Victorian health services performance monitoring framework

Indicators business rules 2017-18

VICTORIA State Government | Health and Human Services

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

ISBN 978-1-76069-014-4 (pdf/online)

Available at HealthVic funding, performance and accountability (refer to 'Performance monitoring') <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring>

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Indicators business rules

This document complements the Victorian health services performance monitoring framework (PMF) published in July 2017.

It provides the next level of detail about calculating performance for each indicator captured in the Statement of Priorities (SoP) for 2017-18 as well as the remainder of the performance measures reflected in the new performance risk assessment approach.

Methodology for assessing improvement has also been included.

The PMF can be found at Health.Vic Funding, performance and accountability (refer to 'Performance monitoring') https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring.

High quality and safe care

Accreditation

Indicator	Compliance with the National Safety and Quality Health Service standards
Description	Consistent with the Australian Health Service Safety and Quality Accreditation Scheme health services are required to be accredited against the National Safety and Quality Health Service Standards ('NSQHS standards'). This scheme applies to all health services including small rural health services and clinical mental health services. It includes contracted/outsourced services as if they are being provided by the health service. Under the scheme the department, as the jurisdictional regulator, has responsibility for verifying the accreditation status of Victorian public health services. In the event of an identified significant patient risk or 'not met' core action item, health services are required to immediately notify the department and submit an action plan to them addressing the issues. The *Accreditation – Performance monitoring and regulatory approach business rules* outlines the department's approach to monitoring performance of Victorian public health services against the NSQHS accreditation requirements. Further details on the accreditation requirements can be found at HealthVic public hospital accreditation <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-accreditation > **Performance breach** As of 2017-18 not met criteria for accreditation is considered a performance breach. For further details about the performance breach notification process to the department, health services can refer to the 2017-18 PMF or by contacting their respective health service lead / regional manager. For Ambulance Victoria ISO 9001:2008 (quality management system) certification applies.
Calculating performance	Full compliance with accreditation standards will be referred to as 'achieved'. Where a health service has not met accreditation standards it will be referred to as 'not achieved'. Where a health service does not achieve the indicator in any quarter the annual result is not achieved. Health services accreditation surveys vary in frequency depending on the accrediting body.
Statewide target	Full compliance
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous accreditation result.
Frequency of reporting and data collection	Performance is monitored quarterly at health service level. The accreditation status as at the end of the quarter for each health service is reported for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 • 1 April to 30 June 2018 in quarter 4. A performance result is also generated annually.

Indicator	Compliance with the Commonwealth's Aged Care Accreditation Standards
Description	It is a requirement that all residential aged care facilities are accredited and maintain full compliance with the relevant accreditation standards. The Commonwealth Government has primary responsibility for funding and regulating the residential aged care sector. In Victoria, a number of residential aged care services are provided by public health services and are subject to the Commonwealth's Aged Care Accreditation Standards.
Calculating performance	This indicator is assessed at the health service level. Where a health service has multiple facilities, all facilities are required to meet the expected outcomes. Full compliance with accreditation standards will be referred to as 'achieved'. Where a health service has not met accreditation standards they will be referred to as 'not achieved'. To achieve this indicator all residential aged care services must be fully compliant with all 44 expected outcomes of the Aged Care Accreditation Standards, at all times. All episodes where expected outcomes are not met during the reporting period will be assessed as 'not achieved'. Any breaches require health services to meet a timetable for improvements set by the Aged Care Standards and Accreditation Agency (ACSAA), usually within a three-month period, which includes submitting action plans and follow-up visits during and after this period. **Performance breach** As of 2017-18 not met criteria for accreditation is considered a performance breach. For further details about the performance breach notification process to the department, health services can refer to the 2017-18 PMF or by contacting their respective health service lead / regional manager. The department's Aged Care team should also be notified of any instances of noncompliance as soon as the ACSAA have identified them.
Statewide target	Full compliance
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous accreditation result.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually. Where a health service does not achieve the indicator in any quarter the annual result is not achieved. The accreditation status as at the end of the quarter for the health service is to be reported for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 • 1 April to 30 June 2018 in quarter 4. For each quarter, a list of residential aged care services that have failed to comply with the Aged Care Accreditation Standards during the relevant quarter will be obtained.

Infection prevention and control

Indicator	Compliance with the Hand Hygiene Australia program	
Description	The hand hygiene program aims to improve compliance with best practice hand hygiene processes so that healthcare-associated infections are reduced. The indicator encourages health services to achieve a high standard of hand hygiene and be fully compliant in their data submission to Hand Hygiene Australia (HHA). This indicator measures the percentage of hand hygiene compliance achieved. This percentage represents compliance with the '5 moments' for hand hygiene methodology.	
Calculating performance	VICNISS coordinates the hand hygiene program for Victoria. Data are reported to HHA. VICNISS analyses the data for each audit period and reports results to the department. Auditing requirements are outlined by Hand Hygiene Australia <www.hha.org.au>. There are three hand hygiene audit periods per year: • 1 July to 31 October • 1 November to 31 March • 1 April to 30 June. The number of moments each campus is required to collect is based on acute inpatient bed numbers submitted to the Agency Information Management System as at 31 March 2017. This indicator is assessed at the health service level. Where a health service has multiple campuses, the compliance is aggregated to produce an average health service result. Where a health service has fewer than 25 acute inpatient beds at each campus, the number of moments required to be collected will be based on the total number of acute inpatient beds at the health service. The department may determine alternative reporting arrangements for campuses with low bed numbers and low occupancy in consultation with Safer Care Victoria and the relevant health services.	
Statewide target	≥80%	
Achievement	Equal to or above 80%	Achieved
	Below 80%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous reporting period.	
Frequency of reporting and data collection	Data is collected at the campus level and used to produce an aggregated health service result. Hand hygiene compliance data is submitted to HHA throughout the year, and VICNISS creates reports for the three audit periods: • 1 July to 31 October (reported with quarter 2) • 1 November to 31 March (reported with quarter 3) • 1 April to 30 June (reported with quarter 4). Where a campus fails to submit the required number of moments in an audit period the measure is deemed not met.	

Indicator	**Percentage of healthcare workers immunised for influenza**	
Description	High coverage rates of immunisation in healthcare workers (HCW) are essential to reduce the risk of influenza transmission in healthcare settings. This indicator aims to measure the percentage of vaccinated health service staff who are permanently, temporarily or casually (bank staff) employed by the nominated hospital / health service and worked one or more shifts during the influenza vaccination campaign. The HCW categories used are aligned with the Australian Council on Safety and Quality in Health Care (ACSQHC) *Australian guidelines for prevention and control of infection in healthcare*. Details can be found at VICNISS <www.vicniss.org.au>.	
Calculating performance	The period used to calculate the rate of HCW immunisation is 3 April to 4 August 2017.	
Numerator	Number of category A, B and C HCW vaccinated as at 4 August 2017.	
Denominator	Number of category A, B and C HCW employed as at 4 August who worked one or more shifts during the influenza vaccination campaign (3 April to 4 August 2017).	
Statewide target	≥75%	
Achievement	Equal to or above 75%	Achieved
	Below 75%	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous year performance.	
Frequency of reporting and data collection	Data on vaccination rates must be submitted to VICNISS by 2 September 2017. If possible, data should be submitted by HCW category. Where data is not submitted, the measure is deemed as not achieved. Performance is monitored and assessed annually and reported in Q1.	

Patient experience

Description	The Victorian healthcare experience survey (VHES) has been implemented in Victorian health services as a survey measuring patient experience since 2014.
Calculating performance for all questions	Indicators are measured at the health service level and mandatory participation is based on health services providing timely patient data to the contractor to enable surveying. Participation is based on health services providing at least 42 responses per quarter and patient data issued to the contractor by the 15 of each months to enable statistically significant analysis. Where data is not submitted in time, the measure is deemed not met. Some small rural health services will not be able to achieve the minimum 42 response rate per quarter. Small rural health services that can meet the minimum 42 response rate as cumulative over the course of the year will have the actual results from the overall patient experience applied. The 'experience score' is calculated by the survey contractor based on the positive response(s) to the questions from the **adult inpatient** category of VHES suite of information. Health service results analysed quarterly.
Frequency of reporting and data collection	Health services are required to submit the details of eligible patients to the survey contractor by 15th of each month. Reported data is lagged by one quarter. Data is supplied at campus level and reported quarterly at health service level.
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous quarter performance.

