Specifications for revisions to the Victorian Admitted Episodes Dataset (VAED) for 1 July 2016

December 2015

VICTORIA State Government | Health and Human Services

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Available at www.health.vic.gov.au/hdss

Contents

Executive Summary

The revisions for the VAED for 1 July 2016 are summarised below:

Amendments to existing data items and associated validations

- Amendment to Advance Care Plan Alert to make reporting conditional mandatory
- Amendment to Procedure Start Date Time to make reporting of time mandatory for emergency admissions to VEMD reporting campuses
- Removal of Funding Arrangement code 5 Rural Patients Initiative
- Removal of Program Identifier code 06 Competitive Elective Surgery Funding Initiative (CESFI)
- Removal of A prefix from Diagnosis Codes

Amendments to validations

- 390 Incompatible Care Type, Carer Availability and Separation Mode – effect changed from warning to rejection
- 709 NHT Account Class / Care Type mismatch amended

Introduction

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

Comments provided by the health sector in response to *Proposals for revisions to the Victorian Admitted Episodes Dataset (VAED) for 1 July 2016* have been considered, and where possible, suggestions have been accommodated, resulting in changes to or withdrawal of some proposals.

The revisions set out in this document are complete as at the date of publication. Where further changes are required during the year, for example to reference files such as the ICD-10-AM/ACHI library file, postcode locality file, data validation rules or supporting documentation, these will be advised via the HDSS Bulletin.

An updated VAED manual will be published in due course. Until then, the current VAED manual and subsequent HDSS Bulletins, together with this document, form the data submission specifications for 2016-17.

Victorian health services must ensure their software can create a submission file in accordance with the revised specifications, and ensure reporting capability is achieved in order to maintain compliance with reporting timeframes set out in the relevant *Department of Health and Human Services policy and funding guidelines* or the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013.*

Orientation to this document

- New data items are marked as (new).
- Changes to existing data items are highlighted in green.
- Redundant values and definitions relating to existing items are ~~struck through~~.
- Comments relating only to the proposal document appear in *[square brackets and italics].*
- Validations that are proposed to change are marked * when listed as part of a data item or below a validation table.
- Changes are shown under the appropriate manual section headings.

Outcome of proposals

Proposal 1 – Addition of Preferred Death Place

The proposal does not proceed. Department to liaise with health services supportive of proposal to request data for modelling and proof of concept to derive performance indication, and also explore possibility of linking with deaths data.

Proposal 2 – Amendment to reporting guide for RUG ADL

The proposal does not proceed.

Proposal 3 – Amendment to Advance Care Plan Alert to make reporting mandatory.

The proposal proceeds but has been amended for patients aged 16 and above only.

Proposal 4 – Amendment to Procedure Start Date Time to make reporting of time mandatory

The proposal proceeds for emergency admissions at VEMD reporting hospitals only.

Proposal 5 – Amendment to Duration of Non-invasive Ventilation (NIV) in ICU to make reporting mandatory

Proposal withdrawn.

Proposal 6 – Removal of Funding Arrangement code 5 Rural Patients Initiative

The proposal proceeds.

Proposal 7 – Removal of Program Identifier code 06 Completive Elective Surgery Funding Initiative (CESFI)

The proposal proceeds.

Proposal 8 – Removal of A prefix from Diagnosis Codes

The proposal proceeds.

Proposal 9 – Amendment to validation 390 Incompatible Care Type, Carer Availability and Separation Mode

The proposal proceeds.

Proposal 10 – Amendment to validation 709 NHT Account Class / Care Type mismatch

The proposal proceeds.

