type
- Referral Out Date

**Administration**

**Purpose:** To assist in the analysis of patient/client flow and service planning.

**Principal users:** Department of Health and Human Services

**Version history:**

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<td>4</td>
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</tr>
<tr>
<td>3</td>
<td>Referral Out Service Type</td>
<td>2013/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Referral Out Service Type</td>
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</tr>
<tr>
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<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
Part II: Transmission Data Elements

Batch Control Identifier

**Definition:**
The mode of provision of the service during the contact.

<table>
<thead>
<tr>
<th><strong>Repeats</strong></th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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**Form:**
Identifier

**Layout:**
X(1-20)

**Size:**
Min. Max.
1 20

**Location:**
Transmission protocol: HL7 Submission
Send Batch BATCH (BHS.11)

Transmission protocol: XML Submission
Contact (insert/update) /Submission/DataCollection/
ReportingOrganisation/PatientsClients/
PatientClient/Episodes/Episode/
Contacts/Contact@batch

Contact (insert/update) /Submission/ DataCollection/
ReportingOrganisation/ PatientsClients/
PatientClient/ Episodes/ Episode/
Contacts@batch

Referral Out (insert/update) /Submission/ DataCollection/
ReportingOrganisation/ PatientsClients/
PatientClient/ Episodes/ Episode/
ReferralsOut/ ReferralOut@batch

Referral Out (insert/update) /Submission/ DataCollection/
ReportingOrganisation/ PatientsClients/
PatientClient/ Episodes/ Episode/
ReferralsOut@batch

Episode (insert/update) /Submission/ DataCollection/
ReportingOrganisation/ PatientsClients/
PatientClient/ Episodes/Episode@batch

Episode (insert/update) /Submission/ DataCollection/
ReportingOrganisation/ PatientsClients/
PatientClient/ Episodes@batch

Patient/Client (insert/update) /Submission/ DataCollection/
ReportingOrganisation/ PatientsClients/
PatientClient@batch

Patient/Client (insert/update) /Submission/ DataCollection/
ReportingOrganisation/ PatientsClients@batch

Referral In (insert/update) /Submission/ DataCollection/ReportingOrganisation/
ReferralsIn/ReferralIn@batch

Referral In (insert/update) /Submission/ DataCollection/ ReportingOrganisation/ ReferralsIn@batch

Any Insert/Update /Submission/ DataCollection/
ReportingOrganisation@batch

**Reported by:**
All programs, dependent on transmission protocol.

**Reported for:**
Required for all HL7 Batches and XML transmissions.

**Reported when:**
All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date/Time (All batch messages)
**Value domain:** Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:** It is permissible to utilise upper case or lower case ASCII alpha characters, digits 0 to 9, dashes, spaces or apostrophes. That is, ASCII hexadecimal values 20, 27, 2D, 41 through 5A inclusive, 61 through 7A inclusive. Identifiers are case-sensitive.

**Validations:** B004 Supplied Batch Control ID has been used previously (<Batch Control ID>)

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
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<th>Previous Name</th>
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</thead>
<tbody>
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<td>Batch Control Identifier</td>
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</tr>
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<td>1</td>
<td>Batch Control Identifier</td>
<td>2005/07/01</td>
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</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Organisations
Contact Identifier

**Definition:**
An identifier, unique to a Contact across all programs within an organisation.

**Repeats:**

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<td>HL7 Submission</td>
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<tr>
<td></td>
<td>Contact (insert)</td>
<td>ADT_A03 (PV1\PV1.19\CX.1)</td>
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</tr>
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<td>ADT_A08 (PV1\PV1.19\CX.1)</td>
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<td>Contact (insert/update)</td>
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**Reported by:**
All programs, dependent on transmission protocol.

**Reported for:**
All contact messages.

**Reported when:**
All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
Message Date/Time (All Contact messages)

**Value domain:**
Organisation-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:**
A Contact and a separately reported Client Service Event must not share a Contact/Client Service Event Identifier within an organisation.

It is permissible to utilise upper case or lower case ASCII alpha characters, digits 0 to 9, dashes, spaces or apostrophes. That is, ASCII hexadecimal values 20, 27, 2D, 41 through 5A inclusive, 61 through 7A inclusive. Identifiers are case-sensitive.

It is assumed that Contact/Client Service Event Identifier has the same scope as Patient/Client Identifier.

**Primary Key**
This data element is the Primary Key for the Contact/Client Service Event.

**Validations:**
E050 Field <element_name> (<Location>) has no value but is part of the primary key for the <structure> record
E051 Cannot insert record, same Primary Key for data structure "<structure>" already exists (<conflict_location>). Key fields: <pk_expanded_val>
E052 A <pk_structure> message (<hl7_message>) has been sent containing a reference to a "<fk_structure>" record that has not been previously received and accepted. Key fields: <fk_expanded>
E061 A <pk_structure> message (<hl7_message_type>) was sent to either update or delete a record that has not been previously received and accepted. Key fields: <key_expanded>

**Related items:**
Episode Identifier
Local Identifier Assigning Authority
Message Date/Time
Patient/Client Identifier
Referral Identifier
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

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<td>Contact/Client Service Event Identifier</td>
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<td>1</td>
<td>Contact/Client Service Event</td>
<td>2005/07/01</td>
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**Definition source:** Department of Health and Human Services

**Value domain source:** Health Services
Contact Person Name Type

**Definition:** A code that represents the type of name.

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<th>Duplicate</th>
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<td>Contact (update)</td>
<td>ADT_A08 (PID.5:XPN.7)</td>
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<td>Contact (delete)</td>
<td>ADT_A13 (PID.5:XPN.7)</td>
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<td>Patient/Client (merge)</td>
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<td>PPP_PCC (PID.5:XPN.7)</td>
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<td>Episode (delete)</td>
<td>PPP_PCD (PID.5:XPN.7)</td>
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<td>Referral Out (insert)</td>
<td>REF_I12 (PID.5:XPN.7)</td>
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<td>Referral Out (update)</td>
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<td>Referral Out (delete)</td>
<td>REF_I14 (PID.5:XPN.7)</td>
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<td>Referral In (insert)</td>
<td>RRI_I12 (PID.5:XPN.7)</td>
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<tr>
<td>Referral In (update)</td>
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<td>Referral In (delete)</td>
<td>RRI_I14 (PID.5:XPN.7)</td>
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</table>

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All messages

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All messages)
- Referral In Received Date (Mandatory)
- Referral In Receipt Acknowledgment Date (Mandatory)
- Episode Start Date (Mandatory)
- Episode Care Plan Documented Date (Mandatory)
- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)
- Episode End Date (Mandatory)
- Patient/Client Death Date (Mandatory)
Value domain: Enumerated

Table identifier   HL70200

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<thead>
<tr>
<th>Code</th>
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<td>Legal Name</td>
</tr>
<tr>
<td>S</td>
<td>Coded pseudo-name to ensure anonymity</td>
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</table>

Reporting guide: 'L - Legal Name' must only be reported when Contact/Client Service Event Account Class is 'VX - Department of Veterans' Affairs (DVA)' or 'WC - WorkSafe Victoria' or 'TA - Transport Accident Commission (TAC)'. Otherwise report code 'S - Coded pseudo-name to ensure anonymity'.

Validations: General edits only, see Format.

Related items: Contact Date/Time
Episode Care Plan Documented Date
Episode End Date
Episode Start Date
Message Date/Time
Patient/Client Death Date
Referral In Receipt Acknowledgment Date
Referral In Received Date

Administration

Purpose: To enable analysis of data for utilisation patterns and funding purposes.

Principal users: Department of Health and Human Services

Version history:

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<th>Version</th>
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<td>4</td>
<td>Contact/Client Service Event Person Name Type</td>
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<td>3</td>
<td>Contact/Client Service Event Person Name Type</td>
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<td>2</td>
<td>Person Name Type</td>
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<tr>
<td>1</td>
<td>Person Name Type Mode</td>
<td>2005/07/01</td>
</tr>
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</table>

Definition source: HL7 (DHHS modified)

Value domain source: HL7 (Consistent with CCDSv2)
Contact Professional Group Sequence Number

**Definition:** A number that identifies the Contact Professional Group transaction segment.

**Repeats:**

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<thead>
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<th>Repeats</th>
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<th>Duplicate</th>
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**Form:** Repeatable Integer

**Layout:** N

**Size:**

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</tbody>
</table>

**Location:**

**Transmission protocol:** HL7 Submission
- Contact (insert) ADT_A03 (ROL\ROL.1\EI.1)
- Contact (update) ADT_A08 (ROL\ROL.1\EI.1)
- Contact (delete) ADT_A13 (ROL\ROL.1\EI.1)

**Transmission protocol:** XML Submission
- Contact (insert/update) Contact/PatientManagement/Health Professional/Discipline/Sequence

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Message Date/Time (All Contact messages)

**Value domain:** A positive integer.

**Reporting guide:**
For the first occurrence of the segment the sequence number shall be 1, for the second occurrence it shall be 2, etc.
- Contact/Client Service Event Professional Group (multiple values possible) is reported in the same repeatable segment (the ROL) as Contact/Client Service Event Delivery Mode (only a single value possible). Contact/Client Service Event Delivery Mode should take the same value in each repeating segment.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
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<tbody>
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<td>3</td>
<td>Contact/Client Service Event Professional Group Sequence Number</td>
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**Definition source:** HL7 (DHHS modified)

**Value domain source:** HL7
**Episode Identifier**

**Definition:** An identifier, unique to an Episode across all services within an organisation.

<table>
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<th>Duplicate</th>
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<table>
<thead>
<tr>
<th>Location:</th>
<th>Transmission protocol: HL7 Submission</th>
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</thead>
<tbody>
<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PV1\PV1.5\CX.1)</td>
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<tr>
<td>Contact (update)</td>
<td>ADT_A08 (PV1\PV1.5\CX.1)</td>
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<tr>
<td>Episode (insert)</td>
<td>PPP_PCB (PV1\PV1.19\CX.1)</td>
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<tr>
<td>Episode (update)</td>
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<td>Referral Out (delete)</td>
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</thead>
<tbody>
<tr>
<td>Referral Out (insert/update)</td>
</tr>
<tr>
<td>Episode (insert/update)</td>
</tr>
<tr>
<td>Contact (insert/update)</td>
</tr>
</tbody>
</table>

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All Episodes (primary key); all HL7 Referral Out messages (foreign key); all HL7 Contact messages (foreign key).

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All Episode, Referral Out and Contact messages)

**Value domain:** Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:** It is permissible to utilise upper case or lower case ASCII alpha characters, digits 0 to 9, dashes, spaces or apostrophes. That is, ASCII hexadecimal values 20, 27, 2D, 41 through 5A inclusive, 61 through 7A inclusive. Identifiers are case-sensitive.

**Primary Key**
This data element is the Primary Key for the Episode.

When reported using HL7 the primary key is reported in PV1.19\CX.1.

**Foreign Key - Contact/Client Service Event**
This data element is used as a Foreign Key on the Contact.

When reported using HL7 the foreign key is reported in PV1.5\CX.

When reported using XML the foreign key is reported in the `<Episodedentifier>` tag of the `<Episode>` node which is a (grand)parent to the `<Contact>` node for the Contact.

**Foreign Key - Referral Out**
This data element is used as a Foreign Key on the Referral Out.

When reported using HL7 the foreign key is reported in RF1.11\EI.1.

When reported using XML the foreign key is reported in the `<Episodedentifier>` tag of the `<Episode>` node which is a (grand)parent to the `<ReferralOut>` node for the Referral Out.
Validations: E050 Field <element_name> (<Location>) has no value but is part of the primary key for the <structure> record

Related items: Contact Identifier
Identifier Type
Local Identifier Assigning Authority
Message Date/Time
Patient/Client Identifier
Referral Identifier

Administration

Purpose: To enable management of VINAH transmissions.

Principal users: VINAH processing.