Overall experience

Indicator	**Question 76: Overall, how would you rate the care you received while in hospital?**	
Description	This indicator measures the results of the 'very good' and 'good' response to the adult inpatient VHES survey question relating to 'overall experience'	
Statewide target	Score equal to or above 95%	
Achievement	Overall experience score equal to or above 95%	Achieved
	Overall experience score below 95%	Not achieved

Key aspects of care questions that influence the overall experience

Indicator	**Question 25: Did you have confidence and trust in the nurses treating you?**	
Description	This indicator measures the results of the 'yes always' response to the adult inpatient VHES survey question relating to 'your nurses'.	
Risk flag	<80%	
Achievement	Equal to or above 80%	Achieved
	Below 80%	Not achieved

Indicator	**Question 33: How often did the doctors, nurses and other healthcare professionals caring for you explain things in a way you could understand?**	
Description	Measures the results of the 'all of the time' and 'most of the time' responses to the adult inpatient VHES survey question relating to 'your care'	
Risk flag	<90%	
Achievement	Equal to or above 90%	Achieved
	Below 90%	Not achieved

Indicator	**Question 37: Were you involved as much as you wanted to be in decisions about your care and treatment?**	
Description	Measures the results of the 'yes definitely' response to the adult inpatient VHES survey question relating to 'your care'.	
Risk flag	<60%	
Achievement	Equal to or above 60%	Achieved
	Below 60%	Not achieved

Indicator	**Question 42: If you needed assistance, were you able to get a member of staff to help you within a reasonable time?**	
Description	Measures the results of the 'all of the time' and 'most of the time' response to the adult inpatient VHES survey question relating to 'your care'.	
Risk flag	<85%	
Achievement	Equal to or above 85%	Achieved
	Below 85%	Not achieved

Transition of care

Indicator	**Transition Index**	
Description	Measures the quality of patient reported discharge care.	
Calculating Performance	This composite indicator captures the average sum of the very positive responses to the following four questions in the adult inpatient VHES relating to transfer of care: • Before leaving hospital did the doctors and nurses give you sufficient information about managing your healthcare at home? • Did hospital staff take your family and home situation into account when planning your discharge? • Thinking about when you left hospital, were adequate arrangements made by the hospital for any services you needed? • If follow-up with your general practitioner was required, was he or she given all the necessary information about the treatment or advice you received while in hospital?	
Statewide Target	≥75%	
Achievement	Equal to or above 75%	Achieved
	Below 75%	Not achieved

Indicator	**Question 69: Before you left hospital, did the doctors and nurses give you sufficient information about managing your health and care at home?**	
Description	This indicator measures the results of the 'yes completely' response to the adult inpatient VHES survey question relating to 'leaving hospital'.	
Risk flag	<70%	
Achievement	Equal to or above 70%	Achieved
	Below 70%	Not achieved

Indicator	**Question 70: Did hospital staff take your family or home situation into account when planning your discharge?**	
Description	This indicator measures the results of the 'yes completely' and 'yes to some extent' response to the adult inpatient VHES survey question relating to 'leaving hospital'.	
Risk flag	<70%	
Achievement	Equal to or above 70%	Achieved
	Below 70%	Not achieved

Indicator	**Question 71: Thinking about when you left hospital, were adequate arrangements made by the hospital for any services you needed? (e.g. transport, meals, mobility aids)**
Description	This indicator measures the results of the 'yes completely' response to the adult inpatient VHES survey question relating to 'leaving hospital'.
Risk flag	<65%

Achievement	Equal to or above 65%	Achieved
	Below 65%	Not achieved

Perception of cleanliness

Indicator	**Patient perception of hospital cleanliness**	
Description	Measures the average sum of the very positive ('very clean') responses to the following two questions from the adult inpatient VHES relating to patient reported cleanliness: Question 12: In your opinion, how clean was the hospital room or ward that you were in? Question 13: How clean were the toilets and bathrooms that you used in hospital?	
Statewide target	≥70%	
Achievement	Equal to or above 70%	Achieved
	Below 70%	Not achieved

Forensicare patient experience

Indicator	Inpatients overall experience at Thomas Embling Hospital	
Description	This indicator measures the results of the 'excellent', 'very good' and 'good' responses to the question "Overall, how would you rate your experience of care?" in the annual Thomas Embling Hospital consumer survey.	
Calculating performance	This indicator is measured at the health service level.	
Numerator	Total number of survey respondents who answered 'excellent', 'very good' and 'good' to the item.	
Denominator	Total number of survey respondents.	
Statewide target	≥90%	
Achievement	Equal to or above 90%	Achieved
	Below 90%	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous survey results.	
Frequency of reporting and data collection	Results and participation will be reported annually in quarter 4. Data source: Forensicare quantitative survey results.	

Indicator	Patient's overall experience at community Forensicare mental health services	
Description	This indicator measures the results of the 'excellent', 'very good' and 'good' responses to the question "Overall, how would you rate your experience of care?" in the annual Community Forensicare Mental Health Service consumer survey.	
Calculating performance	This indicator is measured at the health service level. Improvement will be compared to previous survey results.	
Numerator	Total number of survey respondents who answered 'excellent', 'very good' and 'good' to the item.	
Denominator	Total number of survey respondents.	
Statewide target	≥90%	
Achievement	Equal to or above 90%	Achieved
	Below 90%	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous survey results.	
Frequency of reporting and data collection	Results and participation will be reported annually in quarter 4. Data source: Forensicare quantitative survey results.	

Healthcare associated infections (HAIs)

Indicator	Number of patients with surgical site infection
Description	Surgical site infection (SSI) surveillance focuses on reducing the incidence of healthcare-associated infection (HAI) among nominated surgical procedures.
Calculating performance	This indicator refers to a set of specific types of procedures: • coronary artery bypass grafts • hip arthroplasty • knee arthroplasty • caesarean section for nominated health services • colorectal surgery Relevant procedures expressed as a crude rate per 100 procedures. For each procedure type, where a health service is found to have a statistically significantly higher infection rate than the state aggregate rate, they are deemed an outlier. Further information on the methodology for calculating outliers for Surgical Site Infections can obtained from at VICNISS<www.vicniss.org.au>. **Hip and knee arthroplasty** Campuses performing ≥ 50 hip and knee arthroplasty surgical procedures per annum are required to conduct continuous surveillance. **Coronary artery bypass graft** Campuses performing cardiac bypass surgery are required to conduct continuous surveillance. **Caesarean section for nominated health services** Caesarean section surveillance must be undertaken for the July–December period. Health services may substitute another surgical procedure for caesarean section surveillance between January and June of the reporting year. Alternative surveillance modules must be discussed and agreed with VICNISS. **Colorectal surgery** Health services that undertake >50 relevant procedures a year will be required to report data for at least one quarter. Health services may choose whether to collect data in Q1, Q2 or Q3. Data will be used to determine surveillance approach in 2018-19. List of relevant procedures is available from VICNISS.

Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data reported is lagged. Data is analysed quarterly based on two quarters of data. Rates are calculated using the most recent six months of data in a rolling fashion. VICNISS collates and analyses data from health services and reports quarterly to participants and the department on aggregate, risk-adjusted, procedure-specific infection rates. Data is submitted to VICNISS and performance reported for the periods: • 1 January to 30 June 2017 in quarter 1 (of the Monitor report) • 1 April to 30 September 2017 in quarter 2 • 1 July to 31 December 2017 in quarter 3 • 1 October to 31 March 2018 in quarter 4. This indicator is measured at the health service level. Where a health service has multiple campuses, an outlier at any campus will result in the health service not meeting the indicator. If data is not submitted at a campus level in any month, the entire quarter target will be deemed as not met by the health service. A result is generated annually. Where a health service does not achieve the indicator in a reporting period the annual result is not achieved.
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous reporting period.

Indicator	**Surgical site infection for all reported procedures**
Numerator	The number of patients with a surgical site infection for all reported procedures
Denominator	The total number of all reported procedures
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator	**Surgical site infection post coronary artery bypass grafts**
Numerator	Number of surgical site infection post coronary artery bypass grafts
Denominator	The total number of coronary artery bypass graft procedures
Statewide target	No outliers
Achievement	Achieved Not achieved

Indicator	**Surgical site infection post hip arthroplasty**
Numerator	Number of surgical site infection post hip arthroplasty
Denominator	The total number of hip arthroplasties
Statewide target	No outliers

Achievement	Achieved Not achieved

Indicator	**Surgical site infection post knee arthroplasty**
Description	Number of surgical site infection post knee arthroplasty
Denominator	The total number of knee arthroplasties
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator	**Surgical site infection post caesarean section delivery**
Numerator	Number of surgical site infection post caesarean section delivery
Denominator	The total number of caesarean section deliveries
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator	**Surgical site infection post colorectal surgery**
Numerator	Number of surgical site infection post colorectal surgery.
Denominator	The total number of colorectal surgeries.
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator	Intensive care unit central-line-associated bloodstream infection surveillance
Description	This surveillance measure focuses on reducing the incidence of central-line-associated bloodstream infection (CLABSI) for patients in intensive care unit (ICU) Neonatal intensive care units are excluded.
Calculating performance	Results are presented as rates calculated by the VICNISS on behalf of the department using the data collected from participating ICUs. Rates = numerator/denominator × 1,000
Numerator	The number of CLABSIs
Denominator	The total number of central line days
Statewide target	Nil
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous reporting period.
Frequency of reporting and data collection	This indicator is measured at the hospital level and is relevant to hospitals with an ICU. VICNISS collates and analyses data from health services and reports quarterly to participants and the department on aggregate, risk-adjusted infection rates. Data is submitted to VICNISS and performance reported for the periods: • 1 April to 30 June 2017 in quarter 1 Monitor report • 1 July to 30 September 2017 in quarter 2 • 1 October to 31 December 2017 in quarter 3 • 1 January to 31 March 2018 in quarter 4. Performance is monitored and assessed quarterly. Data reported is lagged by one quarter. Annual performance is based on full year lagged data.

Indicator	**Rate of patients with SAB per occupied bed days**	
Description	This surveillance measure aims to reduce the rate of health care associated *Staphylococcus aureus* bacteraemia (SAB) for all patients admitted to a public hospital with a bacteraemia caused by either Methicillin-susceptible *S. aureus* (MSSA) or Methicillin-resistant *S. aureus* (MRSA).	
Calculating performance	A patient episode of bacteraemia is defined as a positive blood culture for *S. aureus*. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded. A SAB will be considered to be healthcare-associated either if: • the patient's first SAB blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge, or • the patient's first SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the defined clinical criteria was met for the patient episode of SAB. Occupied bed days are defined as the total number of days for all patients who were admitted for an episode of care in the acute health facility, including psychiatric bed days. Further information on the SAB definition can be found at VICNISS<www.vicniss.org.au>. This indicator is expressed as the rate of infections per 10,000 occupied bed days. This indicator is expressed as a rate and rounded to one decimal place (0.05 is rounded down).	
Numerator	Healthcare-associated SAB patient episodes	
Denominator	Number of occupied bed days for health services	
Statewide target	≤1.0 episodes per 10,000 occupied bed days	
Achievement	Equal to or below 1.0	Achieved
	Greater than 1.0	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous quarter performance.	
Frequency of reporting and data collection	VICNISS collects and analyses data from health services and reports quarterly to participants and the department. Reporting periods are: • 1 April to 30 June 2017 reported in quarter 1 Monitor report • 1 July to 30 September 2017 in quarter 2 • 1 October to 31 December 2017 in quarter 3 • 1 January to 31 March 2018 in quarter 4. This indicator is measured at the health service level. Where a health service has multiple campuses, an aggregate for the health service result is produced. Data reported is lagged by one quarter. Performance is monitored and assessed quarterly. Performance result is generated annually based on full year lagged data.	