End of financial year reporting

As shown in the table below:

- Submissions with header dates prior to 1 July 2016 must use 2015-16 format/values for all records
- For submissions with header dates of 1 July onwards, the Separation Date of the episode determines the format/values applicable
  - Separation Date prior to 1 July 2016 must use 2015-16 format/values
  - Separation Date 1 July 2016 or later must use 2016-17 format/values
  - For patients 'remaining in' on 30 June 2016 this may involve updating episode data previously reported in a June submission from 2015-16 format/values to 2016-17 format/values

June submission	Admission Date	Separation Date	Unique Key	Format/Values	Possible format/values
1-30/06/2016	01/06/2016	30/06/2016	000055555	2015-16	2015-16 format – for all records
	20/06/2016	00/00/0000	000066666	2015-16	
July submission					**Separation Date determines format/values**
1-31/07/2016	25/06/2016	30/06/2016	000077777	2015-16	2015-16 format for separations prior to 1 July 2016
	20/06/2016	01/07/2016	000066666	2016-17	2016-17 format for separations from 1 July 2016
	01/07/2016	10/07/2016	000088888	2016-17	
	02/07/2016	00/00/0000	000033333	2016-16	

Test submissions for 1 July changes

Information regarding testing for 1 July changes will be published at a later date in the HDSS Bulletin.

Contact the HDSS help desk at hdss.helpdesk@dhhs.vic.gov.au to add your name to the Bulletin mailing list.

Specifications for changes from 1 July 2016

Revision 1 – Amendment to Advance Care Plan to make reporting conditional mandatory

Section 3

Advance Care Plan Alert (amended)

Specification

Definition	An alert, flag or similar present in the medical record or patient management system that indicates an advance care plan and/or substitute decision maker has been recorded.
Field size	1 **Layout** N
Location	Extra Episode Record
Reported by	Public hospitals ~~optional~~ **~~Note:~~** ~~This item may become mandatory in 2016-17~~
Reported for	Admitted episodes of care where the patient's age at admission is greater than or equal to 16 years. Optional for less than 16 years.
Reported when	A Separation Date is reported in the Episode Record
Code set	1 No advance care plan alert 2 Presence of an advance care plan alert 3 Presence of a substitute decision maker alert 4 Presence of both an advance care plan alert and a substitute decision maker alert
Reporting guide	An advance care plan alert will be identified by an alert identifying any of the following: • A completed Refusal of Treatment Certificate • A formally documented advance care plan • Other advance care planning documentation (documentation of a person's future wishes such as a written letter or advance care planning discussion record) * A resuscitation plan, limitation of treatment order or goals of patient care form alone do not meet the requirements for this data item. A substitute decision maker alert will be identified by an alert, flag or similar identifying any of the following: • Enduring power of attorney (medical treatment) • Enduring Power of Guardianship which includes consent to health care. • Guardian appointed by VCAT with powers to consent to health care

- Nomination in writing of a person responsible
- Identification of the 'person responsible' as per the 'person responsible hierarchy'

Advance care planning: have the conversation: A strategy for Victorian health services 2014-2018 (the Strategy) www.health.vic.gov.au/acp

Validations 707 Invalid Advance Care Plan Alert

Administration

Purpose To provide data on advance care planning that will quantify activity and enable benchmarking across the service system.

Principal data users Department of Health & Human Services

Collection start 2015

Definition source DHHS **Value Domain Source** DHHS

Extra Episode Record (amended)

Refer to Section 3 for code sets for data items. When not required to report a data item, report spaces.

Extra Episode Record File Structure

Note	Data Item	Field Size	Record Position	Layout
M	Transaction Type	2	1	J5
M	Unique Key	9	3	AAAAAAAAA (Hospital-generated) Right justified, zero filled
~~1~~ 2	Advance Care Plan Alert	1	12	N or space
1	Clinical Group	12	13	Characters or spaces
Total			**24**	

M Mandatory

1 Optional ~~in 2015-16~~

2 Mandatory if patient age greater than or equal to 16

Section 8 Validation

707 Invalid Advance Care Plan Alert (amended)

Effect REJECTION

Problem The public hospital E5 Episode Record has a Separation Date and either:

- the patient age is greater than or equal to 16 but the J5 Extra Episode Record's Advance Care Plan Alert is blank or invalid OR
- the patient age is less than 16 but the J5 Extra Episode Record's Advance Care Plan Alert is invalid

Remedy Check Date of Birth, Separation Date and Advance Care Plan Alert, amend as appropriate and re-submit the E5 and J5 as required.

Advance Care Plan Alert is optional if patient's age at admission is less than 16.