Version history:

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
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<tbody>
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<td>2009/07/01</td>
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<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Episode Identifier</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

Definition source: Department of Health and Human Services

Value domain source: Organisation
**Episode Pathway Type**

**Definition:** The nature of an event described by a date on a goal-oriented care pathway.

**Repeats:**

<table>
<thead>
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<th></th>
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<th>Max.</th>
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</thead>
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<td>5</td>
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</tbody>
</table>

**Location:**

Transmission protocol: HL7 Submission
- Episode (insert) PPP_PCB (PTH\PTH.2\CE.1)
- Episode (update) PPP_PCC (PTH\PTH.2\CE.1)
- Episode (delete) PPP_PCD (PTH\PTH.2\CE.1)

**Reported for:** All programs, when required to bind part of a transmission to a specific data element

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date/Time (All Episode messages)

**Value domain:** Enumerated

Table identifier 990078

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB1</td>
<td>Episode First Appointment Booked Date</td>
</tr>
<tr>
<td>ACPD</td>
<td>Episode Advance Care Plan Documented Date</td>
</tr>
<tr>
<td>CPD</td>
<td>Episode Care Plan Documented Date</td>
</tr>
<tr>
<td>HD</td>
<td>Episode Hospital Discharge Date</td>
</tr>
<tr>
<td>PNAB1</td>
<td>Episode Patient/Client Notified of First Appointment Date</td>
</tr>
<tr>
<td>TCPTB</td>
<td>Episode TCP Transition to Bed Based Care</td>
</tr>
<tr>
<td>TCPTH</td>
<td>Episode TCP Transition to Home Based Care</td>
</tr>
</tbody>
</table>

**Reporting guide:** The same HL7 message segment field is used to send several different dates. This data element identifies which data element the field contains in a given message segment, binding the transmission field to the data element.

For backward compatibility purposes, if the value of this data element is Null, it will be assumed to mean "Episode Care Plan Documented Date".

**AB1 - Episode First Appointment Booked Date**
Report this value when the date being transmitted is the date on which a patient/client was notified of the date of their first appointment.

**ACPD - Episode Advance Care Plan Documented Date**
Report this value when the date being transmitted is the date on which an advance care plan was documented.

**CPD - Episode Care Plan Documented Date**
Report this value when the date being transmitted is the date on which a care plan was documented.

**PNAB1 - Episode Patient/Client Notified of First Appointment Date**
Report this value when the date being transmitted is the date for which a patient's/client's first appointment is booked.

**TCPTB - Episode TCP Transition to Bed Based Care**
Report this value when the date being transmitted is an Episode TCP Care Transition Date on which a patient/client transitioned to bed-based care.

**TCPATH - Episode TCP Transition to Home Based Care**
Report this value when the date being transmitted is an Episode TCP Care Transition Date on which a patient/client transitioned to home-based care.
Validations: General edits only, see Format.
Related items: Message Date/Time

Administration

Purpose: To enable management of VINAH transmissions.
Principal users: Department of Health and Human Services

Version history:

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Episode Pathway Type</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

Definition source: HL7 (DHHS modified)

Value domain source: Department of Health and Human Services
**File Processing Directive**

**Definition:** A string of text that instructs the VINAH validation engine to process a submission file in a particular fashion.

**Repeats:**

- **Min.**
- **Max.**
- **Duplicate**

**Form:** Repeatable Structured List

**Layout:** X(...)

**Size:**

- **Min.**
- **Max.**
  - 0
  - 64

**Location:**

- **Transmission protocol:** HL7 Submission
  - Send File
    - FILE (FHS.10)
- **Transmission protocol:** XML Submission
  - Send File
    - Submission/ DataCollection/ Header/Process
      - /StopOnFirstFailedBatch
    - Submission/ DataCollection/ Header/Report/
      - EpisodeContactAudit
    - Submission/ DataCollection/ Header/Report/
      - SubmissionHistory
    - Submission/ DataCollection/ Header/TestMode
    - Submission/ DataCollection/ ReportingOrganisation/
      - Header/ RollBack/PurgeKey
    - Submission/ DataCollection/ ReportingOrganisation/
      - Header/ RollBack/SubID

**Reported by:** All programs, dependent on transmission protocol.

**Reported for:** All File messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All file messages)

**Value domain:**

The processing hint list items are described in the Reporting Guide.

- Table identifier: 990040

**List Item**

- GetEpisodeContactAudit=True;
- HTMLReport=True;
- PurgeAfterLoad=True;
- PurgeKey=<purge_key>;
- PurgeSubID=<sub_id>;
- StopOnFirstFailedBatch=True;
- SubmissionHistory=True;
- OrgMsgHistoryReport=True;
- OrgSubHistoryReport=True;
- RecordTransactionReport=True;

**Reporting guide:**

If submitting multiple processing hints, concatenate the list items together without spaces or HL7 repeating delimiters.

**GetEpisodeContactAudit=True;**

This option returns an XML document providing a list, for data that has been accepted into VINAH, of patient identifiers, the earliest and most recent contact dates and the number of contacts for each patient identifier and episode identifier.

**HTMLReport=True;**

This option returns an additional submission report containing the same data as the XML submission report, but transformed into an HTML document that can be read more easily by a user.

**PurgeAfterLoad=True;**
This option allows immediate deletion of a submission from the VINAH data store.

**PurgeKey=<purge_key>**;
Contains the Purge Key to be used when submitting a roll-back transmission. Must
be used with PurgeSubID.

**PurgeSubID=<sub_id>**;
Contains the Purge Sub ID to be used when submitting a roll-back transmission.
Must be used with PurgeKey.

**StopOnFirstFailedBatch=True**;
This option will cause the termination of the VINAH validation process for a file at
the first instance of a validation being triggered within a batch. Note that the failed
batch will be processed in its entirety, meaning there may be more than one error
returned. However subsequent batches will not be validated or acknowledged. As a
result, the validation report will not include any acceptance information for batches
beyond the first failed batch. The use of this option automatically implies the
PurgeAfterLoad directive; no data will be committed regardless of the validity of the
file. This option is only for use when testing VINAH submissions during change
cycles, or by prior arrangement with the Department.

**SubmissionHistory=True**;
This option returns an XML document which provides a history of submissions that
were processed by VINAH for the current user account.

**Validations:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X001</td>
<td>Submission &lt;filename&gt; was successfully purged from the VINAH System</td>
</tr>
<tr>
<td>X002</td>
<td>Submission &lt;filename&gt; was not successfully purged – incorrect TargetEnvironment/Filename/SubID/HealthService/UserName/PurgeKey combination</td>
</tr>
<tr>
<td>X003</td>
<td>Submission &lt;filename&gt; has already been purged after the initial load, due to the PurgeAfterLoad=True instruction on the original submission</td>
</tr>
<tr>
<td>X004</td>
<td>Submission &lt;filename&gt; could not be purged as it is not the last file submitted for this health service. Only the last existing file for a health service can be purged.</td>
</tr>
</tbody>
</table>

**Related items:**
File Identifier
File Name
File Purge Key
File Purged After Processing Indicator
Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>File Processing Directive</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Reference Period End Date**

**Definition:** A date indicating the end of the period for which the data is being reported.

<table>
<thead>
<tr>
<th><strong>Repeats:</strong></th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form:</td>
<td>Date</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Layout:</td>
<td>YYYYMMDD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Location:** Transmission protocol: HL7 Submission
Send file FILE (FHS.11)

**Reported by:** All VINAH transmissions.

**Reported for:** All file messages.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Processing End Date/Time (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** The File Reference Period End Date indicates the end date for the period of data included in the submission file. This will generally be the end date used when data is extracted from the vendor system.

Where the submission file is a resubmission of the same date range as a previous file, the File Reference Period End Date may be the same as the File Reference Period End Date in the previous file. The File Reference Period End Date cannot be a date prior to a File Reference Period End Date previously reported (and not subsequently purged).

If the submission is a purge file, the File Reference Period End Date should be the same as the value submitted in the file that is being purged.

**Validations:** E005 Invalid Code Supplied (‘<CodeSupplied>’) for field ‘<FieldName>’ (<Location>). Value must exist in code table <CodeTable> and be valid for this Program/Stream <ProgramStream>

**Related items:** File Processing End Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>File Reference Period End Date</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>1</td>
<td>File Reference Period End Date</td>
<td>2008/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** ISO8601:2000
File Sending Application

**Definition:** A code that identifies the application used to generate the VINAH submission.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Form:** Code

**Layout:** XXX[XX]

**Location:**

**Transmission protocol:** HL7 Submission
- Send File: FILE (FHS.3)

**Transmission protocol:** XML Submission
- Send File: Submission/DataCollection/Header/FileSendingApplication

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All file messages.

**Reported when:** All Programs, not elsewhere specified
- The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Message Date/Time (All file messages)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Table identifier</th>
<th>HL70361</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Descriptor</td>
</tr>
<tr>
<td>ADC</td>
<td>Ascribe</td>
</tr>
<tr>
<td>DAVEM</td>
<td>Data Agility VINAH Extract Manager</td>
</tr>
<tr>
<td>DEQ</td>
<td>Dynamic Equilibrium</td>
</tr>
<tr>
<td>ECP</td>
<td>eClinic PalCare</td>
</tr>
<tr>
<td>EPIC</td>
<td>EPIC</td>
</tr>
<tr>
<td>FIXUS</td>
<td>FIXUS</td>
</tr>
<tr>
<td>HMS</td>
<td>Health Management Systems</td>
</tr>
<tr>
<td>HOM</td>
<td>CSC HOMER</td>
</tr>
<tr>
<td>HRA</td>
<td>Health service internal repository A</td>
</tr>
<tr>
<td>i.PM</td>
<td>CSC</td>
</tr>
<tr>
<td>IBA</td>
<td>IBA Health</td>
</tr>
<tr>
<td>IPM</td>
<td>iSoft iPatient Manager</td>
</tr>
<tr>
<td>PJB</td>
<td>PJB Data Manager</td>
</tr>
<tr>
<td>TCM</td>
<td>Database Consultants Australia The Care Manager</td>
</tr>
<tr>
<td>TKC</td>
<td>TrakHealth TrakCare</td>
</tr>
<tr>
<td>UNITI</td>
<td>Uniti</td>
</tr>
</tbody>
</table>

**Reporting guide:** If there is no appropriate code for your extraction or submission application, please contact the HDSS Help Desk to discuss an appropriate code allocation.

Code ‘XXX – Test System’ cannot be reported for File Sending Application.

This data element will be tested against validation rules E001 and E004, which, if triggered will cause edit S001 to trigger in turn.

**HRA - Health service internal repository A**
- Code HRA should be reported in situations where a Health Service has an internally developed data repository that accepts data feeds from multiple source systems and then generates a VINAH data transmission. In the event that a Health Service has multiple repositories that fit this definition, please contact the HDSS Help Desk for additional code assignments.
Validations: E001 The field '<FieldName>' (<Location>) is mandatory, but no value was supplied

Related items: Identifier Type
Local Identifier Assigning Authority
Message Date/Time

Administration

Purpose: To assist with the management of VINAH transmissions and data compliance.

Principal users: VINAH processing.

Version history: Version Previous Name Effective Date
2 File Sending Application 2010/07/01

Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
Identifier Type

**Definition:** A code corresponding to the type of identifier. In some episodes, this code may be used as a qualifier to the ‘Assigning authority’ component.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form:</td>
<td>Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Layout:</td>
<td>U[U]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Size: Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location:</th>
<th>Transmission protocol:</th>
<th>HL7 Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PID:PID.3\CX.5)</td>
<td></td>
</tr>
<tr>
<td>Contact (update)</td>
<td>ADT_A03 (PV1:PV1.19:CX.5)</td>
<td></td>
</tr>
<tr>
<td>Patient/Client (insert)</td>
<td>ADT_A04 (PID:PID.3\CX.5)</td>
<td></td>
</tr>
<tr>
<td>Patient/Client (update)</td>
<td>ADT_A08 (PID:PID.3\CX.5)</td>
<td></td>
</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PID:PID.3\CX.5)</td>
<td></td>
</tr>
<tr>
<td>Contact (merge)</td>
<td>ADT_A30 (PID:PID.3\CX.5)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transmission protocol:</th>
<th>XML Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact (insert/update)</td>
<td>Contact/Key/Scheme</td>
</tr>
<tr>
<td>Patient/Client (insert/update)</td>
<td>Patient/Client/Key/Scheme</td>
</tr>
</tbody>
</table>

| Reported by: | All programs, dependent on transmission protocol |
| Reported for: | All Patient/Client messages. |
| Reported when: | **All Programs, not elsewhere specified** |
| | The current reporting period for this item is the calendar month in which the following events or data elements fall: |
| | Message Date/Time (All messages except Referral In messages that do not lead to an Episode) |
| Value domain: | Enumerated |
| | Table identifier | HL70203 |
| | Code | Descriptor |
| | A | Area/region/district |
| | E | Externally assigned identifier |
| | L | Local |
| | VN | Visit number |

| Reporting guide: | Identifier Type appears in VINAH transmissions whenever a CX composite field is called for in a PID or MRG message segment, specifically in CX.5 (IdentifierTypeCode), in order to give context to the value transmitted in CX.1 (ID). |
| | The CX is used in the PID and MRG Message Segments. |
| | In the PID it is used to transmit the Person Identifier, DVA File Number, TAC Claim Number and VWA File Number. |
| | In the MRG it appears in MRG.1 to transmit the list of Patient Prior Identifiers to be merged with the Patient Identifier being specified in the ADTA40 message. |
| | For a complete picture, it is worth noting that the CX.4 (AssigningAuthority) field will take its value from one of three different reference tables, depending on the value of the Identifier Type in CX.5, as noted below. |
Interaction between Identifier Type and Local Identifier Assigning Authority

Message Segment = PID.3 (Patient/Client) or MRG.1 (Patient/Client)

If Identifier Type (CX.5) value = E (Externally assigned identifier such as TAC Claim Number, Medicare Number, etc.)