Adverse events

Indicator	Sentinel events
Description	Sentinel events are serious and unexpected adverse events that often result in significant or permanent harm or death. This indicator is a trigger for discussion regarding quality, safety and improvement in health services, as well as compliance with mandatory reporting of sentinel events. The sentinel event program aims to improve health service system design and delivery through shared learning from a defined range of serious adverse events (sentinel events). Increasing numbers of sentinel events are concerning particularly in the context of other safety and quality risks. Too low numbers may be a sign of an under-reporting culture. Of most importance is the timeliness of the response and effectiveness of the action taken to prevent re-occurrence. Safer Care Victoria (SCV) coordinates the sentinel event program for Victoria. Health services are required to notify SCV within 3 days of a sentinel event occurring and provide a report outlining a plan to prevent recurrence. A copy of the RCA report must be submitted to SCV within 30 days of the notification.
Calculating performance	This measure captures numbers of reportable sentinel events. Reportable sentinel events must meet one of the following specific criteria: • Procedure involving the wrong patient or body part resulting in death or major permanent loss of function • Suicide in an inpatient unit • Retained instruments or other material after surgery requiring reoperation or further surgical procedure • Intravascular gas embolism resulting in death or neurological damage • Haemolytic blood transfusion reaction resulting from ABO (blood type) incompatibility • Medication error resulting in death of a patient reasonably believed to be due to incorrect administration of drugs • Maternal death associated with labour or delivery • Infant discharged to the wrong family • Other catastrophic event: Incident severity rating one (ISR 1) Further details on the sentinel events program including reporting requirements is outlined at HealthVic sentinel events in health services <www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/sentinel-event-program>
Statewide target	Nil
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous quarter performance.

Frequency of reporting and data collection	Sentinel events are collected and reported at campus level. Performance is assessed and reported monthly. Quarterly and annual results are also calculated. .

Mortality

Indicator	Death in Low Mortality Diagnosis Related Groups (DRG's)
Description	This measure is part of a suite of core hospital-based outcome indicators (CHBOI) of quality of care . It is used as a safety and quality screening tool to flag potential areas of safety concern or best practice. It is intended to identify in-hospital deaths in patients unlikely to die during hospitalisation. The underlying assumption is that when patients admitted for an extremely low-mortality condition or procedure die, a health care error is more likely to be responsible. All Low Mortality DRG related cases resulting in a death should be reviewed to ascertain whether the actual grouping of that separation to a 'low mortality DRG' was appropriate. Further, for each of these deaths a clinical review is to be conducted to determine whether appropriate management was provided and whether the death was avoidable. The review can also highlight evidence of potential clusters. Safer Care Victoria can assist in the review process, including the provision of tools and specialist advice, as necessary. Reviews should be shared with Safer Care Victoria who will undertake to provide feedback.
Calculating performance	The indicator for Death in Low Mortality DRGs counts all in-hospital deaths of patients in acute care who were coded to a Diagnosis Related Group (DRG) with a national mortality rate less than 0.5%. The list of DRGs included in this indicator was supplied by ACSQHC and used APC NMDS data for the financial years 2011-12 to 2013-14 and Version 7 of the DRG grouper. The commission is yet to update this list, hence, data for more recent financial years that use Version 8 of the grouper are regrouped using Version 7 to continue using this list. The measure is provided as a crude rate per 100 episodes. Results are not adjusted for differences in hospital or type of patients.
Numerator	Number of episodes that satisfy the denominator criteria and were separated as a death (i.e. SEPMODE='D') x100
Denominator	Number of episodes where: • Age at date of admission is 18 years and over • Coded to a *low mortality DRG* (see **Attachment A** for list of codes) • Care type = *acute care (i.e. care types* '0','4','5A','5G','5K','5S','K') Excludes any diagnosis (principal or additional) and/or any procedure of *trauma*, *immuno-compromised state*, *cancer* (see **Attachment B**)
Statewide target	Nil
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly and an annual (preceeding twelve months) rate. Data collection: VAED. Results collected and reported at campus level.

Indicator	Hospital standardised mortality ratio
Description	Hospital standardised mortality ratios (HSMRs) are used to screen for safety and quality issues in hospitals. It compares the hospital's overall mortality to other hospitals within Victoria and nationally. The ratio of observed (actual) number of in-hospital deaths to expected number of in-hospital deaths, multiplied by 100, for principal diagnoses accounting for 80 per cent of national in-hospital mortality. The HSMR is risk adjusted by applying logistic regression to estimate the probability of an episode being separated as a death, given the patient's characteristics. These probabilities are aggregated into expected counts. The HSMR is compared against the national average ratio (100).
Calculating performance	An outlier result is represented by a significant variation (above 99% CI) from the national average ratio. Results within the 95% and 99% confidence interval are considered 'higher than expected' against the national rates. All statistically higher or lower mortality rates should be reviewed by the health service to check the hypothesis against expected rates for age and health profile or for potential coding and classification processes that may distort the results. High or rising HSMR should be seen as a prompt to further investigation and action to ensure that findings have been addressed effectively. Reviews should be shared with Safer Care Victoria who will undertake to provide feedback.
Numerator	Observed number of in-hospital deaths x 100
Denominator	Expected number of in-hospital deaths, calculated as the sum of the estimated probabilities of death for all separations meeting the denominator criteria. Estimated probabilities are calculated using national risk-adjustment coefficients. **Denominator criteria** Inclusions • Principal diagnosis is in the national list of the top 80% of diagnoses, by frequency of in-hospital death • Age at date of admission is between 29 days and 120 years, inclusive • Care type = *acute care((i.e. care types* '0','4','5A','5G','5K','5S','K'), *geriatric evaluation and management and maintenance care* • Length of stay (LOS, including leave days) is between 1 and 365 days, inclusive (1 ≤ LOS ≤ 365) • Admission type is Emergency or Elective ('O', 'C', 'K', or 'P') • Sex is male or female Exclusions • Neonates, aged ≤ 28 days at admission • Missing admission type, sex.
Statewide target	No outliers
Achievement	Achieved Not achieved

Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly rate and an annual (preceding twelve months) rate. Outliers are calculated based on the annual rate. For quarterly results, in scope separations for the quarter is 50. For annual reporting, in scope separations in the twelve months up to and including the reporting quarter is 100. Data collection: VAED. Results are collected and reported at campus level. Number of observed and expected deaths is based on episodic, not patient level data. National rates supplied by ACSQHC. Reference sets for outlier calculation can be supplied by the Victorian Agency for Health Information (VAHI), upon request.

Indicator	In hospital mortality Acute Myocardial Infarction (AMI)
Description	A condition specific mortality measure generated from admitted patient data for specific, high-morbidity populations (e.g. in this case AMI).
Calculating performance	It measures the ratio of actual number of in-hospital deaths for AMI patients (observed) to number of separations expected to end in in-hospital death for AMI patients (expected), multiplied by the national mortality rate for AMI patients (3.086038433). This measure is risk adjusted and expressed as a rate per 100 separations. Significant variation from the national rate should be verified in terms of data quality and consistency and/or quality and safety concerns. Reviews of cases reflecting significant variation may identify resource, process of care or professional issues. Reviews should be shared with Safer Care Victoria who will undertake to provide feedback. Results above the 99% confidence interval are considered outliers. Results between the 95-99%CI reflect higher or lower than expected rates. High outlier rates should be seen as a prompt to further investigation. Learnings may be applied from low outlier rates.
Numerator	Observed number of in-hospital deaths for AMI patients × national in-hospital mortality rate for AMI patients, where: National mortality rate = national observed number of in-hospital deaths for AMI ÷ national observed number of separations for AMI
Denominator	Expected number of in-hospital deaths for AMI patients, calculated as the sum of the estimated probabilities of death for all separations (meeting the denominator criteria). Estimated probabilities are calculated using national risk-adjustment coefficients. **Denominator criteria** • Principal diagnosis of AMI (I21) • Age at admission date is between 18 and 89 years, inclusive • Admission type is Emergency • Length of stay (LOS), including leave days) is between 1 and 30 days, inclusive (1 ≤ LOS ≤ 30) (but not including same day). Exclusions: • Additional diagnosis of Cardiac arrest (I46.x) AND Condition onset flag = *Condition not noted as arising during the episode of admitted patient care*. • Same day separations (where date of admission is equal to the date of separation).
Statewide target	No outliers
Achievement	Achieved Not achieved

Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly rate and an annual (preceding twelve months) rate. Outliers are calculated based on the annual rate. For quarterly results, in-scope separations for the quarter is 20. For annual results, the in-scope separations for the twelve month (including the reporting quarter) is 50. Data collection: VAED. Number of observed and expected deaths is based on episodic, not patient level data. National rates supplied by ACSQHC. Reference sets for outlier calculation can be supplied by the Victorian Agency for Health Information (VAHI), upon request. Results are collected and reported at campus level.
Indicator	**In hospital mortality fractured neck of femur (FNOF)**
Description	A condition specific mortality measure generated from admitted patient data for specific, high-morbidity populations (e.g. in this case FNOF).
Calculating performance	The ratio of actual number of in-hospital deaths for FNOF patients (observed) to number of separations expected to end in in-hospital death for FNOF patients (expected), multiplied by the national mortality rate for FNOF patients (3.022937504). This measure is risk adjusted and expressed as a rate per 100 separations. Results above the 99% confidence interval are considered outliers. Results between the 95-99%CI reflect higher or lower than expected rates. Significant variation from the national rate should be verified in terms of data quality and consistency and/or quality and safety concerns. Reviews of cases reflecting of significant variation may identify resource, process of care or professional issues. Outcomes for management of hip fracture are sensitive to adherence to clinical best practice. There is also evidence of association between delay in operation for hip fracture and higher mortality rate, although other medical reasons can also be contributing factors. Reviews should be shared with Safer Care Victoria who will undertake to provide feedback.
Numerator	Observed number of in-hospital deaths for FNOF patients × national in-hospital mortality rate for FNOF patients, where National mortality rate = national observed number of in-hospital deaths for FNOF ÷ national observed number of separations for FNOF

Denominator	Expected number of in-hospital deaths for FNOF patients, calculated as the sum of the estimated probabilities of death for all separations (meeting the denominator criteria). Estimated probabilities are calculated using national risk-adjustment coefficients. **Denominator criteria** Principal diagnosis of NOF (S72.0, S72.10, S72.11) AND Procedure code in (47519-00 [1479] , 47522-00 [1489], 47528-01 [1486],47531-00 [1486], 49315-00 [1489]) AND External cause code of Falls (W00.x – W19.x,) OR secondary diagnosis code of Tendency to fall not elsewhere classified (R29.6). • Age at date of admission is between 50 and 120, inclusive • Length of stay (LOS, including leave days) is between 1 and 30 days, inclusive (1 ≤ LOS ≤ 30).
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly rate and an annual (preceding twelve months) rate. Outliers are calculated based on the annual rate. For quarterly results, in-scope separations for the quarter is 20. For annual results, the in-scope separations for the twelve month (including the reporting quarter) is 50. Data collection: VAED. Number of observed and expected deaths is based on episodic, not patient level data. National rates supplied by ACSQHC. Reference sets for outlier calculation can be supplied by the Victorian Agency for Health Information (VAHI), upon request. Results are collected and reported at campus level.

Indicator	In hospital mortality stroke
Description	A condition specific mortality measure generated from admitted patient data for specific, high-morbidity populations (e.g. in this case stroke).
Calculating performance	The ratio of actual number of in-hospital deaths for stroke patients (observed) to number of separations expected to end in in-hospital death for stroke patients (expected), multiplied by the national mortality rate for stroke patients(10.50549466). This measure is risk adjusted and expressed as a rate per 100 separations. Significant variation from the national rate should be verified in terms of data quality and consistency and/or quality and safety concerns. Reviews of cases reflecting of significant variation may identify resource, process of care or professional issues. Reviews should be shared with Safer Care Victoria who will undertake to provide feedback. Results above the 99% confidence interval are considered outliers. Results between the 95-99%CI reflect higher or lower than expected rates.
Numerator	Observed number of in-hospital deaths for stroke patients × national in-hospital mortality rate for stroke patients, where National mortality rate = national observed number of in-hospital deaths for stroke ÷ national observed number of separations for stroke
Denominator	Expected number of in-hospital deaths for stroke patients, calculated as the sum of the estimated probabilities of death for all separations (meeting the denominator criteria). Estimated probabilities are calculated using national risk-adjustment coefficients. Denominator criteria: Principal diagnosis of stroke (I61.x – I64.x) Age at date of admission is between 18 and 89 years, inclusive Care type = acute care (excluding neonates) Length of stay (LOS, including leave days) is between 1 and 30 days, inclusive (1 ≤ LOS ≤ 30) Exclusions Episodes with any of the following procedure codes: 33500-00 [700], 32703-00 [718].
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly rate and an annual (preceding twelve months) rate. Outliers are calculated based on the annual rate. For quarterly results, in-scope separations for the quarter is 20. For annual results, the in-scope separations for the twelve month (including the reporting quarter) is 50. Data collection: VAED. Number of observed and expected deaths is based on episodic, not patient level data. National rates supplied by ACSQHC. Reference sets for outlier calculation can be supplied by the Victorian Agency for Health Information (VAHI), upon request. Results are collected and reported at campus level.

Indicator	**In hospital mortality pneumonia**
Description	A condition specific mortality measure generated from admitted patient data for specific, high-morbidity populations (e.g. in this case pneumonia).
Calculating performance	The ratio of actual number of in-hospital deaths for pneumonia patients (observed) to number of separations expected to end in in-hospital death for pneumonia patients (expected), multiplied by the national mortality rate for the pneumonia patients. This measure is risk adjusted and expressed as a rate per 100 separations. It compares individual hospitals against a national rate (4.597868217). Significant variation from the national rate should be verified in terms of data quality and consistency and/or quality and safety concerns. Reviews of cases reflecting of significant variation may identify resource, process of care or professional issues. Reviews should be shared with Safer Care Victoria who will undertake to provide feedback. Results above the 99% confidence interval are considered outliers. Results between the 95-99%CI reflect higher or lower than expected rates.
Numerator	Observed number of in-hospital deaths for pneumonia patients × national in-hospital mortality rate for pneumonia patients, where National mortality rate = national observed number of in-hospital deaths for pneumonia ÷ national observed number of separations for pneumonia.

Denominator	Expected number of in-hospital deaths for pneumonia patients, calculated as the sum of the estimated probabilities of death for all separations (meeting the denominator criteria). Estimated probabilities are calculated using national risk-adjustment coefficients. **Denominator criteria** • Principal diagnosis of pneumonia (J13.x – J16.x, J18.x) • Age at date of admission is between 18 and 89 years, inclusive • Care type = acute care (excluding neonates) • Length of stay (LOS, including leave days) is between 1 and 30 days, inclusive (1 ≤ LOS ≤ 30)
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly rate and an annual (preceding twelve months) rate. Outliers are calculated based on the annual rate. For quarterly results, in-scope separations for the quarter is 20. For annual results, the in-scope separations for the twelve month (including the reporting quarter) is 50. Data collection: VAED. Number of observed and expected deaths is based on episodic, not patient level data. National rates supplied by ACSQHC. Reference sets for outlier calculation can be supplied by the Victorian Agency for Health Information (VAHI), upon request. Results are collected and reported at campus level. Improvement is assessed against previous quarter performance and based on the annual rate (outlier status).

Unplanned re-admission

Description	Unplanned re-admission refers to an unexpected readmission for treatment of the same condition, a related condition or a complication of the condition for which the patient was previously hospitalised. The unplanned readmission indicators for Acute Myocardial Infarction, Knee replacement, Hip replacement, Heart failure and Paediatric Tonsillectomy and Adenoidectomy are part of a suite of core hospital-based outcome indicators (CHBOI) focused on improving safety and quality of patient care.
Calculating performance	Results should fall within the expected range against statewide rates. Results above the 99.8% confidence interval are considered outliers. Results between the 95-99.8%CI reflect higher or lower than expected rates. High rates should be seen as a prompt to further investigation. Investigation should consider a comprehensive range of possible explanations including: case mix, structural or resource issues, changes in treatment protocols, professional practice. Reviews should be shared with Safer Care Victoria who will undertake to provide feedback.
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly rate and an annual (preceding twelve months) rate. Outliers are calculated based on the annual rate. For quarterly results, the in scope separations for the quarter is at least 15 or 2 or more readmissions for two consecutive quarters. For annual results, the in-scope separations is 50 or more in the twelve months up to and including the reporting quarter. Data collection: VAED. Results are collected and reported at campus level.
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Indicator	**Unplanned readmission for Acute Myocardial Infarction**
Description	Unplanned readmissions to the same hospital within 30 days of patients' separation, for management of Acute Myocardial Infarction.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following: • The separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) • Has a principal diagnosis code (i.e. the readmission) of either I21 or I22 • Occurs within 30 days of the previous date of separation • The readmission is an acute admission (Care Type = 'U', '4', 'K') • Admission type of the readmission is 'Emergency'('O' or 'C') • Excludes transfers from other campuses (Admission Source = 'T')

Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following • Has an ICD-10-AM principal diagnosis code of I21 or I22 • Is an acute separation (Care Type = 'U', '4', 'K') • Patient age is between 30-89 years (inclusive) • Admission Type of admission is 'emergency' ('O', 'C') • Excludes transfers in and transfers out (Admission Source or Separation Mode = 'T') • LOS is between 4-30 patient days (inclusive) • Excludes in-hospital deaths (Separation Mode = 'D')
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Indicator	**Unplanned readmission for knee replacement**
Description	Unplanned readmissions to the same hospital within 60 days of patients' separation from acute care for knee replacement surgery.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following • The separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) • The principal diagnosis code (i.e. of the readmission) is in ('I21','I26','I50','I74','M17','M23','N13','R33','S89','T81','T84','I80.1','I80.2','I97.8','J15.1','J18.0','J18.9','J95.8','L89.2','M24.6','M25.6','N39.0','S82.0','T88.7','L03.11','S72.10','S83.44','T85.78','T85.88') • The readmission occurs within 60 days of the previous date of separation • The readmission is an acute admission (Care Type = 'U', '4', 'K')
Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following • Has any of the following procedure codes: 49518-00, 49519-00, 49521-02 • Is an acute separation(Care Type = 'U', '4', 'K') • Patient age is at least 20 years • LOS is greater than or equal to 4 days • Excludes in-hospital deaths(Separation Mode = 'D')
Statewide target	No outliers
Achievement	Achieved Not achieved

Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Indicator	**Unplanned readmission for hip replacement**
Description	Unplanned readmissions to the same hospital within 60 days of patients' separation from acute care, for hip replacement surgery.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following • The separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) • The principal diagnosis code (i.e. of the readmission) is in ('G46','I21','I26','I50','I74','I80','J15','L89','N13','N30','R33','S73','T84','T89','I62.1','I63.3','I97.8','J18.0','J18.9','J95.8','L03.9','M25.6','M96.8','N390','T81.1','T81.3','T81.5','T81.6','T81.8','T81.9','T85.9','T88.7','L03.11','S72.00','S72.08','T85.87','T85.88') • The readmission occurs within 60 days of the previous date of separation • The readmission is an acute admission (Care Type = 'U', '4', 'K')
Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following • Has any of the following procedure codes: 49318-00,49319-00 • Is an acute separation (Care Type = 'U', '4', 'K') • Patient age is at least 20 years • LOS is greater than or equal to 3 days • Excludes in-hospital deaths (Separation Mode = 'D')
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Indicator	**Unplanned readmission for Paediatric Tonsillectomy and Adenoidectomy**
Description	Unplanned readmissions to the same hospital within 15 days of patients' separation, for management of paediatric tonsillectomy and adenoidectomy (0 to 14 years inclusive).

Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following • The separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) • The principal diagnosis code (i.e. of the readmission) is in ('E86','J03','J06','J18','J19','J20','J21','J22','J35','J36','R11','R50','R53','R56','R58','T81','Z48','E89.8','E8.99','J95.8','J95.9','K91.0','K91.8','K91.9','K92.0','R04.0','R07.0','T88.8','T88.9','Z03.8','Z03.9') • The readmission occurs within 15 days of the previous date of separation • The readmission is an acute admission (Care Type = 'U', '4', 'K')
Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following • Has any of the following procedure codes: 41789-00, 41801-00, 41789-01 • Is an acute separation (Care Type = 'U', '4', 'K') • Patient age is at most 14 years • LOS <= 30 patient days • Excludes in-hospital deaths (Separation Mode = 'D')
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Indicator	**Unplanned readmission for heart failure**
Description	Unplanned readmissions to the same hospital within 30 days of patients' separation, for management of heart failure.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following The separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) Has a principal diagnosis code(i.e. the readmission) of I50 The readmission occurs within 30 days of the previous date of separation The readmission is an acute admission (Care Type = 'U', '4', 'K') Admission Type of admission is 'emergency' ('O', 'C') Excludes transfers from other campuses (Admission Source = 'T')

Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following Has an ICD-10-AM principal diagnosis code of I50 Is an acute separation (Care Type = ‘U’, ‘4’, ‘K’) Patient age is between 30-89 years (inclusive)Admission Type of admission is ‘emergency’ (‘O’, ‘C’) Excludes transfers in and transfers out (Admission Source or Separation Mode = ‘T’) LOS is between 1-30 patient days (inclusive) Excludes in-hospital deaths (Separation Mode = ‘D’) Patient must have spent at least one night in hospital (i.e. non-same day patient)
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Indicator	Unplanned readmission of mother after birth
Description	This indicator measures potentially preventable readmission of mother within 28 days of discharge from birthing episode admission. While not all unplanned readmissions following birth can be prevented, it is unusual that women and babies need to return to hospital for further treatment. Unplanned readmissions represent a deviation from the normal course of post-natal recovery. This measure looks at the quality of intrapartum and/or postnatal care including how effective care is transferred between acute hospital and community based care (e.g. maternal and child health services). It serves as a trigger for health services to develop systems that explore factors influencing results. Preliminary evidence suggests that higher readmission rates are associated with inconsistent discharge procedures, poorer post-natal care and limited support in community. Effective transition and ongoing care relies on careful planning and a tailored response to meet the needs of individual mother and their babies.
Calculating performance	The measure is calculated for the hospital that provided postnatal care prior to discharge. It includes admissions to any Victorian health service after birth, not just a readmission to the birthing suite. Data is collected at campus level. Includes only mothers who received postnatal care before discharge. Reporting thresholds >=10 cases in the denominator. Results are assessed and reported quarterly and expressed as percentage. Outlier status (above 99.7% CI) assessed against state-wide rates. Data lagged by two quarters. Because of the unavoidable time lag between data submission and performance reporting, health services should regularly review their own re-admission performance and use these results to supplement evaluation to best practice and peer-group benchmarking. Improvement is compared to prior quarter performance.

Numerator	The number of episodes with live births meeting the denominator that were readmitted within 28 days of discharge and where at least one of the following maternal readmission diagnosis codes is found anywhere in the diagnosis string of the readmission episode. **Maternal readmission diagnosis codes:** • Delayed & sec postpartum haemorrhage (ICD10 Code O722) • Infection of obstetric surgical wound (ICD10 Code O860) • Puerperal sepsis (ICD10 Code O85) • Nonpurulent mastitis wo atchmt difficult (ICD10 Code O9120) • Fitting and adjustment of urinary device (ICD10 Code Z466) • Spinal epidural headache during puerp (ICD10 Code O894) • Disruption of perineal obstetric wound (ICD 10 Code O90) • Pre-eclampsia unspecified (ICD10 Code O149) • Unspecified maternal hypertension (ICD10 Code O16) • Anm comp brth & puerp (ICD10 Code O9903) • Retained portion placenta & memb wo haem (ICD10 Code O731) • Other immediate postpartum haemorrhage (ICD10 Code O721) • Haematoma of obstetric wound (ICD10 Code O902) • Urinary tract infectn following delivery (ICD10 Code O862) • Disruption of caesarean section wound (ICD10 Code O900) • Care and examination of lactating mother (ICD10 Code Z391) • Gestational H/T (ICD10 Code O13) • Urinary tract infection site not spec (ICD10 Code N390) • Nonpurulent mastitis w atchmt difficulty (ICD10 Code O9121) • Sev ment & beh disrd ass w puerp NEC(ICD10 Code F531) • Mild ment & beh disrd ass w puerp NEC (ICD10 Code F530) • Oth reaction to spinal & lumbar puncture (ICD10 Code G971) • Fever unspecified (ICD10 Code R509) • Retention of urine (ICD10 Code R33) • Eclampsia in the puerperium (ICD10 Code O152) • Third-stage haemorrhage (ICD10 Code O720)
Denominator	The number of episodes with live births that either received postnatal care or were separated into an episode (including transfers) with postnatal care.
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Indicator	Unplanned readmission of newborn after birth
Description	This measure calculates potentially preventable readmission of newborn within 28 days of discharge from birthing episode admission.
Calculating performance	Calculated for the hospital that discharged the newborn episode. Includes admissions to any Victorian health service after birth, not just a readmission to the birthing suite. Data is collected at campus level. Reporting thresholds >=10 cases in the denominator. Results are analysed, reported quarterly and expressed as a percentage. Outlier status (above 99.7% CI) assessed against state-wide rates. Data lagged by two quarters. Improvement is compared to prior quarter performance.
Numerator	The number of birth episodes discharged home that have been readmitted within 28 days of discharge and where at least one of the following neonate readmission diagnosis codes is found anywhere in the diagnosis string of the readmission episode. **Neonate readmission diagnosis codes:** • Neonatal jaundice unspecified (ICD10 Code P599) • Abnormal weight loss (ICD10 Code R634) • Feeding problem of newborn unspecified (ICD10 Code P929) • Oth lack normal physiological devt (ICD10 Code R628 • Bacterial sepsis of newborn unspecified (ICD10 Code P369) • Other feeding problems of newborn (ICD10 Code P928) • Neonatal jaundice w preterm delivery (ICD10 Code P590) • Neonatal jaundice from oth spec causes (ICD10 Code P598) • Oth pret infnt >=32 but <37 compl wk (ICD10 Code P0732) • ABO isoimmunisation of fetus and newborn (ICD10 Code P551) • Obs newb for suspect infectious cond (ICD10 Code Z0371) • Apnoea of newborn, unspecified (ICD10 Code P2840) • Cyanotic attacks of newborn (ICD10 Code P282) • Enteroviral meningitis (ICD10 Code A870) • Omphalitis newborn w or wo mild haem (ICD10 Code P38) • Dehydration of newborn (ICD10 Code P741) • Hypothermia of newborn unspecified (ICD10 Code P809) • Convulsions of newborn (ICD10 Code P90)
Denominator	The number of birth episodes that have been discharged home.
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status).

Mental Health

Indicator	**Percentage of adult mental health inpatients who are readmitted within 28 days of discharge**	
Description	Adult specialist mental health services are aimed primarily at people with a serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder. Readmission rates for adult mental health patients can reflect the quality of care, effectiveness of discharge planning and level of support provided to patients after discharge, as well as other factors.	
Calculating performance	This indicator includes adult mental health patients who are admitted overnight or longer in hospital. Exclusions are overnight separations for electroconvulsive therapy (ECT), transfers to other acute hospitals or to residential aged care, and patients who leave against medical advice or abscond. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Non-same day separations from adult general acute psychiatric inpatient units that result in a non-same-day readmission to the same or to another public sector acute psychiatric inpatient unit within 28 days of discharge	
Denominator	Number of non-same-day separations from adult general acute psychiatric inpatient units	
Statewide target	≤14%	
Achievement	Less than or equal to 14%	Achieved
	Greater than 14%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The 28-day lag inherent in the indicator means that reporting is lagged by one month. For example, quarter 2 will report the mental health results for separations occurring in the period September to November 2017 Performance is reported for the periods: • 1 June to 31 August 2017 in quarter 1 • 1 September to 30 November 2017 in quarter 2 • 1 December 2017 to 28 February 2018 in quarter 3 • 1 March to 31 May 2018 in quarter 4. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.	