Revision 2 - Amendment to Procedure Start Date Time to make reporting of time mandatory for emergency admissions to VEMD reporting campuses

Section 3

Procedure Start Date Time (amended)

Specification

Definition	Date and Time at which a procedure commenced for an admitted patient.		
Field size	12	**Layout**	DDMMYYYYHHMM or spaces
Location	Diagnosis Record		
Reported by	All Victorian hospitals (public and private).		
Reported for	All admitted episodes of care where a procedure occurring in an operating room or a cardiac catheter laboratory or involving a scope is recorded as the first coded procedure. Time of procedure is required if: • Campus reports to VEMD and • Admission Type is C or O (emergency admissions) For all other episodes time of procedure is optional and may be reported as spaces, eg '01082015 ' ~~(Note: Time of procedure is optional and may be reported as spaces, e.g. '01082015').~~		
Reported when	The Diagnosis Record is reported.		
Code set	Valid date time.		
Reporting guide	Procedure Start Date time should be reported for an episode where the first coded procedure is one identified in the ICD-10-AM/ACHI Library file for the current year as requiring the procedure start date time: [On Library file: column Coding practices, code 4] The Library file is available from HDSS help desk • The procedure is deemed to have commenced when: • The first incision is made for a surgical procedure. • The instrument is inserted for procedures in a cardiac catheter laboratory or those involving the use of a scope. ~~If the time of commencement is not available report DDMMYYYY and four spaces.~~ If this data element is not applicable to the episode, report all spaces in		

this field.

Validations	655	Invalid Procedure Start DateTime*
	656	Proc Start DateTime < Adm Date or > Sep Date
	657	Proc Start DateTime and Valid Proc Mismatch

Related items Section 3 Procedure codes

Administration

Purpose To enable analysis of wait times for surgical and significant procedures.

Principal data users Department of Health and Human Services

Collection start 2009-10

Definition source DHHS

Section 8 Validation

655 Invalid Procedure Start DateTime (amended)

Effect REJECTION (X5)

Problem The first reported procedure code in this X5 Diagnosis Record is one which requires reporting of the Procedure Start DateTime in the X5 Diagnosis Record. However, the content of the Procedure Start DateTime field in this X5 Diagnosis Record is invalid. Refer to Section 3 of this manual for the correct ~~PRS/2~~ format.

Remedy Check the patient record for the date and time the first reported procedure started and check format as below.

If campus reports to VEMD and Admission Type is C or O (emergency admissions) format must be DDMMYYYYHHMM

For all other episodes time of procedure is optional and may be reported as spaces eg ‘DDMMYYYY ‘

~~and ensure the date, at least, is entered in the field within the hospital information system that is the source for the Procedure Start DateTime field in the X5 Diagnosis Record. Also check the format being used to report this detail to PRS/2~~.

When the details have been corrected, resubmit the X5 Diagnosis Record.

Revision 3 – Removal of Funding Arrangement code 5 Rural Patients Initiative

Section 3 Data definitions

Funding Arrangement (amended)

Specification

Definition Identifies the specific funding arrangement, if any, which applies to this episode of care.

Field size 1 **Layout** N or space

Location Episode Record

Reported by

- Any Victorian public and private hospital involved in contracted care arrangements with another hospital (purchasers and providers of contracted care).
- Any Victorian public and private hospital involved in hub and spoke arrangements with another hospital or satellite site.
- Any Victorian public or private hospital treating a patient identified as a Coordinated Care Trial patient.
- ~~Any Victorian public hospital involved in the Rural Patients Initiative program~~.
- Any Victorian public hospital involved in the Elective Surgery Access Service program (ESAS).
- Any Victorian private hospital involved in the Public/Private Elective Surgery Initiative (PHESI).
- Any Victorian public or private hospital involved in the National Bowel Cancer Screening Program
- Any Victorian public hospital involved in the Healthlinks program

All other circumstances, report a space in this field.

Reported for Episodes where an admitted service is provided under contract, hub and spoke, Coordinated Care Trial arrangements, ~~Rural Patients Initiative~~, Elective Surgery Access Service (ESAS) or Private Hospital Elective Surgery Initiative or Healthlinks program

Otherwise, report a space in this field.