Then

Assigning Authority (CX.4) contains value from table = HL70363

Identifier Type (CX.5) value = A (Indicates identifier is unique within the organisation)

Then

Assigning Authority (CX.4) contains value from table = HL703632 Organisation Identifier.

If Identifier Type (CX.5) value = L (Indicates identifier is NOT unique within the organisation)

Then

Assigning Authority (CX.4) contains value from table = HL70300 or HL70361 (or both, concatenated)

Use in Referral In Messages

Patient/Client Identifier and the associated values of Identifier Type and Local Identifier Assigning Authority may be left null in Referral In messages. However, if transmitted, they must identify a registered patient or client.

Prefixing Identifiers

The Identifier Type is relevant only to Patient Identifiers. To uniquely identify other identifiers across campuses and/or vendor systems, services may choose to prefix identifiers with a unique code. The code may indicate the vendor system, or program area, or other assigner or combination of assigners.

Codes can be created according to the requirements of the service and are not validated.

Prefixing identifiers ensures that data will not be overwritten or interfere with identifiers sent from other vendor systems or campuses if identifiers are not unique across all systems in the service.

XML

Identifier type is maintained in the XML transmission in a <Type> node as a legacy implementation until a common identifier and scope structure can be implemented.

Validations:

E001 The field '<FieldName>' (<Location>) is mandatory, but no value was supplied

E050 Field <element_name> (<Location>) has no value but is part of the primary key for the <structure> record

E051 Cannot insert record, same Primary Key for data structure "<structure>" already exists (<conflict_location>). Key fields: <pk_expanded_val>

Related items:

Batch Control Identifier
Contact Identifier
Contact TAC Claim Number
Contact VWA File Number
Episode Identifier
File Sending Application
Local Identifier Assigning Authority
Message Date/Time
Organisation Identifier
Patient/Client DVA File Number
Patient/Client Identifier
Patient/Client Prior Identifier
Referral Identifier
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Identifier Type</td>
<td>2012/07/01</td>
</tr>
<tr>
<td>5</td>
<td>Identifier Type</td>
<td>2009/11/01</td>
</tr>
<tr>
<td>4</td>
<td>Identifier Type</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Identifier Type</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Identifier Type</td>
<td>2008/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7, NHDD (DHHS modified)

**Value domain source:** HL7, NHDD 000841 (DHHS modified)
Local Identifier Assigning Authority

**Definition:** The assigning authority is a unique code identifying the system (or organisation or agency or department) that created the local identifier.

<table>
<thead>
<tr>
<th><strong>Repeats:</strong></th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form:</strong></td>
<td>Structured Code</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Layout:</strong></td>
<td>[UUU]XXX</td>
<td>Min.</td>
<td>Max.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

**Location:**

<table>
<thead>
<tr>
<th>Transmission protocol:</th>
<th>HL7 Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Patient/Client (insert)</td>
<td>ADT_A04 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Contact (update)</td>
<td>ADT_A08 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Patient/Client (update)</td>
<td>ADT_A08 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Patient/Client (merge)</td>
<td>ADT_A40 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Episode (insert)</td>
<td>PPP_PCB (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Episode (update)</td>
<td>PPP_PCC (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Episode (delete)</td>
<td>PPP_PCD (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Referral Out (insert)</td>
<td>REF_I12 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Referral Out (update)</td>
<td>REF_I13 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Referral Out (delete)</td>
<td>REF_I14 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Referral In (insert)</td>
<td>RRI_I12 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Referral In (update)</td>
<td>RRI_I13 (PID\PID.3\CX.4\HD.1)</td>
</tr>
<tr>
<td>Referral In (delete)</td>
<td>RRI_I14 (PID\PID.3\CX.4\HD.1)</td>
</tr>
</tbody>
</table>

**Transmission protocol:** XML Submission

| Contact (insert/update) | Contact/Key/Assigner |
| Episode (insert/update) | Episode/Key/Assigner |
| Patient/Client (insert/update) | PatientClient/Key/Assigner |
| Referral In (insert/update) | ReferralIn/Key/Assigner |
| Referral Out (insert/update) | ReferralOut/Key/Assigner |

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date/Time (All messages)

**Value domain:** See reporting guide, below. Refer to Table HL70300 in Section 9: Code Lists for Local Assigning Authority codes based on Geographic or Organisational bases.

Refer to Table HL70361, below for prefix codes based on software system. Refer to Table HL70363 for codes based on external assigning authorities.

**Reporting guide:** When included as part of the identifier for a person this code should identify the establishment assigning the Person Identifier to the client. For example, if a care provider uses identifiers generated by the Patient Master Index of a particular establishment, the code reported in this data element should be the identifier allocated to that establishment.

The Identifier Type indicates the level at which the indicator has been assigned. If the Identifier Type is ‘A’ (the identifier is unique to the organisation), the Local Identifier Assigning Authority takes the value of the Organisation Identifier (table HL70362). If the Identifier Type is ‘L’ (the identifier is not unique to the organisation), the Local Assigning Authority identifies the party who allocated
the Identifier.

A value from the Local Identifier Assigning Authority codeset (table HL70300 or HL70361, or both concatenated). If the Identifier has been allocated by an external organisation (Identifier Type = ‘E’) the Local Assigning Authority is an appropriate value from table HL70363.

The value domain for this data element was generated on the assumption that values would be assigned at a local establishment level, that is, on a geographic or organisational basis. However, in the event that this is not an accurate reflection of the situation at a given organisation, for example where there are multiple systems that use common identifiers across multiple establishments but do not share the identifiers between systems.

To this end additional codes have been created for this data element allowing vendors to specify their system as the assigning authority by prefixing or replacing the geographic/organisationally-based code with a 3-character code. If you are a software vendor and wish to take up this option, but there is no appropriate code, please contact the HDSS Help Desk to discuss an appropriate code allocation.

**Layout**

Part 1: Three character software system code.
Layout: AAA
Part 2: Geographic or organisationally-based code
Layout: XXX

For example, valid codes for Test Hospital (code ‘500’) reporting a local identifier from Test System (code ‘XXX’) could be XXX, XXX500 or 500.

This supports a situation where separate systems are in place in different locations (for example system AAA for HARP programs at locations 111 and 222 and system BBB for SACS programs also at locations 111 and 222) and the systems can neither communicate common identifiers between different sites or each other.

**Use in Referral In Messages**

Patient/Client Identifier and the associated values of Identifier Type and Local Identifier Assigning Authority may be left null in Referral In messages. However, if transmitted, they must identify a registered patient or client.

**Validations:**

E001 The field '<Field Name>' (<Location>) is mandatory, but no value was supplied
E050 Field <element_name> (<Location>) has no value but is part of the primary key for the <structure> record
E051 Cannot insert record, same Primary Key for data structure "<structure>" already exists (<conflict_location>). Key fields: <pk_expanded_val>

**Related items:**

Contact Identifier
Episode Identifier
File Sending Application
Identifier Type
Message Date/Time
Organisation Identifier
Patient/Client Identifier
Referral Identifier
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Local Identifier Assigning Authority</td>
<td>2012/07/01</td>
</tr>
<tr>
<td>4</td>
<td>Local Identifier Assigning Authority</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Local Identifier Assigning Authority</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Local Identifier Assigning Authority</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Local Identifier Assigning Authority</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7 (DHHS modified)

**Value domain source:** Department of Health and Human Services
Message Accept Acknowledgement Code

**Definition:** A code that identifies the conditions under which accept or application acknowledgments are required to be returned in response to this message.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
</table>

**Form:** Code

**Layout:** UU

**Location:**

- **Transmission protocol:** HL7 Submission
  - Contact (insert) ADT_A03 (MSH.15)
  - Patient/Client (insert) ADT_A04 (MSH.15)
  - Contact (update) ADT_A08 (MSH.15)
  - Contact (delete) ADT_A13 (MSH.15)
  - Patient/Client (merge) ADT_A40 (MSH.15)
  - Episode (insert) PPP_PCB (MSH.15)
  - Episode (update) PPP_PCC (MSH.15)
  - Episode (delete) PPP_PCD (MSH.15)
  - Referral Out (insert) REF_I12 (MSH.15)
  - Referral Out (update) REF_I13 (MSH.15)
  - Referral Out (delete) REF_I14 (MSH.15)
  - Referral In (insert) RRI_I12 (MSH.15)
  - Referral In (update) RRI_I13 (MSH.15)
  - Referral In (delete) RRI_I14 (MSH.15)

**Location:**

- **Reported by:** All programs, dependent on transmission protocol
- **Reported for:** All messages.
- **Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All messages)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE</td>
<td>Never</td>
</tr>
</tbody>
</table>

**Reporting guide:** 'NE - Never' is the only value from the HL7 data definition table accepted by VINAH.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time

**Administration**

**Purpose:** VINAH processing.

**Principal users:** Department of Health and Human Services

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Message Accept Acknowledgement Code</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Message Accept Acknowledgement Code</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Message Accept Acknowledgement Code</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Message Accept Acknowledgement Code</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7 (DHHS modified)

**Value domain source:** HL7
**Message Action Code**

**Definition:** A code identifying the intent of the message; whether to add, update, correct, and delete from the record pathways that are utilised to address an individual’s health care.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form:</strong></td>
<td>Code</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Layout:</strong></td>
<td>UU</td>
<td>Min.</td>
<td>Max.</td>
</tr>
<tr>
<td><strong>Location:</strong></td>
<td>Transmission protocol:</td>
<td>HL7 Submission</td>
<td></td>
</tr>
<tr>
<td>Episode (insert)</td>
<td>PPP_PCB (PTH.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episode (update)</td>
<td>PPP_PCC (PTH.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episode (delete)</td>
<td>PPP_PCD (PTH.1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All Episode messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date/Time (All Episode messages)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>Add</td>
</tr>
<tr>
<td>DE</td>
<td>Delete</td>
</tr>
<tr>
<td>UP</td>
<td>Update</td>
</tr>
</tbody>
</table>

**Reporting guide:** The VINAH update protocols are implemented at message level so the value of this item is implicit in the message type being sent, as described below.

These codes are the only values from the HL7 data definition table accepted by VINAH.

Note that this value will not instruct VINAH how to process a record; it is used only audit the intended action the record will have on the VINAH system.

**AD - Add**

Report code ‘AD’ when opening an Episode or reporting a completed Contact, that is: in the PPPPCB and ADTA03 messages.

**DE - Delete**

Report code ‘DE’ when deleting an Episode or Contact, that is: PPPPCD or ADTA13.