Indicator	**Rate of seclusion events relating to a mental health acute admission – all age groups**	
Description	Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in adult acute inpatient units in Victoria. This indicator is to measure any period of seclusion relating to an acute admission.	
Calculating performance	This indicator is a composite comprising: adult mental health services; child and adolescent mental health services (CAMHS); and aged acute inpatient services provided by public mental health services. It includes adult, CAMHS and aged acute admissions as well as patients at ORYGEN Youth Health Melbourne Clinic campus. Occupied bed days are calculated where the admission event type is one of the following: • SA (statistical admission) • R (return from leave) • A (admission – formal) • T (ward transfer). • Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each adult acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to an adult acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000.	
Numerator	Adult, CAMHS and aged acute seclusion events during the reference period	
Denominator	Total adult, CAMHS aged acute occupied bed days during reference period	
Statewide target	≤15 seclusions per 1,000 bed days (< 15/1,000)	
Achievement	Less than or equal to 15/1,000	Achieved
	Greater than 15/1,000	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. Performance is monitored quarterly for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 • 1 April to 30 June 2018 in quarter 4. In addition to quarterly monitoring, a performance result is generated annually based on the full year data.	

Indicator	**Rate of seclusion events relating to a child and adolescent acute mental health admission**	
Description	Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in child and adolescent mental health service (CAMHS) acute inpatient units in Victoria. This indicator is to measure any period of seclusion relating to a child or adolescent acute admission.	
Calculating performance	This indicator comprises CAMHS acute inpatient services provided by public mental health services and includes all CAMHS acute admissions. Occupied bed days are calculated where the admission event type is one of the following: • SA (statistical admission) • R (return from leave) • A (admission – formal) • T (ward transfer). • Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each CAMHS acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to a CAMHS acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. CAMHS clients are identified by program type.	
Numerator	CAMHS acute seclusion events during the reference period	
Denominator	Total CAMHS acute occupied bed days during the reference period	
Statewide target	≤15 seclusions per 1,000 bed days (< 15/1,000)	
Achievement	Less than or equal to < 15/1,000	Achieved
	Greater than > 15/1,000	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 • 1 April to 30 June 2018 in quarter 4. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The data source is CMI/ODS.	

Indicator	**Rate of seclusion events relating to an adult acute mental health admission**	
Description	Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in adult acute inpatient units in Victoria. This indicator is to measure any period of seclusion relating to an adult acute admission.	
Calculating performance	This indicator comprises adult acute inpatient services provided by public mental health services and includes adult acute admissions as well as patients at ORYGEN Youth Health Melbourne Clinic campus. Occupied bed days are calculated where the admission event type is one of the following: • SA (statistical admission) • R (return from leave) • A (admission – formal) • T (ward transfer). • Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each adult acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to an adult acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. Improvement is compared to previous quarter performance.	
Numerator	Adult acute seclusion events during the reference period	
Denominator	Total adult acute occupied bed days during the reference period	
Statewide target	≤15 seclusions per 1,000 bed days (< 15/1,000)	
Achievement	Less than or equal to 15/1,000	Achieved
	Greater than > 15/1,000	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 • 1 April to 30 June 2018 in quarter 4. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.	

Indicator	**Rate of seclusion events relating to an aged acute mental health admission**	
Description	Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in aged acute inpatient units in Victoria. This indicator is to measure any period of seclusion relating to an aged acute admission.	
Calculating performance	This indicator comprises aged acute inpatient services provided by public mental health services and includes all aged acute admissions. Occupied bed days are calculated where the admission event type is one of the following: SA (statistical admission) R (return from leave) A (admission – formal) T (ward transfer). Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each aged acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to an aged acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. Aged clients are identified by the type of admission.	
Numerator	Aged acute seclusion events during the reference period	
Denominator	Total aged acute occupied bed days during the reference period	
Statewide target	≤15 seclusions per 1,000 bed days (< 15/1,000)	
Achievement	Less than or equal to < 15/1,000	Achieved
	Greater than > 15/1,000	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly for the periods: 1 July to 30 September 2017 in quarter 1 1 October to 31 December 2017 in quarter 2 1 January to 31 March 2018 in quarter 3 1 April to 30 June 2018 in quarter 4. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.	

Indicator	**Percentage of child and adolescent mental health inpatients with post-discharge follow-up within seven days**	
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at a national level.	
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care. Separations are counted against the mental health area (catchment campus) of the client, rather than the campus of separation. The separation type is 'home' and patients must be admitted overnight or longer in hospital. Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service. Child and adolescent mental health service (CAMHS) clients are identified by admission type in the Client Management Interface (CMI) system. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Number of post-discharge follow-ups within seven days	
Denominator	Total non-same-day acute mental health CAMHS separations to a private residence	
Statewide target	≥75%	
Achievement	Greater than or equal to 75%	Achieved
	Less than 75%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then separations from 24 June 2017 to 24 September 2017 are included. Results are reported for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 • 1 April to 30 June 2018 in quarter 4. The data source for this indicator is the CMI, which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.	

Indicator	**Percentage of adult mental health patients who have post-discharge follow-up within seven days**	
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at the Commonwealth level.	
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care. The separation type is home and patients must be admitted overnight or longer in hospital. Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service. This indicator is expressed as a percentage of post-discharge follow-ups on the total number of non-same-day acute adult separations. This indicator is rounded to the nearest whole number.	
Numerator	Number of post-discharge follow-ups within seven days	
Denominator	Total non-same-day acute mental health adult separation to a private residence or accommodation	
Statewide target	≥75%	
Achievement	Greater than or equal to 75%	Achieved
	Less than 75%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then separations from 24 June 2017 to 24 September 2017 are included. Performance is reported for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 1 April to 30 June 2018 in quarter 4. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.	

Indicator	**Percentage of aged mental health inpatients who have post-discharge follow-up within seven days**	
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at the Commonwealth level.	
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care. The separation type is home or residential aged care and patients must be admitted overnight or longer in hospital. Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service. This indicator is expressed as a percentage of post-discharge follow-ups on the total number of non-same-day acute aged separations. Aged clients are identified by the type of admission. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Number of post-discharge follow-ups within seven days	
Denominator	Total non-same-day acute mental health aged separations to a private residence or accommodation	
Statewide target	≥75%	
Achievement	Greater than or equal to 75%	Achieved
	Less than 75%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then separations from 24 June 2017 to 24 September 2017 are included. Performance is reported for the periods: • 1 July to 30 September 2017 in quarter 1 • 1 October to 31 December 2017 in quarter 2 • 1 January to 31 March 2018 in quarter 3 • 1 April to 30 June 2018 in quarter 4. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.	

Maternity and Newborn

Indicator	**Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes**	
Description	This indicator measures the wellbeing of babies at birth. It is used as a proxy for the quality of intrapartum care and neonatal resuscitation, where necessary, following birth. Singleton infants who are more than 37 weeks gestation and without congenital anomalies are expected to be born in good condition, show healthy physiological adaption to birth and not require significant resuscitation measures. The Apgar score is an assessment of a newborn's wellbeing at birth based on five physiological attributes at one and five minutes (and longer if applicable): colour (circulation), breathing, heart rate, muscle tone and reflexes. It is a verified measure of adverse long-term outcomes in infants and correlates highly with Victorian Managed Insurance Authority claims within the first year of life. This indicator excludes infants born at less than 37 weeks gestation, infants born with congenital anomalies, multiple births and stillbirths.	
Calculating performance	An Apgar score <7 at five minutes indicates an infant who requires significant or ongoing resuscitation measures or additional care that may be due to avoidable factors during labour and childbirth and/or the immediate resuscitation measures at birth. It may also indicate sub-optimal triaging and/or management of higher complexity pregnancies. Health services should ensure there are adequate mechanisms to capture, review and report on adverse intrapartum and neonatal resuscitation events and outcomes. This includes multidisciplinary reviews of low Apgar events and outcomes to identify areas of clinical practice or system improvement.	
Numerator	The number of singleton, liveborn, term infants without congenital anomalies with an Apgar score < 7 at five minutes	
Denominator	The number of singleton, liveborn term infants without congenital anomalies	
Statewide target	≤1.6%	
Achievement:	Less than or equal to 1.6%	Achieved
	Greater than 1.6%	Not achieved
Improvement	Improvement is assessed against previous quarter performance.	

Frequency of reporting and data collection	Data for this indicator is derived from the Victorian Perinatal Data Collection (VPDC) and lagged by one quarter. Due to low numbers of births at some health services, this measure is calculated using a rolling two quarter data reporting period. Results are reported quarterly at campus level, using two quarters rolling data, with one quarter lag time. For example, Q1 2017-18 result will report on data from Q3 and Q4 2016-17(combined). Results are not reported where minimum threshold of >=10 case in denominator is not achieved. Data is required to be submitted by health services monthly. All data reported to the VPDC is due within 30 days. Health services are required to submit VPDC data for the previous month by the end of the following month. (This may mean that a birth may take up to 60 days to be reported by a health service if it occurred at the start of the month).

Indicator	**Rate of Severe foetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks**	
Description	The purpose of this indicator is to identify the proportion of severely growth-restricted singleton babies who were not born by 40 weeks' gestation. A baby is considered to be severely growth restricted when their birthweight is below the third centile for gestation, sex and plurality. Severe fetal growth restriction is associated with an increased risk of perinatal mortality and morbidity, admission to a special care nursery or neonatal intensive care unit, and long term health consequences. The risk of mortality for a severely growth-restricted baby increases as the pregnancy advances. It should therefore be identified early in pregnancy for appropriate medical management and delivery before 40 weeks' gestation. Severe fetal growth restriction closely correlates with adverse outcomes at one year of age and Victorian Managed Insurance Authority claims within one year of birth.	
Calculating performance	The rate of sever FGR in singleton babies who were not born by 40 weeks' gestation has been chosen as the performance indicator for quality of antenatal care. FGR can be difficult to diagnose and health services should monitor their rates at regular intervals and aim to review these cases to understand why they had not been detected or managed. This indicator excludes all babies without severe FGR and multiple births.	
Numerator	Birth at 40 or more weeks gestation of a singleton baby with severe FGR	
Denominator	All singleton births (live and stillborn) with severe FGR	
Statewide target	≤28.6%	
Achievement:	Equal to or less than 28.6%	Achieved
	Greater than 28.6%	Not achieved
Improvement	Improvement is assessed against previous quarter performance.	
Frequency of reporting and data collection	Data for this indicator will be derived from the Victorian Perinatal Data Collection (VPDC). Data is lagged by one quarter. This indicator is reported quarterly at campus level, with one quarter lag time Results are not reported where minimum threshold of >=10 case in denominator is not achieved. Data is required to be submitted by health services monthly. All data reported to the VPDC is due within 30 days. Health services are required to submit VPDC data for the previous month by the end of the following month. (This may mean that a birth may take up to 60 days to be reported by a health service if it occurred at the start of the month).	