Reported when The Episode Record is reported

Code set

Code	Descriptor
1	Contract
2	Hub and spoke
4	Coordinated Care Trial
~~5~~	~~Rural Patients Initiative~~
6	Elective Surgery Access Service
7	Private Hospital Elective Surgery Initiative

8 National Bowel Cancer Screening Program

9 Healthlinks program

Reporting guide

1 Contract

Patient receiving contracted hospital care under an agreement between a purchaser of hospital care (contractor) and a provider of an admitted or non-admitted service (contracted hospital).

2 Hub and Spoke

Patient receiving a specialist service at another hospital or satellite site (spoke) under a hub and spoke arrangement. This hospital is the hub hospital. (Any service provided at a spoke hospital or satellite site is reported by the hub hospital only.)

4 Coordinated Care Trial

Patient identified as a Coordinated Care Trial patient.

~~**5 Rural Patients Initiative**~~

~~Admission under the Rural Patients Initiative. Use code 5 only if the public hospital has been allocated resources through the Rural Patients Initiative.~~

~~Private hospitals: Do not use code 5.~~

6 Elective Surgery Access Service (ESAS)

Admission under the Elective Surgery Access Service (ESAS). Use code 6 only if the public hospital has been allocated resources through the Elective Surgery Access Service.

Private hospitals: Do not use code 6.

7 Private Hospital Elective Surgery Initiative

Admission under the Public/Private Elective Surgery Initiative. Use code 7 only if approved by DH.

Public hospitals: Do not use code 7.

8 National Bowel Cancer Screening Program

Admission under the National Bowel Cancer Screening Program.

Use code 8 only if a designated provider.

9 Healthlinks Program

Admission under the Healthlinks program

Validations

410 Illegal Comb Fund Arrang & Contract

416 Invalid Fund Arrangement

423 Invalid Comb Funding/Contract/Transfer

456 Contract Leave, No Contract

477 Funding Arrangement 5, not approved for Rural Patients Initiative

478 Funding Arrangement 6, not approved for ESAS

491 Incompat Fields for ESAS

~~492 Incompat Fields for RPI~~

626 Invalid combination for Funding Arrangement PHESI

635 NBCSP but Age < 50 Years

638 Private Hosp, Public Account Without Contract

Related items	Section 2: Contracted Care and Hub and Spoke. Section 3: Contract Role and Contract Type Section 4: Business Rules (non-tabular) Contracted Care and Hub and Spoke. Business Rules (tabular) Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement and Contract Fields, and Contracting: Funding Arrangement, Contract Type and Contract Role with Admission Source and Separation Mode, and Funding Arrangement: Elective Surgery Access Service, ~~Funding Arrangement: Rural Patients Initiative~~ and Funding Arrangement: Private Hospital Elective Surgery Initiative.

Administration

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

Section 4 Business rules

~~Funding Arrangement: Rural Patients Initiative~~ (table removed)

Funding Arrangement and Contract fields (amended)

Below are the valid reporting combinations for Funding Arrangement and Contract fields. Validations ~~s~~ 456 is ~~are~~ applied when Separation Date is present.

Funding Arrangement	Contract Type	Contract Role	Contract / Spoke Identifier	Contract Leave Days MTD	Contract Leave Days YTD	Contract Leave Days TOT
Contracted Care						
1 Contract	1	B	Contract / Spoke Identifier of external purchaser/program	Spaces	Spaces	Spaces
	2, 3, 5	A	Campus code of B	Value or spaces*	Value or spaces*	Value or spaces*
		B	Campus code of A	Spaces	Spaces	Spaces
	4	A	Campus code of B	Spaces	Spaces	Spaces
		B	Campus code of A	Spaces	Spaces	Spaces
	6	A	Campus code of B	Spaces	Spaces	Spaces
Hub and Spoke						
2 Hub and spoke	Space	Space	Campus code or Contract/Spoke Identifier of Spoke hospital/site	Spaces	Spaces	Spaces
Other funding						
4 Coordinated Care Trial	Space	Space	Spaces	Spaces	Spaces	Spaces
~~5 Rural Patient Initiative~~	~~Space~~	~~Space~~	~~Spaces~~	~~Spaces~~	~~Spaces~~	~~Spaces~~
6 Elective Surgery Access Service	Space	Space	Spaces	Spaces	Spaces	Spaces
7 Private Hospital Elective Surgery Initiative	Space	Space	Spaces	Spaces	Spaces	Spaces
8 National Bowel Cancer Screening Program	Space	Space	Spaces	Spaces	Spaces	Spaces
9 Healthlinks Program	Space	Space	Spaces	Spaces	Spaces	Spaces

* Can be spaces: if contract leave is same day, no Leave Day is counted.