**UP - Update**

Report code ‘UP’ when updating or closing an Episode, that is: in the PPPPCC and in the Contact messages ADTA03, ADTA13.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Message Action Code</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Message Action Code</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Message Action Code</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Message Action Code</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7 (DHHS modified)

**Value domain source:** HL7
**Message Character Set Code**

**Definition:** A code that specifies the character set used for the entire HL7 message

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Form:**
- Code

**Layout:**
- UUUUUU
  - Size:
    - Min.: 5
    - Max.: 5

**Location:**
- **Transmission protocol:** HL7 Submission
  - Contact (insert): ADT_A03 (MSH.18)
  - Patient/Client (insert): ADT_A04 (MSH.18)
  - Contact (update): ADT_A08 (MSH.18)
  - Contact (delete): ADT_A13 (MSH.18)
  - Patient/Client (merge): ADT_A40 (MSH.18)
  - Episode (insert): PPP_PCB (MSH.18)
  - Episode (update): PPP_PCC (MSH.18)
  - Episode (delete): PPP_PCD (MSH.18)
  - Referral Out (insert): REF_I12 (MSH.18)
  - Referral Out (update): REF_I13 (MSH.18)
  - Referral Out (delete): REF_I14 (MSH.18)
  - Referral In (insert): RRI_I12 (MSH.18)
  - Referral In (update): RRI_I13 (MSH.18)
  - Referral In (delete): RRI_I14 (MSH.18)

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Message Date/Time (All messages)

**Value domain:** Enumerated

Table identifier: HL70211

**Reporting guide:** All transmissions to VINAH must use the 7-bit ASCII character set.

**Validations:** F005 Illegal Extended ASCII Character supplied (Code <ASCIICode>) at position <Position> in File. File may only contain 7-bit ASCII characters.

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Message Character Set Code</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Message Character Set Code</td>
<td>2009/07/01</td>
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<tr>
<td>2</td>
<td>Message Character Set Code</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Message Character Set Code</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7

**Value domain source:** HL7
**Message Control Identifier**

**Definition:** A unique message identifier for a message across applications within an organisation.

**Repeats:**

<table>
<thead>
<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form:</strong></td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Layout:</strong></td>
<td>X(1-20)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Size:**

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<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

**Location:**

**Transmission protocol:** HL7 Submission
- Contact (insert) ADT_A03 (MSH.10)
- Patient/Client (insert) ADT_A04 (MSH.10)
- Contact (update) ADT_A08 (MSH.10)
- Contact (delete) ADT_A13 (MSH.10)
- Patient/Client (merge) ADT_A40 (MSH.10)
- Episode (insert) PPP_PCB (MSH.10)
- Episode (update) PPP_PCC (MSH.10)
- Episode (delete) PPP_PCD (MSH.10)
- Referral Out (insert) REF_I12 (MSH.10)
- Referral Out (update) REF_I13 (MSH.10)
- Referral Out (delete) REF_I14 (MSH.10)
- Referral In (insert) RRI_I12 (MSH.10)
- Referral In (update) RRI_I13 (MSH.10)
- Referral In (delete) RRI_I14 (MSH.10)

**Transmission protocol:** XML Submission
- Contact (insert/update) Contact/Header/HL7Message/Identifier
- Episode (insert/update) Episode/Header/HL7Message/Identifier
- Patient/Client (insert/update) PatientClient/Header/HL7Message/Identifier
- Referral In (insert/update) ReferralIn/Header/HL7Message/Identifier
- Referral Out (insert/update) ReferralOut/Header/HL7Message/Identifier

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All HL7 messages. Optional for XML messages.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Message Date/Time (All messages)

**Value domain:** Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:** It is permissible to utilise upper case or lower case ASCII alpha characters, digits 0 to 9, dashes, spaces or apostrophes. That is, ASCII hexadecimal values 20, 27, 2D, 41 through 5A inclusive, 61 through 7A inclusive. Identifiers are case-sensitive.

**XML**
The full extent of the available locations is optional for XML transmissions. They are provided to enable applications which have been constructed to use HL7 to transmit an equivalent message control identifier in XML.
The location in the XML file should correspond to the appropriate message type, as follows:
- HL7 Message ADT_A03 is transmitted in XML Node <Contact>;
- HL7 Message ADT_A04 is transmitted in XML Node <PatientClient>;
- HL7 Message ADT_A08 is transmitted in XML Node <PatientClient> or <Contact> or <BirthEvent>.
HL7 Message ADT_A13 is transmitted in XML Node <Contact> or <BirthEvent>;
HL7 Message ADT_A40 is transmitted in XML Node <PatientClient>;
HL7 Message PPP_PCB is transmitted in XML Node <Episode>;
HL7 Message PPP_PCC is transmitted in XML Node <Episode>;
HL7 Message PPP_PCD is transmitted in XML Node <Episode>;
HL7 Message REF_I12 is transmitted in XML Node <ReferralOut>;
HL7 Message REF_I13 is transmitted in XML Node <ReferralOut>;
HL7 Message REF_I14 is transmitted in XML Node <ReferralOut>;
HL7 Message RRI_I12 is transmitted in XML Node <ReferralIn>;
HL7 Message RRI_I13 is transmitted in XML Node <ReferralIn>;
HL7 Message RRI_I14 is transmitted in XML Node <ReferralIn>.

**Validations:**
HL7011  Message Control Identifier <MCID> has already been allocated to a previous message

**Related items:**
Message Date/Time

**Administration**

**Purpose:**
To enable management of VINAH transmissions.

**Principal users:**
VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Message Control Identifier</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Message Control Identifier</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Message Control Identifier</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Message Control Identifier</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:**
Department of Health and Human Services

**Value domain source:**
Organisation
**Message Date/Time**

**Definition:** The date and time that the sending system created the HL7 message. If the time zone is specified, it will be used throughout the message as the default time zone.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
</table>

**Form:**
- Date and Time

**Layout:**
- YYYYMMDD[hhmmss]

**Location:**
- Transmission protocol: HL7 Submission
  - Contact (insert) ADT_A03 (MSH.7\TS.1)
  - Patient/Client (insert) ADT_A04 (MSH.7\TS.1)
  - Contact (update) ADT_A08 (MSH.7\TS.1)
  - Contact (delete) ADT_A13 (MSH.7\TS.1)
  - Patient/Client (merge) ADT_A40 (MSH.7\TS.1)
  - Episode (insert) PPP_PCB (MSH.7\TS.1)
  - Episode (update) PPP_PCC (MSH.7\TS.1)
  - Episode (delete) PPP_PCD (MSH.7\TS.1)
  - Referral Out (insert) REF_I12 (MSH.7\TS.1)
  - Referral Out (update) REF_I13 (MSH.7\TS.1)
  - Referral Out (delete) REF_I14 (MSH.7\TS.1)
  - Referral In (insert) RRI_I12 (MSH.7\TS.1)
  - Referral In (update) RRI_I13 (MSH.7\TS.1)
  - Referral In (delete) RRI_I14 (MSH.7\TS.1)

- Transmission protocol: XML Submission
  - Send File Submission/DataCollection/Header/Compilation/DateTime
  - Contact (insert/update) Contact/Header/HL7Message/DateTime
  - Episode (insert/update) Episode/Header/HL7Message/DateTime
  - Patient/Client (insert/update) PatientClient/Header/HL7Message/DateTime
  - Referral In (insert/update) ReferralIn/Header/HL7Message/DateTime
  - Referral Out (insert/update) ReferralOut/Header/HL7Message/DateTime

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All HL7 messages, Optional for XML messages.

**Reported when:** A valid date and time.

**Value domain:** See Message Set Representation in Section 5 for more details on specification of dates and times.

**XML**

The full extent of the available locations is optional for XML transmissions. They are provided to enable applications which have been constructed to use HL7 to transmit an equivalent message control identifier in XML.

The location in the XML file should correspond to the appropriate message type, for example, a date and time for an ADT_A04 would be transmitted in the PatientClient node and a date and time for a PPP_PCB would be transmitted in the Episode node; see Message Control Identifier for more information.

A date and time must be present for the Batch/DataCollection.

**Validations:** General edits only, see Format.

**Related items:**
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Message Date/Time</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Message Date and Time</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Message Date and Time</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Message Date and Time</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7

**Value domain source:** ISO8601:2000
**Message Origin Country Code**

**Definition:** A code that identifies the country of origin for the message.

**Repeats:**

<table>
<thead>
<tr>
<th>Form: Code</th>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Location:**

- **Transmission protocol:** HL7 Submission
- **Contact (insert)** ADT_A03 (MSH.17)
- **Patient/Client (insert)** ADT_A04 (MSH.17)
- **Contact (update)** ADT_A08 (MSH.17)
- **Contact (delete)** ADT_A13 (MSH.17)
- **Patient/Client (merge)** ADT_A40 (MSH.17)
- **Episode (insert)** PPP_PCB (MSH.17)
- **Episode (update)** PPP_PCC (MSH.17)
- **Episode (delete)** PPP_PCD (MSH.17)
- **Referral Out (insert)** REF_I12 (MSH.17)
- **Referral Out (update)** REF_I13 (MSH.17)
- **Referral Out (delete)** REF_I14 (MSH.17)
- **Referral In (insert)** RRI_I12 (MSH.17)
- **Referral In (update)** RRI_I13 (MSH.17)
- **Referral In (delete)** RRI_I14 (MSH.17)

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All HL7 messages, Optional for XML messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All messages)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Table identifier</th>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>HL70399</td>
<td>AU</td>
<td>Australia (two character form)</td>
</tr>
<tr>
<td></td>
<td>AUS</td>
<td>Australia (three character form)</td>
</tr>
</tbody>
</table>

**Reporting guide:** HL7 specifies that the three-character (alphabetic) form be used for the country code. VINAH also accepts the two-character alphabetic form. Australia (code ‘AU’ or code ‘AUS’) is the only acceptable value. This data element should not be confused with Patient/Client Birth Country, which uses the ABS SACC code set.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Message Origin Country Code</td>
<td>2010/07/01</td>
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<tr>
<td>3</td>
<td>Message Origin Country Code</td>
<td>2009/07/01</td>
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<tr>
<td>2</td>
<td>Message Origin Country Code</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Message Origin Country Code</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7

**Value domain source:** ISO 3166
Message Processing Identifier

**Definition:** A code indicating whether to process the message as defined in HL7 Application (level 7) processing rules; it defines whether the message is part of a production, training, or debugging system.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tbody>
<tr>
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<td>Min.</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>1</td>
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</table>

**Location:**

- **Transmission protocol:** HL7 Submission
- **Contact (insert):** ADT_A03 (MSH.11\PT.1)
- **Patient/Client (insert):** ADT_A04 (MSH.11\PT.1)
- **Contact (update):** ADT_A08 (MSH.11\PT.1)
- **Contact (delete):** ADT_A13 (MSH.11\PT.1)
- **Patient/Client (merge):** ADT_A40 (MSH.11\PT.1)
- **Episode (insert):** PPP_PCB (MSH.11\PT.1)
- **Episode (update):** PPP_PCC (MSH.11\PT.1)
- **Episode (delete):** PPP_PCD (MSH.11\PT.1)
- **Referral Out (insert):** REF_I12 (MSH.11\PT.1)
- **Referral Out (update):** REF_I13 (MSH.11\PT.1)
- **Referral Out (delete):** REF_I14 (MSH.11\PT.1)
- **Referral In (insert):** RRI_I12 (MSH.11\PT.1)
- **Referral In (update):** RRI_I13 (MSH.11\PT.1)
- **Referral In (delete):** RRI_I14 (MSH.11\PT.1)

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All messages)

**Value domain:** Enumerated

- **Table identifier:** HL70103
- **Code:** D
- **Descriptor:** Debugging
- **P:** Production
- **T:** Training

**Reporting guide:** This value should vary depending on whether the interface is in development, test or production mode. However validation will not fail if, for example, Processing Identifier is set to ‘P’ when a message is sent to the test environment.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time
### Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

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<td>Processing Identifier</td>
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</tr>
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<td>1</td>
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<td>2005/07/01</td>
</tr>
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</table>

**Definition source:** HL7 (DHHS modified)

**Value domain source:** HL7
Message Type

Definition: A HL7 message is the atomic unit of data transferred between systems.

Each message has a message type that defines its purpose, a real-world trigger event that initiates an exchange of messages, and an abstract internal structure of segments and fields that define how the message is assembled.

This data element is composed of these three components that define the type of message.

The first component is the message type code defined by HL7 Table 0076 - Message type.

The second component is the trigger event code defined by HL7 Table 0003 - Event type.

The third component is the abstract message structure code defined by HL7 Table 0354 - Message structure.