Aboriginal Health

Indicator	**Perinatal mortality rate per 1000 of babies of Aboriginal mothers, using rolling 3 year average (unit: rate per 1,000 – 3 years rolling average)**	
Description	Perinatal mortality reflects the health status and health care of the general population, access to and quality of preconception, reproductive, antenatal and obstetric services for women, and health care in the neonatal period. This indicator measures changes in babies of Aboriginal mothers perinatal mortality over time.	
Calculating performance	The Perinatal Mortality Rate (PMR) is calculated as the number of stillbirths and neonatal deaths in babies of Aboriginal mothers per 1,000 total births (stillbirths and live births). The rate refers to all births of at least 20 weeks gestation or, if gestation is unknown, of birth weight of at least 400 g to Aboriginal mothers. It excludes terminations due to maternal psychosocial indication.	
Numerator	Stillbirths and neonatal deaths in babies of Aboriginal mothers.	
Denominator	Total births (stillbirths and live births) in babies of Aboriginal mothers. The rate is reported by 1,000 total births	
Statewide target	Less than or equal to 13.6 per 1,000 total births	
Achievement	≤13.6/1,000	Achieved
	Greater than 13.6/1,000	Not achieved
Improvement	Improvement will be compared to previous year results.	
Frequency of reporting and data collection	This indicator is systematically collected and reported since 2001 by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) The rate is calculated triennially due to very small numbers. Results are reported annually as three year rolling average.	

Indicator	Smoking cessation in Aboriginal mothers	
Description	Smoking in pregnancy is a preventable cause of significant obstetric and perinatal complications and adverse outcomes. Pregnancy is therefore an important time for health professionals to implement strategies and interventions to help women quit smoking. This indicator indirectly assesses the performance of health services in providing smoking cessation advice, assistance and follow-up during the antenatal period to reduce both the rate of smoking among pregnant Aboriginal mothers and the risk of smoking-associated adverse health outcomes for their babies.	
Calculating performance	This indicator measures the rate of Aboriginal women who smoked after 20 weeks gestation as compared to before 20 weeks gestation. The 'smoking cessation rate' represents the relative reduction between these two rates. It reflects the effectiveness of smoking cessation interventions offered. All Aboriginal women giving birth in public and private hospitals and homebirths will be included.	
Numerator	The difference between the rate of Aboriginal women who smoked before 20 weeks' gestation and the rate of Aboriginal women who smoked after 20 weeks' gestation	
Denominator	Rate of Aboriginal women who smoked before 20 weeks' gestation The rate is expressed as a percentage.	
Statewide target	>=37.6%	
Achievement	Equal to or above 37.6%	Achieved
	Below 37.6%	Not achieved
Improvement	Improvement is assessed against previous quarter performance.	
Frequency of reporting and data collection	The data is collected by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) in the Victorian Perinatal Data Collection (VPDC) on a monthly basis. Performance is assessed and reported quarterly. Results are not reported where minimum threshold of >=10 case in denominator is not achieved.	

Continuing Care

FIM Efficiency

Description	The Functional Independence Measure (FIM™) instrument is a basic indicator of patient disability. FIM™ is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation or Geriatric Evaluation and Management (GEM) care. FIM™ is comprised of 18 items, grouped into 2 subscales - motor and cognition; each of which is assessed against a seven point ordinal scale, where the higher the score for an item, the more independently the patient is able to perform the tasks assessed by that item. Total scores range from 18 to 126. A low FIM™ score is a good indicator of need for subacute bed based care due to reduced function. Equally, a higher FIM™ admission score may indicate that care through the Health Independence Program may be as effective in meeting the patient's needs.
Calculating performance	FIM™ efficiency is measured by the difference between FIM™ on discharge and FIM™ on admission divided by the number of days of the episode of care. This indicator applies to all health services providing subacute care (rehabilitation and/or GEM). Excludes palliative care, non-acute care and paediatric rehabilitation. Performance is calculated separately as individual scores for GEM and rehabilitation.
Improvement	Improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Data extracted from VAED and reported monthly with a one month lag. Results are reported at health service level.

Indicator	**Rehabilitation**	
Numerator	Total FIM score on discharge minus total FIM™ score on rehabilitation admission	
Denominator	Length of episode stay per rehabilitation stream	
Statewide target	≥ 0.645	
Achievement	Equal to or above 0.645	Achieved
	Below 0.645	Not achieved

Indicator	**Geriatric Evaluation and Management**	
Numerator	Total FIM score on discharge minus total FIM™ score on GEM admission	
Denominator	Length of episode stay per GEM service stream	
Statewide target	≥ 0.39	
Achievement	Equal to or above 0.39	Achieved

	Below 0.39	Not achieved

Ambulance services

Indicator	**Percentage of emergency patients satisfied or very satisfied with the quality of care provided by paramedics**	
Description	Thisindicator is measured by the Council of Ambulance Authorities (CAA The CAA conducts an annual survey to measure the service quality and satisfaction ratings of ambulance services. The patient satisfaction measure is reported annually in the *Report on Government Services*. This indicator measures the proportion of emergency patients satisfied or very satisfied with the quality of care provided by the attending paramedics.	
Calculating performance	This indicator is measured by randomly selecting a sample of at least 1,300 (Code 1 and 2) patients transported within two months of the sampling date. A review is performed to ensure that the percentage of samples in each Victorian region is similar to the percentage of transports performed in each region. To avoid the risk of distressing family members or carers, known deceased patients, cardiac arrest patients and children aged under five years are excluded from the random selection process. Data is collected by Ambulance Victoria and submitted to the CAA. Performance results are based on the findings of the CAA annual survey and exclude nil/don't know responses. This indicator is expressed as a percentage to one decimal place.	
Numerator	Number of completed surveys from Code 1 and 2 patients who were satisfied or very satisfied when answering the question: 'How satisfied were you overall with your last experience using the Ambulance service?'	
Denominator	Total number of completed surveys excluding nil/don't know responses	
Statewide target	95%	
Achievement	Equal to or greater than 95%	Achieved
	Less than 95%	Not achieved
Improvement	Improvement is compared to previous year performance.	
Frequency of reporting and data collection	Performance is monitored annually. Data is submitted to the department annually from Ambulance Victoria.	

Indicator	**Percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly**	
Description	Adequate relief of pain is one of a series of key measures of the clinical effectiveness of interventions by paramedics. The indicator of the proportion of patients experiencing severe cardiac or traumatic pain, whose level of pain is significantly reduced, focuses the attention of the organisation on the effectiveness of clinical interventions in two common areas of service provision – cardiac care and trauma care. Assessment of pain severity and the extent of relief that paramedics can provide is central to the provision of appropriate care. This indicator applies to patients of all ages experiencing traumatic pain and patients who are 15 years old or older with cardiac pain.	
Calculating performance	This indicator measures the difference between the initial pain score and the final pain score according to Ambulance Victoria (clinical practice guidelines. Patients experiencing severe pain are defined as those having an initial pain score of 8 or more, with pain measured out of 10. A patient is deemed to have had a significant reduction in pain if the difference between their initial and final pain score is 2 or more. This indicator excludes: patients with a Glasgow Coma Score < 9; intubated patients; patients unable to rate pain; patients who have < 2 recorded pain scores and patients who refuse analgesia. This indicator is expressed as a percentage to one decimal place.	
Numerator	Total number of adult cardiac, adult trauma and paediatric trauma patients with an initial pain score assessed as 8 or more experiencing a reduction in score of 2 or more	
Denominator	Total number of adult cardiac, adult trauma and paediatric trauma patients with an initial pain score assessed as 8 or more	
Statewide target	90%	
Achievement	Equal to or greater than 90%	Achieved
	Less than 90%	Not achieved
Improvement	Improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored quarterly. Data is submitted to the department quarterly from Ambulance Victoria.	

Indicator	**Percentage of acute adult stroke patients transported to definitive care within 60 minutes**	
Description	The early recognition of stroke symptoms and the timing and the destination to which patients are transported are critical to ensuring optimal outcomes for stroke patients. This indicator is a measure of ambulance response to adult patients (15 years or older) suspected of having a stroke within the last six hours who are transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis. A list of health services providing thrombolysis for stroke patients can be found at HealthVic statewide frameworks for acute stroke services <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-networks/clinical-network-stroke/stroke-statewide-frameworks>	
Calculating performance	This indicator excludes inter-hospital transfers, patients with an estimated stroke onset of greater than six hours, patients with significant pre-existing disability or dependent on others for daily living. This indicator is expressed as a percentage to one decimal place.	
Numerator	Total number of adult patients suspected of having a stroke and meeting the above criteria who were transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis.	
Denominator	Total number of adult patients suspected of having a stroke and meeting the above criteria	
Statewide target	90%	
Achievement	Equal to or greater than 90%	Achieved
	Less than 90%	Not achieved
Improvement	Improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored quarterly. Data is submitted to the department quarterly from Ambulance Victoria.	