Validation	410	Illegal Comb Fund Arrange & Contract*
	456	Contract Leave, No Contract

Section 8 Validation

410 Illegal comb Fund Arrange & Contract (amended)

Effect REJECTION

Problem The E5 Episode Record has invalid combination of Funding Arrangement and the fields describing Contract arrangements. ~~This validation is not applied until a Separation Date is present.~~

Remedy Check Funding Arrangement and the various Contract fields; amend as appropriate and re-submit the E5.

Refer to: Section 4: Business Rules (tabular) Contracting: Contract Fields, Contract Leave and Funding Arrangement, and Contracting: Funding Arrangement and Contract Fields.

416 Invalid Fund Arrangement (change to function only)

~~492 Incompat Fields for RPI~~ (removed)

Revision 4 – Removal of Program Identifier code 06 Competitive Elective Surgery Funding Initiative (CESFI)

Section 3 Data definitions

Program Identifier (amended)

Specification

Definition Identifies the specified program, if any, which applies to this episode of care.

Field size 2 Layout NN or space

Location Episode Record

Reported by Public and Private Hospitals

Reported for Episodes for patients admitted under a specified DHHS program.
Otherwise, report a space in this field.

Reported when An Episode Record is transmitted.

Code set

Code	Descriptor
05	Home Birthing Program
~~06~~	~~Competitive Elective Surgery Funding Initiative (CESFI)~~
07	Program Identifier A
08	Program Identifier B
09	Specialist ABI Rehabilitation Service

Reporting guide Report the corresponding code for the program when advised to do so by the Department of Health unit responsible for administration of the program.

05 Home Birthing Program

Patient identified as a Home Birthing Program patient as approved by DH. Use code 05 for both mother and baby episodes.

~~**06 Competitive Elective Surgery Funding Initiative (CESFI)**~~

~~Patient identified as a CESFI patient, as approved by DH. Use code 06 only with Care Type 4.~~

09 Specialist ABI Rehabilitation Service

Patient admitted to centre providing statewide specialist Acquired Brain Injury (ABI) rehabilitation for Victorians with severe/catastrophic ABI.

Validations

648	Invalid Program Identifier*
649	Program Identifier Care Type Mismatch*
651	Program Identifier, campus not approved for program

Administration

Purpose	To: Identify whether a specified program applies to this episode. Facilitate health services planning and monitoring.		
Principal data users	Multiple internal and external data users.		
Collection start	2009-10		
Definition source	DHHS	**Code set source**	DHHS

Section 8 Validation

648 Invalid Program Identifier (change in function only)

Effect REJECTION (E5)

Problem The E5 Episode Record has a Program Identifier which is:

- Invalid, OR
- Has an end-date before the episode Admission Date (that is, was not valid at the time the patient was admitted), OR
- Has start-date after the episode Admission Date (that is, was not valid at the time the patient was admitted).

Remedy Check the E5 Episode Record Program Identifier and Admission Date.

649 Program Identifier Care Type mismatch (change in function only)

Effect REJECTION

Problem The E5 Episode Record has an invalid combination of Care Type and Program Identifier.

Remedy Check Care Type and Program Identifier, amend as appropriate and re-submit the E5.

651 Program Identifier, campus not approved for program (change in function only)

Effect REJECTION

Problem The E5 Episode Record has a Program Identifier, but the Hospital campus is not approved for this program.

Remedy Check Program Identifier, amend as appropriate and re-submit the E5. If you believe the hospital campus is approved to report this Program Identifier, contact the HDSS Help Desk.