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Referral In (insert)       RRI_I12 (MSH.9(MSG.1))
Referral In (insert)       RRI_I12 (MSH.9(MSG.2))
Referral In (insert)       RRI_I12 (MSH.9(MSG.3))
Referral In (update)       RRI_I13 (MSH.9(MSG.1))
Referral In (update)       RRI_I13 (MSH.9(MSG.2))
Referral In (update)       RRI_I13 (MSH.9(MSG.3))
Referral In (delete)       RRI_I14 (MSH.9(MSG.1))
Referral In (delete)       RRI_I14 (MSH.9(MSG.2))
Referral In (delete)       RRI_I14 (MSH.9(MSG.3))

Transmission protocol: XML Submission
Contact (insert/update)   Contact/Header/HL7Message/Type
Episode (insert/update)   Episode/Header/HL7Message/Type
Patient/Client (insert/update)   PatientClient/Header/HL7Message/Type
Referral In (insert/update) ReferralIn/Header/HL7Message/Type
Referral Out (insert/update) ReferralOut/Header/HL7Message/Type

Reported by: All programs, dependent on transmission protocol
Reported for: All messages.
Reported when: All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
Message Date/Time (All messages)

Value domain: HL70354 - Message structure.

Table identifier HL70003

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<td>Discharge/end visit event</td>
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<td>A04</td>
<td>Register a patient event</td>
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<tr>
<td>A08</td>
<td>Update patient information event</td>
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<tr>
<td>A13</td>
<td>Cancel discharge / end visit event</td>
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<td>A40</td>
<td>Merge patient - patient identifier list</td>
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<td>I12</td>
<td>Patient referral</td>
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<td>I13</td>
<td>Modify patient referral</td>
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<tr>
<td>I14</td>
<td>Cancel patient referral</td>
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<td>PCB</td>
<td>Pathway (Problem-Oriented) Add</td>
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<td>PCC</td>
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Table Identifier HL70076

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<td>Patient administration unsolicited update</td>
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<tr>
<td>PPP</td>
<td>Patient pathway (problem-oriented) message</td>
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<td>REF</td>
<td>Patient referral</td>
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<td>RRI</td>
<td>Return referral information</td>
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Table Identifier HL70354

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<td>PPP_PCG</td>
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<td>REF_I12</td>
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</table>
Reporting guide: Valid combinations for transaction types are:
Patient/Client (insert): ADT^A04^ADT_A01
Patient/Client (update): ADT^A08^ADT_A01
Patient/Client (merge): ADT^A40^ADT_A39
Referral In (insert): RRI^I12^REF_I12
Referral In (update): RRI^I13^REF_I12
Referral In (delete): RRI^I14^REF_I12
Episode (insert): PPP^PCB^PPP_PCB
Episode (update): PPP^PCC^PPP_PCB
Episode (delete): PPP^PCD^PPP_PCB
Contact/Client Service Event (insert): ADT^A03^ADT_A01
Contact/Client Service Event (update): ADT^A08^ADT_A01
Contact/Client Service Event (delete): ADT^A13^ADT_A01
Referral Out (insert): REF^I12^REF_I12
Referral Out (update): REF^I13^REF_I12
Referral Out (delete): REF^I14^REF_I12

Validations: HL7010 Invalid Message Type <MessageType>

Administration

Purpose: To enable management of VINAH transmissions.

Principal users: VINAH processing.

Version history:

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Definition source: HL7 (DHHS modified)

Value domain source: HL7
**Message Version Code**

**Definition:** A code that identifies the HL7 version of a message.

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**Location:**

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<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (MSH.12)</td>
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<td>ADT_A40 (MSH.12)</td>
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<td>PPP_PCB (MSH.12)</td>
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**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All messages.

**Reported when:** **All Programs, not elsewhere specified**

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All messages)

**Value domain:** Enumerated

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**Reporting guide:** '2.5-Release 2.5' is the only value from the HL7 data definition table accepted by VINAH.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

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</tr>
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<td></td>
<td>1</td>
<td>Message Version Code</td>
<td>2005/07/01</td>
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**Definition source:** HL7

**Value domain source:** HL7
Message Visit Indicator Code

**Definition:** A code indicating the conceptual level on which data are being sent.

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<td>Transmission protocol:</td>
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<td>Contact (delete)</td>
<td>ADT_A13 (PV1.51)</td>
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**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All Episode messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date/Time (All Episode, Referral and Contact messages)

**Value domain:** Enumerated

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<th>Descriptor</th>
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<tbody>
<tr>
<td>E</td>
<td>Episode</td>
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<tr>
<td>O</td>
<td>Contact</td>
</tr>
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</table>

**Reporting guide:** XML

This is optional for reporting via XML except for reporting historical Client Service Events, where it is required.

**E - Episode**
Report code 'E' in the Episode and Referral messages that is: PPP_PCB, PPP_PCC, PPP_PCD, RRI_I12, RRI_I13, RRI_I14, REF_I12, REF_I13, REF_I14.

**O - Contact**
Report code 'O' in the Contact/Client Service Event messages (ADT_A03, ADT_A08, ADT_A13) when the reporting level is Contact.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time
Administration

Purpose: To enable management of VINAH transmissions.

Principal users: VINAH processing.

Version history:

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<th>Version</th>
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<td>3</td>
<td>Message Visit Indicator Code</td>
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<td>2005/07/01</td>
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Definition source: HL7 (DHHS modified)

Value domain source: HL7 (DHHS modified)
Observation Bound Data Element

**Definition:** A code that identifies the data element being transmitted in the HL7 observation code field.

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</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>8</td>
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</tbody>
</table>

**Location:**

- **Transmission protocol:** HL7 Submission
  - Episode (insert) PPP_PCB (OBX\OBX.3\CE.3)
  - Episode (update) PPP_PCC (OBX\OBX.3\CE.3)
  - Episode (delete) PPP_PCD (OBX\OBX.3\CE.3)

**Reported by:** All programs, when required to bind part of a transmission to a specific data element.

**Reported for:** All Episode messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All Episode messages)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Table identifier</th>
<th>Code</th>
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<tr>
<td>HL70396</td>
<td>990033</td>
<td>Malignancy Flag</td>
</tr>
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<td></td>
<td>990036</td>
<td>Other Factors Affecting Health</td>
</tr>
<tr>
<td></td>
<td>990080</td>
<td>Health-related problems and diseases</td>
</tr>
<tr>
<td></td>
<td>BARTHEL</td>
<td>Barthel Index</td>
</tr>
<tr>
<td></td>
<td>FIM</td>
<td>FIM Score</td>
</tr>
</tbody>
</table>

**Reporting guide:** HL7 application

The same HL7 message segment field is used to send the Episode Malignancy Flag, Episode Other Factors Affecting Health, Episode Health Conditions, Episode Assessment Score - Barthel Index and Episode Assessment Score - FIM Score. This data element identifies which data element the field contains in a given message segment.

This data element identifies which data element the CE.1 field contains in a given message segment.

The specified values are the only values from the HL7 data definition table accepted by VINAH.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

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<tr>
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<td>2011/07/01</td>
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<td>5</td>
<td>Observation Bound Data Element</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>4</td>
<td>Observation Code Table</td>
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<td>3</td>
<td>Observation Code Table</td>
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</tr>
<tr>
<td>2</td>
<td>Observation Code Table</td>
<td>2007/07/01</td>
</tr>
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<td>Observation Code Table</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** HL7 (DHHS modified)
Observation Sequence Number

**Definition:** A number that identifies the Observation transaction segment.

<table>
<thead>
<tr>
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<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tbody>
<tr>
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<td>Size:</td>
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<td></td>
<td></td>
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<td>No limit</td>
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</tbody>
</table>

**Location:**

Transmission protocol: HL7 Submission
- Episode (insert) PPP_PCB (OBX/OBX.1)
- Episode (update) PPP_PCC (OBX/OBX.1)
- Episode (delete) PPP_PCD (OBX/OBX.1)

Transmission protocol: XML Submission
- Episode (insert/update) Episode/Diagnosis/HealthCondition/ Sequence

**Reported by:** All programs, when required to sequence part of a transmission to a specific data element.

**Reported for:** All Episode messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- Message Date/Time (All Episode messages)

**Value domain:** A positive integer.

**Reporting guide:** HL7

For the first occurrence of the segment the sequence number shall be 1, for the second occurrence it shall be 2, etc.

There can be multiple OBX segments in this message - one for the Malignancy Flag and one or more for the Episode Health Condition(s) and Episode Other Factors Affecting Health.

XML

For the first occurrence of the parent node the sequence number shall be 1, for the second occurrence it shall be 2, etc.

**Validations:** General edits only, see Format.

**Related items:**
- Birth Event Health Condition
- Birth Event Health Condition Context
- Birth Event Procedure
- Episode Health Conditions
- Episode Malignancy Flag
- Episode Other Factors Affecting Health
- Message Date/Time
- Observation Bound Data Element

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
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<th>Previous Name</th>
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</tr>
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<td>3</td>
<td>Observation Sequence Number</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Observation Sequence Number</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Observation Sequence Number</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7 (DHHS modified)

**Value domain source:** HL7
Organisation Identifier

**Definition:** An identifier for an organisation, unique within the State or Territory.

<table>
<thead>
<tr>
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<th><strong>Min.</strong></th>
<th><strong>Max.</strong></th>
<th><strong>Duplicate</strong></th>
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<td><strong>Layout:</strong></td>
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<td>226</td>
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</table>

**Location:**

**Transmission protocol:**
- HL7 Submission
  - Contact/Client Service Event (insert): ADT_A03 (MSH:MSH.4:HD.1)
  - Patient/Client (insert): ADT_A04 (MSH:MSH.4:HD.1)
  - Contact/Client Service Event (update): ADT_A08 (MSH:MSH.4:HD.1)
  - Patient/Client (update): ADT_A08 (MSH:MSH.4:HD.1)
  - Contact/Client Service Event (delete): ADT_A13 (MSH:MSH.4:HD.1)
  - Patient/Client (merge): ADT_A40 (MSH:MSH.4:HD.1)
  - Send File: FILE (FHS.4:HD.1)
  - Episode (insert): PPP_PCB (MSH:MSH.4:HD.1)
  - Episode (update): PPP_PCC (MSH:MSH.4:HD.1)
  - Episode (delete): PPP_PCD (MSH:MSH.4:HD.1)
  - Referral Out (insert): REF_I12 (MSH:MSH.4:HD.1)
  - Referral Out (update): REF_I13 (MSH:MSH.4:HD.1)
  - Referral Out (delete): REF_I14 (MSH:MSH.4:HD.1)
  - Referral In (insert): RRI_I12 (MSH:MSH.4:HD.1)
  - Referral In (update): RRI_I13 (MSH:MSH.4:HD.1)
  - Referral In (delete): RRI_I14 (MSH:MSH.4:HD.1)

**Transmission protocol:**
- XML Submission
  - Contact (insert/update): /Submission/ DataCollection/ ReportingOrganisation/Key/Key
  - Referral Out (insert/update): /Submission/ DataCollection/ ReportingOrganisation/Key/Key
  - Referral In (insert/update): /Submission/ DataCollection/ ReportingOrganisation/Key/Key
  - Patient/Client (insert/update): /Submission/ DataCollection/ ReportingOrganisation/Key/Key
  - Episode (insert/update): /Submission/ DataCollection/ ReportingOrganisation/Key/Key

**Reported by:** All programs, dependent on transmission protocol

**Reported for:** All VINAH transmissions including File and Batch headers.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:
- Referral In Received Date (Mandatory)
- Referral In Receipt Acknowledgment Date (Mandatory)
- Episode Start Date (Mandatory)
- Episode Care Plan Documented Date (Mandatory)
- First Contact Date/Time (Mandatory)
- Second and Subsequent Contact Date/Time (Mandatory)
- Episode End Date (Mandatory)
- Patient/Client Death Date (Mandatory)
- Message Date and Time (All Patient/Client, Episode and Birth Event messages)
- Message Date and Time (All messages)
Value domain: Refer to Section 9: Code Lists
Table identifier HL70362
For full code set see Section 9.

Reporting guide: When used in the FILE message this code should identify the organisation that is the sending facility of the file.

When used in the BATCH message this code should identify the organisation funding the care.

Where a care providing organisation is funded by multiple fund-holding organisations the funding organisation should be identified in the Batch Message. The implication from this is that patients should be clearly aligned with one funding organisation so that they may be appropriately and completely reported by the responsible fund-holding organisation. For example, where a Community Health Service is a member of multiple HARP alliances, patients/clients of the Health Centre should be identified as being with the appropriate HARP alliance for the care received and reported to that alliance accordingly. Care within a single episode should not be split between funding organisations.

The organisation identified in the FILE and BATCH message will often be the same organisation.

In all other messages this code should match that used in the parent BATCH message.

Organisation Identifier also includes a code for DHHS ('AUSDHV') and is used in the HL7 messages as the receiving facility for transmissions to VINAH. HL7 ACK messages will have the sending and receiving facility codes reversed. Also see Episode Provider.

Validations: General edits only, see Format.
Related items: Contact Date/Time
Episode Care Plan Documented Date
Episode End Date
Episode Start Date
Message Date and Time
Patient/Client Death Date
Referral In Receipt Acknowledgment Date
Referral In Received Date

Administration

Purpose: For use in policy development and planning. To enable management of VINAH transmissions.

Principal users: Department of Health and Human Services

Version history: Version Previous Name Effective Date
5 Organisation Identifier 2010/07/01
4 Organisation Identifier 2009/07/01
3 Organisation Identifier 2007/07/01
2 Organisation Identifier 2006/07/01
1 Health Service Identifier 2005/07/01

Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
**Patient/Client Prior Identifier**

**Definition:** The mode of provision of the service during the contact.

<table>
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<th>Max.</th>
<th>Duplicate</th>
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</table>

**Location:**
- **Transmission protocol:** HL7 Submission
  - Patient/Client (merge)
  - ADT_A40 (MRG.1\CX.1)
- **Transmission protocol:** XML Submission
  - Patient/Client (merge)
  - TBA

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Medi-Hotel
- Palliative Care
- Post Acute Care
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** Merge patient/client identifier messages.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date and Time (Ad hoc; this item is transmitted when the Submitting Organisation determines a need to merge person identifiers)

**Value domain:** Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:** XML

This data element must only be transmitted when Transmission Processing Directive is "M".

Currently, VINAH only supports Patient/Client merges.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
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<td>Patient/Client Prior Identifier</td>
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<td>3</td>
<td>Patient/Client Prior Identifier</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Prior Person Identifier</td>
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</tr>
<tr>
<td>1</td>
<td>Prior Person Identifier</td>
<td>2005/07/01</td>
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</table>

**Definition source:** HL7 (DHHS modified)

**Value domain source:** Health Service
Procedure Bound Data Element

**Definition:** A code that identifies the data element being transmitted in the HL7 procedure code field.

<table>
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<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<td><strong>Location:</strong></td>
<td>Transmission protocol:</td>
<td>HL7 Submission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact (insert)</td>
<td>ADT_A03 (PR1\PR1.3\CE.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact (update)</td>
<td>ADT_A08 (PR1\PR1.3\CE.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact (delete)</td>
<td>ADT_A13 (PR1\PR1.3\CE.3)</td>
<td></td>
</tr>
<tr>
<td><strong>Reported by:</strong></td>
<td>All programs, when required to bind part of a transmission to a specific data element.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reported for:</strong></td>
<td>All Episode messages.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reported when:</strong></td>
<td>All Programs, not elsewhere specified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The current reporting period for this item is the calendar month in which the following events or data elements fall:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Message Date/Time (All Contact messages)</td>
<td></td>
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</tr>
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<td><strong>Value domain:</strong></td>
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<td>Code Descriptor</td>
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<td></td>
<td>HL70230 Contact Main Purpose</td>
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</tr>
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<td></td>
<td>990084 Medicare Benefits Schedule Item Number</td>
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</tr>
<tr>
<td><strong>Reporting guide:</strong></td>
<td>XML</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The same HL7 message segment field is used to send the Contact Purpose and Contact Medicare Benefits Schedule Number. This data element identifies which data element the field contains in a given message segment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This data element identifies which data element the CE.1 field contains in a given message segment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The specified values are the only values from the HL7 data definition table accepted by VINAH.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For backwards compatibility purposes, if this value may be left NULL, in which case it will be interpreted to mean 'HL70230 - Contact Purpose'.</td>
<td></td>
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<tr>
<td><strong>Validations:</strong></td>
<td>General edits only, see Format.</td>
<td></td>
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<tr>
<td><strong>Related items:</strong></td>
<td>Message Date/Time</td>
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**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
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</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** HL7 (DHHS modified)
**Procedure Sequence Number**

**Definition:** A number that identifies the Procedure transaction segment.

**Repeats:**

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<th>Min.</th>
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**Form:** Repeatable Integer

**Layout:** N[N]

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**Location:**

<table>
<thead>
<tr>
<th>Transmission protocol:</th>
<th>HL7 Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact (insert)</td>
<td>ADT_A03 (PR1\PR1.1)</td>
</tr>
<tr>
<td>Contact (update)</td>
<td>ADT_A08 (PR1\PR1.1)</td>
</tr>
<tr>
<td>Contact (delete)</td>
<td>ADT_A13 (PR1\PR1.1)</td>
</tr>
</tbody>
</table>

**Transmission protocol:** XML Submission

| Contact (insert/update) | Contact/PatientManagement/Purpose/Sequence |

**Reported by:** All programs, when required to sequence part of a transmission to a specific data element.

**Reported for:** All contacts completed in the current reporting period.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date/Time (All Contact messages)

**Value domain:** A positive integer.

**Reporting guide:** For the first occurrence of the segment the sequence number shall be 1, for the second occurrence it shall be 2, etc.

**Contact Main Purpose**

For Palliative Care, more than one purpose may be optionally reported, even at contact level. The main purpose must be reported with a Contact/Client Service Event Purpose Sequence Number of ‘1’, additional purposes reported with values of ‘2’, ‘3’, ‘4’... and so on.

For backwards compatibility reasons, all Contact Purposes must be reported in repeating instances of this segment before any Contact Medicare Benefits Schedule Numbers.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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</thead>
<tbody>
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</tr>
<tr>
<td>3</td>
<td>Contact/Client Service Event Main Purpose Sequence Number</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Contact/Client Service Event Main Purpose Sequence Number</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Client Service Event Type Sequence Number</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** HL7 (DHHS modified)

**Value domain source:** HL7
Referral Identifier

**Definition:** An identifier, unique to a Referral across all programs within an organisation. A referral includes referrals in and out.

<table>
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<th>Max.</th>
<th>Duplicate</th>
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<tbody>
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<td>HL7 Submission</td>
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<tr>
<td></td>
<td>Episode (insert)</td>
<td>PPP_PCB (PV1\PV1.5\CX.1)</td>
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</tr>
<tr>
<td></td>
<td>Episode (update)</td>
<td>PPP_PCC (PV1\PV1.5\CX.1)</td>
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<tr>
<td></td>
<td>Episode (delete)</td>
<td>PPP_PCD (PV1\PV1.5\CX.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral Out (insert)</td>
<td>REF_I12 (RF1\RF1.6\E1.1)</td>
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<td>Referral Out (update)</td>
<td>REF_I13 (RF1\RF1.6\E1.1)</td>
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<tr>
<td></td>
<td>Referral Out (delete)</td>
<td>REF_I14 (RF1\RF1.6\E1.1)</td>
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<td>Referral In (insert)</td>
<td>RRI_I12 (RF1\RF1.6\E1.1)</td>
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</tr>
<tr>
<td></td>
<td>Referral In (update)</td>
<td>RRI_I13 (RF1\RF1.6\E1.1)</td>
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</tr>
<tr>
<td></td>
<td>Referral In (delete)</td>
<td>RRI_I14 (RF1\RF1.6\E1.1)</td>
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</tr>
<tr>
<td></td>
<td>Transmission protocol:</td>
<td>XML Submission</td>
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<tr>
<td></td>
<td>Referral In (insert/update)</td>
<td>ReferralIn/Key/Key</td>
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</tr>
<tr>
<td></td>
<td>Referral Out (insert/update)</td>
<td>ReferralOut/Key/Key</td>
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</tr>
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**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All Referrals.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

Message Date/Time (All Contact messages)

**Value domain:** Organisation generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting guide:** It is permissible to utilise upper case or lower case ASCII alpha characters, digits 0 to 9, dashes, spaces or apostrophes. That is, ASCII hexadecimal values 20, 27, 2D, 41 through 5A inclusive, 61 through 7A inclusive. Identifiers are case-sensitive.

A Received Source (that may lead to an Episode being opened) and a Referral Destination (made from within an episode to another service) must not share the same Referral Identifier within an organisation.

**Primary Key**

This data element is the Primary Key for the Referral In and the Referral Out. When reported using HL7 the primary key is reported in RF1.6\E1.1.

**Foreign Key - Episode**

---

**Page 220**  
**Section 3 – Data elements, VINAH manual, 11th edition, July 2015**
This data element is used as a Foreign Key on the Episode.

When reported using HL7 the foreign key is reported in PV1.5\CX.1.
When reported using XML the foreign key is reported in the <Episode><FK>
<ReferralInIdentifier> node.

**Validations:**

- E050  Field `<element_name>` (<Location>) has no value but is part of the primary key for the `<structure>` record
- E051  Cannot insert record, same Primary Key for data structure "<structure>" already exists (<conflict_location>). Key fields: `<pk_expanded_val>`
- E052  A `<pk_structure>` message `<hl7_message>` has been sent containing a reference to a "<fk_structure>" record that has not been previously received and accepted. Key fields: `<fk_expanded>`
- E061  A `<pk_structure>` message `<hl7_message_type>` was sent to either update or delete a record that has not been previously received and accepted. Key fields: `<key_expanded>`
- E206  Open episode sent for a referral specified as not accepted (<ref_details>)

**Related items:**
Contact Identifier
Episode Identifier
Episode Start Date
Identifier Type
Local Identifier Assigning Authority
Message Date/Time
Patient/Client Identifier

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Referral Identifier</td>
<td>20010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>Referral Identifier</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>Referral Identifier</td>
<td>2007/07/01</td>
</tr>
<tr>
<td>1</td>
<td>Referral Identifier</td>
<td>2005/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Health Services
**VINAH Version**

**Definition:** A code that identifies the version of VINAH being reported in the current file.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tr>
<td>Form:</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Layout:</td>
<td>X(0-10)</td>
<td>Min.</td>
<td>Max.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

**Location:**

**Transmission protocol:**
- HL7 Submission
  - Send File
    - FILE (FHS.5)
- XML Submission
  - Send File
    - Submission/ DataCollection/ Header/VersionMajor

**Reported by:**
- Family Choice Program
- Hospital Admission Risk Program
- Hospital Based Palliative Care Consultancy Team
- Palliative Care
- Post Acute Care
- Residential In-Reach
- Specialist Clinics (Outpatients)
- Sub-acute Ambulatory Care Services
- Transition Care Program
- Victorian HIV Service
- Victorian Respiratory Support Service

**Reported for:** All file messages.

**Reported when:**

**Value domain:** Enumerated

**Reporting guide:** Reporting for 2015-16

Specialist Clinics (Outpatients) must report VINAH8 from 1 July 2012.

Programs that are not Specialist Clinics (Outpatients) should report VINAH8 from 1 July 2012, but must report VINAH8 from 1 January 2013.

Programs that are not Specialist Clinics (Outpatients) must report at least VINAH7 from 1 July 2012.

**Validations:** General edits only, see Format.

**Related items:** Message Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH processing.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>VINAH Version</td>
<td>2014/07/01</td>
</tr>
<tr>
<td>6</td>
<td>VINAH Version</td>
<td>2012/07/01</td>
</tr>
<tr>
<td>5</td>
<td>VINAH Version</td>
<td>2011/07/01</td>
</tr>
<tr>
<td>4</td>
<td>VINAH Version</td>
<td>2010/07/01</td>
</tr>
<tr>
<td>3</td>
<td>VINAH Version</td>
<td>2009/07/01</td>
</tr>
<tr>
<td>2</td>
<td>VINAH Version</td>
<td>2008/07/01</td>
</tr>
<tr>
<td>1</td>
<td>VINAH Version</td>
<td>2007/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
Part III: Processing Data Elements

File Batch Accepted Indicator

**Definition:** A boolean value indicating if the batch in its entirety was accepted.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
</table>

**Form:** Code

**Layout:** N

**Size:** Min. Max.

<table>
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<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location:**
- **Transmission protocol:** XML Validation Report
- **Submission Summary** /Submission/Acceptance/Batch/Accepted

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:** **All Programs, not elsewhere specified**
The current reporting period for this item is the calendar month in which the following events or data elements fall:
- File Processing End Date/Time (Optional)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Batch not accepted</td>
</tr>
<tr>
<td>1</td>
<td>Batch accepted</td>
</tr>
</tbody>
</table>

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This element reflects if all the messages within a batch have been accepted.