Revision 5 – Removal of A prefix from Diagnosis Codes

Section 3 Data definitions

Diagnosis Codes (amended)

Specification

Definition	At least one (principal diagnosis) and up to 40 ICD-10-AM codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care.		
Field size	8 (x 40)	**Layout**	AANNNNspacespace Left justify, with trailing spaces.
Location	Diagnosis Record (12) Extra Diagnosis Record (28)		
Reported by	All Victorian hospitals (public and private)		
Reported for	All admitted episodes of care.		
Reported when	A Separation Date is reported in the Episode Record.		
Code set	DHHS ICD-10-AM Library File is available on application to the HDSS help desk.		
Reporting guide	Report diagnoses in accordance with *Australian Coding Standards* and the *Victorian Additions to Australian Coding Standards*. The Victorian Additions to Australian Coding Standards are available at: http://www.health.vic.gov.au/hdss/healthclassifications/vic-additions-acs.htm Omit punctuation as shown in ICD-10-AM books (that is, no dot or oblique in codes): for example, ICD-10-AM diagnosis code A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae must be entered as A000. When a code is shown in ICD-10-AM with a symbol (dagger or asterisk), omit the symbol when transmitting to PRS/2. The first character of the field is the prefix: P, **A**, C or M (see below for more information). In the first diagnosis code field: • Character 1 must be P (except for neonate in birth episode where it may be C). • Next five characters must contain an alpha/numeric code of three, four or five characters (with trailing spaces if required). • Characters 7 and 8 must be spaces. For the remaining thirty nine diagnosis code fields, *if* a code is present: Character 1 must be P, **A**, C or M. • Next six characters must contain an alpha/numeric code of three, four, five or six characters (with trailing spaces if required). • Character 8 must be a space.		

Morphology codes (where first character is M)
Submit without punctuation (oblique) and with M prefix: for example MM80703

Prefixes: Definitions for P, ~~A~~, C, M
All diagnosis codes require a prefix. Prefixes indicate whether the condition was present on, or arose during admission, and also denote morphology codes. ~~DH~~ The department will map prefixes to the NHDD Condition Onset Flag in order to report to the Commonwealth.
Refer to the *Victorian Additions to the Australian Coding Standards*

~~**Effect of prefix A**~~
~~A secondary function of the A prefix is to suppress the code description appearing in data extracts provided to TAC and on DRG statements generated by PRS/2 for Work Cover Patients.~~

Section 8 Validation

~~564 Prefix = A, unusual code combination~~ (removed)

Revision 6 – Amendment to validation 390 Incompatible Care Type, Carer Availability and Separation Mode

Section 8 Validation

390 Incompat Care Type, Carer Avail and Sep Mode (amended)

Effect	~~Warning~~ REJECTION
Problem	The Public Hospital E5 Episode Record has an invalid combination of Care Type, Carer Availability and Separation Mode. The Care Type is 1, P, 6, 8, 9 or MC and either: • Separation Mode is H and there is no Carer Availability, or • Separation Mode is not H and there is a Carer Availability
Remedy	Check Care Type, Carer Availability and Separation Mode, amend as appropriate and re-submit the E5.

~~421 Not separated: Carer Avail present~~ (removed)

Revision 7 – Amendment to validation 709 NHT Account Class / Care Type mismatch

Section 8 Validation

709 NHT Account Class / Care Type mismatch (amended)

Effect REJECTION

Problem Either this Episode Record's

- Account Class is MN, M5, PS, PT, PU, PV, VN, V5, WN, TN, AN, SN, CN, ON, JN or XN indicating nursing home type or compensable non-acute patient but Care Type is not 1 NHT/Non-Acute or 5T OR
- Care Type is 1 NHT/Non-Acute or 5T and Account Class is not MN, M5, PS, PT, PU, PV, VN, V5, WN, TN, AN, SN, CN, ON, JN or XN

Remedy Check Account Class and Care Type amend as appropriate and re-submit the E5.

~~445 Dt of Accid incompat w TAC Claim Nbr~~ (removed)

Duplicate to 446 Dt of Accid incompat w TAC Claim Nbr

Updated Medicare Eligibility Status

The following concepts were reviewed and updates will be included in the next edition of the VAED manual. These changes have no impact on the VAED extract.

Section 2 Concepts and derived items

~~Asylum Seeker~~ (removed)

~~Medicare Eligibility Status - Eligible Person~~ (removed)

~~Medicare Eligibility Status - Ineligible Person~~ (removed)

Medicare Eligibility Status (new)