Where the value of any File Batch Message Accepted Indicator within a batch is equal to '0 – Message not Accepted', the value of this data element will always be '0 – Batch not Accepted'.

Where the value of all File Batch Message Accepted Indicators within a batch are equal to '1 – Message Accepted', the value of this data element will always be '1 – Batch Accepted'.

**Validations:** None.

**Related items:**
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Batch Accepted Indicator</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Batch Identifier**

**Definition:** A boolean value indicating if a message was accepted by VINAH. A unique value generated by the VINAH Validation Engine to uniquely identify a batch of records.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tbody>
<tr>
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<tr>
<td>Layout:</td>
<td>N(1-10)</td>
<td>Size: Min.</td>
<td>Max.</td>
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**Location:**

<table>
<thead>
<tr>
<th>Submission Summary</th>
<th>XML Validation Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>/Submission/Acceptance/Batch/</td>
<td>sub_batch_id</td>
</tr>
</tbody>
</table>

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- File Processing End Date/Time (Optional)

**Value domain:** Enumerated

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This data element differs from the Batch Control Identifier, and is used for internal reference in the VINAH Validation Engine.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Batch Identifier</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Batch Message Accepted Indicator**

**Definition:** A boolean value indicating if a message was accepted by VINAH.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
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**Form:** Code

**Layout:** N

**Size:**

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</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
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</tbody>
</table>

**Location:**
- Transmission protocol: XML Validation Report
- Submission Summary
- /Submission/Acceptance/Batch/
- Message/Accepted

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- File Processing End Date/Time (Optional)

**Value domain:** Enumerated

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Code</strong></td>
<td><strong>Descriptor</strong></td>
</tr>
<tr>
<td>0</td>
<td>Message not accepted</td>
</tr>
<tr>
<td>1</td>
<td>Message accepted</td>
</tr>
</tbody>
</table>

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

Where the value of the element File Batch Message Valid Indicator is ‘0 – The message caused one or more validation events’, the value of this element will always be ‘0 – Message Not Accepted’.

Where the value of the File Batch Message Valid Indicator is ‘1 – The message did not cause any validation events’, the value of this element may either be ‘1 – Message Accepted’ or ‘0 – Message Not Accepted’.

The value of this data element will only be ‘1 – Message Accepted’ if all messages with the same batch have a File Batch Message Valid Indicator of ‘1 – The message did not cause any validation events’.

It is possible for all messages to have a File Batch Message Valid Indicator of ‘1 – The message did not cause any validation events’ and for all messages to have a File Batch Message Accepted Indicator of ‘0 – Not Accepted’.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Batch Message Accepted Indicator</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
File Batch Message Count

**Definition:** The total number of messages contained within a batch.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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</thead>
<tbody>
<tr>
<td>Form:</td>
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<td>1</td>
</tr>
</tbody>
</table>

**Location:**
- Transmission protocol: XML Validation Report
  - Submission Summary /Submission/Acceptance/Batch/Message_Count

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- File Processing End Date/Time (Optional)

**Value domain:** Positive Integer equal to the count of messages in the batch

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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<tbody>
<tr>
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<td>File Batch Message Count</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
File Batch Message Implied Program

**Definition:** A value indicating the program under which the activity data was being reported.

**Repeats:** Min. 1 Max. 1 Duplicate Not applicable

**Form:** List

**Layout:**

<table>
<thead>
<tr>
<th>Size</th>
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<tbody>
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**Location:**

<table>
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<th>Transmission protocol:</th>
<th>XML Validation Report</th>
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<tbody>
<tr>
<td>Submission Summary</td>
<td>/Submission/Acceptance/Batch/Message/Implied_Context</td>
</tr>
</tbody>
</table>

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Processing End Date/Time (Optional)

**Value domain:** Enumerated

**List Item**

- Neutral
- FCP
- HARP
- HBPCCT
- MEDIHOTEL
- OP
- PAC
- PC
- RIR
- SACS
- TCP
- VHS
- VRSS

**Reporting guide:**

THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This data element will reflect which Program-specific validations were applied to the message. For Episode messages and messages attached to the episode such as Contacts and Referrals Out, the Program is explicitly derived from the Program/Stream Value. For records above the Episode such as Patient, the Program/Stream may be implied in order to validate required data elements.

**NEUTRAL**

This indicates that no data was collected at episode level, or the Program is not determinable.

**Validations:** None.
**Related items:**  
File Batch Accepted Indicator  
File Batch Identifier  
File Batch Message Accepted Indicator  
File Batch Message Count  
File Batch Message Sequence Number  
File Batch Message Valid Indicator  
File Batch Sequence Number  
File Processing End Date/Time  
File Processing Start Date/Time  
File Submission Date/Time  
File Validation Event Code  
File Validation Event Date/Time  
File Validation Event Identifier  
File Validation Event Message  
File Validation Event Record Identifier  
File Validation Event Record Identifier Type

**Administration**

**Purpose:**  
To enable management of VINAH transmissions.

**Principal users:**  
VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
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<tbody>
<tr>
<td>1</td>
<td>File Batch Message Implied Program</td>
<td>2010/07/01</td>
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</tbody>
</table>

**Definition source:**  
Department of Health and Human Services

**Value domain source:**  
Department of Health and Human Services
File Batch Message Sequence Number

**Definition:** A value indicating the sequence of a particular message with a batch.

<table>
<thead>
<tr>
<th><strong>Repeats</strong></th>
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<th>Max.</th>
<th>Duplicate</th>
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</thead>
<tbody>
<tr>
<td>Form:</td>
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<tr>
<td>Layout:</td>
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<td>Max.</td>
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**Location:**
- **Transmission protocol:** XML Validation Report
  - Submission Summary
    - /Submission/Acceptance/Batch/Message/msg_batch_seq_no

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:** All Programs, not elsewhere specified
- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - File Processing End Date/Time (Optional)

**Value domain:** Integer

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th><strong>Version</strong></th>
<th><strong>Previous Name</strong></th>
<th><strong>Effective Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Batch Message Sequence Number</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Batch Message Valid Indicator**

**Definition:** A boolean value indicating if a message caused any validations events to be raised

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min</th>
<th>Max</th>
<th>Duplicate</th>
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<td></td>
</tr>
<tr>
<td>Layout:</td>
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<table>
<thead>
<tr>
<th>Location:</th>
<th>Transmission protocol:</th>
<th>XML Validation Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Submission Summary</td>
<td>/Submission/Acceptance/Batch/Message/ok_br</td>
</tr>
</tbody>
</table>

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Processing End Date/Time (Optional)

**Value domain:** Enumerated

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The message caused one or more validation events</td>
</tr>
<tr>
<td>1</td>
<td>The message did not cause any validation events</td>
</tr>
</tbody>
</table>

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

Where the value of this element is ‘0 - The message caused one or more validation events’, the value of the element File Batch Message Accepted Indicator will always be ‘0 – Message Not accepted’.

The specific validation events that were caused are listed in the Validations section of the submission report.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type
Administration

Purpose: To enable management of VINAH transmissions.

Principal users: VINAH Validation Engine, VINAH Data Submitters.

Version history:  

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>1</td>
<td>File Batch Message Valid Indicator</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
File Batch Sequence Number

**Definition:** A value indicating the sequence of a particular batch within a file.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form:</td>
<td>Integer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Layout:</td>
<td>N(1-5)</td>
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<td>Min.</td>
</tr>
</tbody>
</table>

**Location:**

<table>
<thead>
<tr>
<th>Transmission protocol:</th>
<th>XML Validation Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission Summary</td>
<td>/Submission/Acceptance/Batch/batch_no</td>
</tr>
</tbody>
</table>

**Reported by:** VINAH Validation Engine

**Reported for:**
All VINAH Submissions where no validation events were raised at the File, HL7 or Batch Levels.

**Reported when:**
All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Processing End Date/Time (Optional)

**Value domain:** Integer

**Reporting guide:**
THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

**Validations:**
None.

**Related items:**
File Batch Accepted Indicator
File Batch Identifier
File Batch Message Accepted Indicator
File Batch Message Count
File Batch Message Implied Program
File Batch Message Sequence Number
File Batch Message Valid Indicator
File Processing End Date/Time
File Processing Start Date/Time
File Submission Date/Time
File Validation Event Code
File Validation Event Date/Time
File Validation Event Identifier
File Validation Event Message
File Validation Event Record Identifier
File Validation Event Record Identifier Type

**Administration**

**Purpose:**
To enable management of VINAH transmissions.

**Principal users:**
VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Batch Sequence Number</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:**
Department of Health and Human Services

**Value domain source:**
Department of Health and Human Services
File Identifier

**Definition:** An identifier generated by the VINAH Validation Engine to identify a submission file received and processed by the Department.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form: Identifier</td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
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<tr>
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<td>Max.</td>
</tr>
<tr>
<td>1</td>
<td>No limit</td>
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**Location:**
- Transmission protocol: XML Validation Report
  - Batch Summary: /Submission/Acceptance/Batch/sub_id
  - Submission Summary: /Submission/sub_id
  - Validations Summary: /Submission/Validations/sub_id
  - Validation Instance: /Submission/Validations/Validation/sub_id
  - Acceptance Summary: /Submission/Validations/Validation/sub_id

**Reported by:** VINAH Validation Engine

**Reported for:** All processed VINAH submissions.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
File Processing End Date/Time (Mandatory)

**Value domain:** Integer

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

The data element will increment by 1 for each VINAH submission processed.

**Validations:**
- X002 Submission <filename> was not successfully purged – incorrect TargetEnvironment/Filename/SubID/HealthService/UserName/PurgeKey combination.

**Related items:**
- File Name
- File Processing Directive
- File Processing Start Date/Time
- File Purge Key

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Identifier</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
File Name

Definition: The name of the submission file, as accorded by the system that generated the submission file.

Repeats: Min.  Max.  Duplicate

Form: Structured Text  1  1  Not applicable

Location: Transmission protocol: XML Validation Report

Size: Min.  Max.

Location: Submission Summary

Size: Min.  Max.

Location: /Submission/Filename

Value domain: String

Reporting guide: THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

The file name is defined and tested by the defined regular expression.

The file extension must be .hl7 for an HL7 file.

The file extension must be .xml for an XML file.

The file extension must be .zip for Flat Files.

A valid Organisation Identifier must be the first characters in the file name.

The Organisation Identifier must exist in the code table HL70362.

The file name must be unique in time. File names may only be re-used if the original file was not acknowledged by the HealthCollect Portal.

Example:

hs_20100601_01.hl7

In the example, the Organisation Identifier is the first two characters (‘hs’) and the date of submission (01 June 2009) has been used along with a sequence number (‘01’) to provide a unique file name. The structure of the filename should reflect the time of generation of the file and should not attempt to reflect a time period of the data contained within. It is acceptable to include in the filename other metadata such as the system or application that generated the file, to avoid the possibility that two different systems at the same health service produce the same filename. It is important that the system that generates the VINAH submission file also generates the filename. Users should be instructed not to alter the filename unless advised otherwise.

File names must be unique for each submission across the life of the data collection. A file name must never be reused if it has been received by the VINAH system. This holds even if the file is empty, corrupt, contains numerous errors and is subsequently resubmitted.

Regular Expression

The content of this data element is validated against the following regular expression.

[0-9_a-zA-Z]{1,30}[.]([hl7]xml|zip)
Validations:

X001 Submission <filename> was successfully purged from the VINAH System
X002 Submission <filename> was not successfully purged – incorrect TargetEnvironment/Filename/SubID/HealthService/UserName/PurgeKey combination
X003 Submission <filename> has already been purged after the initial load, due to the PurgeAfterLoad=True instruction on the original submission
X004 Submission <filename> could not be purged as it is not the last file submitted for this health service. Only the last existing file for a health service can be purged.

Related items:
- File Identifier
- File Processing Directive
- File Purge Key
- File Purged After Processing Indicator

Administration

Purpose: To enable management of VINAH transmissions.
Principal users: VINAH Validation Engine, VINAH Data Submitters.

Version history:

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Name</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services
### File Processing End Date/Time

**Definition:** The date and time that the VINAH Validation Engine completed processing the file.

<table>
<thead>
<tr>
<th>Repeat</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
</table>

**Form:** Date and Time

**Layout:** YYYYMMDD[hhmmss]

**Location:**
- Transmission protocol: XML Validation Report
  - Submission Summary /Submission/process_end_date

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submission.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Processing End Date/Time (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type

### Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Processing End Date/Time</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Processing Start Date/Time**

**Definition:** The date and time that the VINAH Validation Engine commenced processing the file.

**Repeats:** Min. Max. Duplicate

**Form:** Date and Time

**Layout:** [YYYY] [MM] [DD]T HH:NN

**Size:** Min. Max.

**Location:** Transmission protocol: XML Validation Report

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submission.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Processing Start Date/Time (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Processing Start Date/Time</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
File Purge Key

**Definition:** A Universally Unique Identifier (UUID) that acts as a key which can be used at a later date to authorise the purge of Submission File from the VINAH Repository.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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</thead>
<tbody>
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</tr>
<tr>
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<td><strong>Size:</strong></td>
<td>Min.</td>
</tr>
</tbody>
</table>

**Location:**
- Transmission protocol: XML Validation Report
  - Submission Summary
  - /Submission/purge_key

**Reported by:** All VINAH transmissions

**Reported for:** All VINAH submissions.

**Reported when:** All Programs, not elsewhere specified
- The current reporting period for this item is the calendar month in which the following events or data elements fall:
  - File Processing Start Date/Time (Mandatory)

**Value domain:** Valid UUID - Refer ISO 11578:1996

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.
- See Section 5.

**Validations:**
- X002 Submission <filename> was not successfully purged – incorrect TargetEnvironment/Filename/SubID/HealthService/UserName/PurgeKey combination

**Related items:**
- File Identifier
- File Name
- File Processing Directive
- File Processing End Date/Time

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Purge Key</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
File Purged After Processing Indicator

**Definition:** Indicates if the submission was purged immediately after processing had completed as a result of the File Processing Directive ‘PurgeAfterLoad=True’ being present in the File Header Segment.

**Repeats:** | Min. | Max. | Duplicate |
--- | --- | --- | --- |
**Form:** | Code | 1 | 1 | Not applicable |
**Layout:** | N | Size: | Min. | Max. |

**Location:**
- Transmission protocol: XML Validation Report
  - Submission Summary /Submission/purged_after_load
  - Submission Summary /Submission/Validations/Validation /val_event_id

**Reported by:** All VINAH transmissions

**Reported for:** All VINAH submissions.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

- File Processing Start Date/Time (Mandatory)

**Value domain:** Enumerated.

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This element can be used to determine if the File Processing Directive to Purge the file after the completion of processing was carried out successfully.

**Validations:** X003 Submission <filename> has already been purged after the initial load, due to the PurgeAfterLoad=True instruction on the original submission

**Related items:** File Name
- File Processing Directive
- File Processing End Date/Time
- File Validation Event Identifier

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Purged After Processing Indicator</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Submission Date/Time**

**Definition:** The date and time that the submission was first received by a relevant acquisition method at the department (i.e. the HealthCollect Portal).

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Form:** Date and Time

**Layout:** [YYYY] [MM] [DD]T[HH]:[NN]:

**Size:**

<table>
<thead>
<tr>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
</table>

**Location:** Transmission protocol: XML Validation Report

Submission Summary /Submission/submission_date

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submissions.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Submission Date/Time (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type

### Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Submission Date/Time</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Validation Event Code**

**Definition:** The Validation Code of a specific instance of a validation event occurring on a message.

<table>
<thead>
<tr>
<th><strong>Repeats</strong></th>
<th><strong>Min.</strong></th>
<th><strong>Max.</strong></th>
<th><strong>Duplicate</strong></th>
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<tbody>
<tr>
<td><strong>Form:</strong></td>
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<tr>
<td><strong>Layout:</strong></td>
<td>ANN</td>
<td>Min.</td>
<td>Max.</td>
</tr>
</tbody>
</table>

**Location:**
- **Transmission protocol:** XML Validation Report
  - Submission Summary
  - /Submission/Validations/Validation/edit_code

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submissions where a validation event is generated.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- File Validation Event Date/Time (Mandatory)

**Value domain:** See Section 8 – Validations for list of Validation Codes

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This element can be used in conjunction with the Submission Validation Event Message to analyse the type of data quality problem identified by the VINAH Validation Engine.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th><strong>Version</strong></th>
<th><strong>Previous Name</strong></th>
<th><strong>Effective Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Validation Event Code</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Validation Event Date/Time**

**Definition:** The date and time when the validation event occurred.

**Repeats:** Min. 1  Max. 1  Duplicate Not applicable

**Form:** Date and Time

**Layout:** [YYYY] [MM] [DD]T[HH]:[NN]:

**Size:** Min.  Size  Max.  Size

**Location:** Transmission protocol: XML Validation Report
Submission Summary /Submission/Validations/Validation/ identifier_type

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH Submissions where a validation event is generated with relation to a data structure.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Validation Event Date/Time (Mandatory)

**Value domain:** Valid date.

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.
This element represents the exact date/time that the VINAH Validation Engine detected and raised the validation event.

**Validations:** None.

**Related items:** File Batch Accepted Indicator
File Batch Identifier
File Batch Message Accepted Indicator
File Batch Message Count
File Batch Message Implied Program
File Batch Message Sequence Number
File Batch Message Valid Indicator
File Batch Sequence Number
File Processing End Date/Time
File Processing Start Date/Time
File Submission Date/Time
File Validation Event Code
File Validation Event Date/Time
File Validation Event Identifier
File Validation Event Message
File Validation Event Record Identifier
File Validation Event Record Identifier Type

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Validation Event Date/Time</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Validation Event Identifier**

**Definition:** A value generated by the VINAH Validation Engine to identify a specific instance of a validation event occurring on a message.

<table>
<thead>
<tr>
<th>Repeats</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
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<tr>
<td>Form:</td>
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<td>Layout:</td>
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<td>Size: Min.</td>
<td>Max.</td>
</tr>
</tbody>
</table>

**Location:** Transmission protocol: XML Validation Report

Submission Summary /Submission/Validations/Validation /val_event_id

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submissions where a validation event is generated.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Validation Event Date/Time (Mandatory)

**Value domain:** Positive Integer

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This element can be used as a reference for specific instance of a validation event occurring on a message.

**Validations:** None.

**Related items:** File Batch Accepted Indicator

File Batch Identifier

File Batch Message Accepted Indicator

File Batch Message Count

File Batch Message Implied Program

File Batch Message Sequence Number

File Batch Message Valid Indicator

File Batch Sequence Number

File Processing End Date/Time

File Processing Start Date/Time

File Purged After Processing Indicator

File Submission Date/Time

File Validation Event Code

File Validation Event Date/Time

File Validation Event Message

File Validation Event Record Identifier

File Validation Event Record Identifier Type

**Administration**

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
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<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Validation Event Identifier</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Validation Event Message**

**Definition:** The Validation Message a specific instance of a validation event occurring on a message.

**Repeats:**

<table>
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<th>Duplicate</th>
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<td>1</td>
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**Form:** Text

**Layout:** ANNN

**Size:** Min. Max.

**Location:**

- **Transmission protocol:** Submission Summary /Submission/Validations/Validation/edit_text
- **XML Validation Report**

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submissions where a validation event is generated.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

- File Validation Event Date/Time (Mandatory)

**Value domain:** See Section 8 – Validations for list of Validation Messages.

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This element can be used in conjunction with the File Validation Event Code to analyse the type of data quality problem identified by the VINAH Validation Engine.

The value of this data element will be based on the message templates outlined for each validation in Section 8. Any parameters embedded in the template (values surrounded by inequality signs (< >) will be substituted with values specific to the instance of the validation event. Note that the inequality signs will also be replaced when the template substitution occurs.

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Record Identifier
- File Validation Event Record Identifier Type
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
<thead>
<tr>
<th>Version</th>
<th>Previous Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Validation Event Message</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
**File Validation Event Record Identifier**

**Definition:** A value that identifies the primary key of the data record upon which the validation event was applied.

<table>
<thead>
<tr>
<th>Repeats:</th>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form:</td>
<td>Identifier</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Not applicable</td>
</tr>
<tr>
<td>Layout:</td>
<td>X(1-50)</td>
<td>Size:</td>
<td>Min.</td>
</tr>
</tbody>
</table>

**Location:**
- Transmission protocol: Submission Summary /Submission/Validations/Validation /identifier
- XML Validation Report

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submissions where a validation event is generated with relation to a data structure.

**Reported when:** All Programs, not elsewhere specified
The current reporting period for this item is the calendar month in which the following events or data elements fall:
- File Validation Event Date/Time (Optional)

**Value domain:** Any value as submitted by the Organisation, with relation to the File Validation Event Record Identifier Type.

**Reporting guide:** THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This element can be used in conjunction with the File Validation Event Record Identifier Type to identify the data record upon which the validation event was applied.

**Example:**
- File Validation Event Record Identifier = 03441
- File Validation Event Record Identifier Type = Episode Identifier

**Validations:** None.

**Related items:**
- File Batch Accepted Indicator
- File Batch Identifier
- File Batch Message Accepted Indicator
- File Batch Message Count
- File Batch Message Implied Program
- File Batch Message Sequence Number
- File Batch Message Valid Indicator
- File Batch Sequence Number
- File Processing End Date/Time
- File Processing Start Date/Time
- File Submission Date/Time
- File Validation Event Code
- File Validation Event Date/Time
- File Validation Event Identifier
- File Validation Event Message
- File Validation Event Record Identifier Type
Administration

**Purpose:** To enable management of VINAH transmissions.

**Principal users:** VINAH Validation Engine, VINAH Data Submitters.

**Version history:**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>File Validation Event Record Identifier</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

**Definition source:** Department of Health and Human Services

**Value domain source:** Department of Health and Human Services
File Validation Event Record Identifier Type

**Definition:** The type of record upon which the validation event was applied.

**Repeats:**

<table>
<thead>
<tr>
<th>Min.</th>
<th>Max.</th>
<th>Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Form:** List

**Layout:** X(1-50)

**Location:**

**Transmission protocol:** XML Validation Report

Submission Summary /Submission/Validations/Validation/identifier_type

**Reported by:** VINAH Validation Engine

**Reported for:** All VINAH submissions where a validation event is generated with relation to a data structure.

**Reported when:** All Programs, not elsewhere specified

The current reporting period for this item is the calendar month in which the following events or data elements fall:

File Validation Event Date/Time (Optional)

**Value domain:**

Enumerated

Table identifier: VVE0001

**List Item**

Batch Control Identifier
Contact/Client Service Event Identifier
Episode Identifier
Inbound Referral Identifier
Message Control Identifier
NULL
Patient Identifier
Referral Out Identifier

**Reporting guide:**

THIS DATA ELEMENT IS NOT REPORTED BY HEALTH SERVICES. IT DEFINES CONTENT IN THE VALIDATION REPORT RETURNED BY VINAH.

This element can be used in conjunction with the File Validation Event Record Identifier to identify the data record upon which the validation event was applied.

Example:

File Validation Event Record Identifier = 03441
File Validation Event Record Identifier Type = Episode Identifier

**Validations:** None.

**Related items:**

File Batch Accepted Indicator
File Batch Identifier
File Batch Message Accepted Indicator
File Batch Message Count
File Batch Message Implied Program
File Batch Message Sequence Number
File Batch Message Valid Indicator
File Batch Sequence Number
File Processing End Date/Time
File Processing Start Date/Time
Administration

Purpose: To enable management of VINAH transmissions.

Principal users: VINAH Validation Engine, VINAH Data Submitters.

Version history:

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<tbody>
<tr>
<td>1</td>
<td>File Validation Event Record Identifier Type</td>
<td>2010/07/01</td>
</tr>
</tbody>
</table>

Definition source: Department of Health and Human Services

Value domain source: Department of Health and Human Services