Indicator	**Percentage of major trauma patients that meet destination compliance**	
Description	Mortality and morbidity can be reduced by effective field triage, treatment and transport of severely injured patients to specialised trauma hospitals. This indicator is a measure of ambulance response to patients defined as major trauma who are transported to a major trauma service or to the highest level designated trauma service within 45 minutes of the ambulance departing the scene. Major trauma patients are defined by the Victorian State Trauma Registry, and this process relies on hospital diagnostic procedures, and in hospital treatment data which causes a lag of one quarter for all data.	
Calculating performance	This indicator excludes inter-hospital transports and patients not meeting the AV Trauma Triage Guidelines. This indicator is expressed as a percentage to one decimal place.	
Numerator	Total number of major trauma patients transported to a major trauma service or to the highest level designated trauma service within 45 minutes travel time (from scene)	
Denominator	Number of patients defined as major trauma	
Statewide target	85%	
Achievement	Equal to or greater than 85%	Achieved
	Less than 85%	Not achieved
Improvement	Improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored quarterly. Data reported is lagged by one quarter. Data is submitted to the department quarterly from Ambulance Victoria.	

Indicator	Percentage of adult cardiac arrest patients surviving to hospital	
Description	Cardiac arrest survival is strongly impacted by Emergency Medical Services (EMS) response times, clinical interventions and treatments. The cardiac arrest survival to hospital rate describes the percentage of adult patients in out-of-hospital cardiac arrest, that initially present in a shockable rhythm where any chest compressions and/or defibrillation was undertaken by ambulance/EMS (fire brigade first responders, community emergency response teams or ambulance) or where defibrillation was performed by a public access defibrillator (PAD) and who have a return to spontaneous circulation (palpable pulse) on arrival at hospital. Data is collected and reported according to the internationally recognised Utstein template and definitions. The Victorian Ambulance Cardiac Arrest Registry captures data on all out-of-hospital cardiac arrest patients attended by EMS in Victoria. This indicator applies to adult patients (15 years or older) who are in ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) on EMS arrival for whom resuscitation is commenced (minimum is cardiopulmonary resuscitation) by EMS.	
Calculating performance	This indicator applies to adult patients who are in VF/VT on EMS arrival for whom resuscitation is commenced by EMS or patients defibrillated by PAD. Excludes cardiac arrests witnessed by EMS and patients where vital signs at hospital are unknown. This indicator is expressed as a percentage to one decimal place.	
Numerator	The number of adult VF/VT cardiac arrest patients with a palpable pulse on arrival at hospital	
Denominator	The total number of adult VF/VT cardiac arrest patients meeting the criteria	
Statewide target	50%	
Achievement	Equal to or greater than 50%	Achieved
	Less than 50%	Not achieved
Improvement	Improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored quarterly using 12-months rolling percentages due to small sample sizes. Data is submitted to the department quarterly from Ambulance Victoria.	

Indicator	**Percentage of adult cardiac arrest patients surviving to hospital discharge**	
Description	Cardiac arrest survival is strongly impacted byEmergency Medical Services (EMS) response times, clinical interventions and treatments. Data is collected and reported according to the internationally recognised Utstein template. The Victorian Ambulance Cardiac Arrest Registry captures data on all out-of-hospital cardiac arrest patients attended by EMS in Victoria. This indicator applies to adult patients (15 years or older) who were in ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) on EMS arrival for whom resuscitation was commenced by EMS or who were defibrillated via public access defibrillator (PAD).	
Calculating performance	This indicator applies to adult patients who were in VF/VT on EMS arrival for whom resuscitation was commenced by EMS or patients defibrillated by PAD. Excludes cardiac arrests witnessed by EMS and patients where discharge status is unknown. This indicator is expressed as a percentage to one decimal place.	
Numerator	The number of adult VF/VT cardiac arrest patients discharged alive from hospital	
Denominator	The total number of adult VF/VT cardiac arrest patients meeting the criteria	
Statewide target	25%	
Achievement	Equal to or greater than 25%	Achieved
	Less than 25%	Not achieved
Improvement	Improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored quarterly using 12-month rolling percentages. Data is submitted to the department quarterly from Ambulance Victoria.	

Strong Governance, leadership and culture

Organisational culture

Description	Organisational culture can significantly influence patient safety through its impact on effective communication, collaboration and engagement across the health service. Poor safety cultures have been identified internationally as recurring features of serious failings in care. Organisational culture surveys (such as the People Matter survey) offer an independent mechanism of assessing staff's anonymous perception of safety within the organisation. As of 2017, all Victorian public healthcare organisations must participate in the People Matter survey annually. While staff participation in the survey is voluntary, low participation rates can generate misleading results or signal staff engagement concerns.
Calculating performance	The survey includes eight questions that specifically assess health service staff perspectives about the safety culture of the organisation. For the overall response measure, performance is based on a composite score of the eight safety culture agreement questions and expressed as the percentage of staff responses that either 'agree' or 'strongly agree' with each question. Performance against each of the eight individual safety questions is also measured by assessing the percentage of staff responses that either 'agree' or 'strongly agree' with each question. Denominator excludes "Neither agree or disagree" and "Don't know" responses.
Improvement	Improvement for any of the People Matter survey related measures is assessed against the previous year result.
Frequency of reporting and data collection	Performance is monitored and assessed annually. These indicators measure performance at the health service level. The data source for this measure is the Victorian Public Sector Commission. Health services receive a report on their results and are also benchmarked against other like healthcare organisations. Data is submitted to the department by 31 August 2017 and reported in quarter 1.

Indicator	**Percentage of staff with an overall positive response to safety culture question in People Matter survey**	
Numerator	The number of 'agree' or 'strongly agree' responses to each of the eight safety culture questions in the health service's People Matter survey	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to each of the eight safety culture questions in the health service's People Matter survey	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	**I am encouraged by my colleagues to report any patient safety concerns I may have**	
Numerator	The number of ‘agree’ or ‘strongly agree’ responses to the People Matter survey question: I am encouraged by my colleagues to report any patient safety concerns I may have	
Denominator	The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’ responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	**Patient care errors are handled appropriately in my work area**	
Numerator	The number of ‘agree’ or ‘strongly agree’ responses to the People Matter survey question: Patient care errors are handled appropriately in my work area	
Denominator	The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’ responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	**My suggestions about patient safety would be acted upon if I expressed them to my manager**	
Numerator	The number of ‘agree’ or ‘strongly agree’ responses to the People Matter survey question: My suggestions about patient safety would be acted upon if I expressed them to my manager	
Denominator	The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’ responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	Management is driving us to be a safety-centred organisation	
Numerator	Percentage of staff with a positive response to the safety culture question: Management is driving us to be a safety-centred organisation	
Denominator	The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’ responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	The culture in my work area makes it easy to learn from the errors of others	
Numerator	The number of ‘agree’ or ‘strongly agree’ responses to the People Matter survey question: The culture in my work area makes it easy to learn from the errors of others	
Denominator	The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’ responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	This health service does a good job of training new and existing staff	
Numerator	Percentage of staff with a positive response to the safety culture question: This health service does a good job of training new and existing staff	
Denominator	The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’ responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	Trainees in my discipline are adequately supervised	
Numerator	Percentage of staff with a positive response to the safety culture question: Trainees in my discipline are adequately supervised	
Denominator	The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’ responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	I would recommend a friend or relative to be treated as a patient here	
Numerator	Percentage of staff with a positive response to the safety culture question: I would recommend a friend or relative to be treated as a patient here	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator	Percentage of staff who responded to the People Matter Survey	
Numerator	Number of staff who responded to the People Matter Survey	
Denominator	Total number of staff who could have participated in the survey	
Statewide target	30%	
Achievement	Equal to or greater than 30%	Achieved
	Less than 30%	Not achieved

Indicator	Bullying	
Description	Relates to the People Matter survey question: Have you personally experienced bullying at work in the last 12months'? This measure aims to identify bullying risks within the organisation. A target is not applied as no staff should be experiencing bullying. The risk flag should trigger further attention to potential bullying concerns within the organisation.	
Numerator	The responses 'yes but not currently experiencing it' and 'Yes and currently experiencing it' are counted for the numerator	
Denominator	All responses to the People Matter survey are included in denominator	
Risk Flag	20%	
Achievement	Less than 20%	Achieved
	Equal to or over 20%	Not achieved

Indicator	Learner's experience
Description	**Learner perceptions about their feeling of safety and wellbeing as identified through the Best Practice Clinical Learning Environment (BPCLE) Framework**
Calculating performance	The Best Practice Clinical Learning Environment (BPCLE) Framework is a guide for health and human services organisations, in partnership with education providers, to coordinate and deliver high-quality training for learners. The BPCLE Framework and supplementary resources are available from HealthVic Best Practice Clinical Learning Environment (BPCLE) <https://www2.health.vic.gov.au/health-workforce/education-and-training/building-a-quality-health-workforce/bpcle-framework> Results obtained through BPCLE Framework can provide additional context to potential safety culture or bullying concerns within the organisation. For 2017-18, the Victorian Health Services Performance Monitoring Framework prescribes no specific performance targets for BPCLE Framework related measures. Health service performance will however be assessed against key risk flags associated with the three components of the BPCLE Framework (Indicator 23): • Learner perceptions of their safety • Learner perceptions of their own wellbeing • Learner experience/awareness of bullying. Each of these components will be assessed as individual measures to ascertain if there are potential safety and wellbeing vulnerabilities pertaining to students and other learners employed by health services. Each of these measures apply to three learner levels: • Professional entry (formerly 'undergraduate') – defined as learners enrolled in a higher education course of study leading to initial registration for, or qualification to, practice as a health professional. • Early graduate – An individual who has completed their entry-level professional qualification within the last one or two years. For example, this will encompass: – Junior doctors employed in pre-vocational positions for postgraduate years 1 and 2 (PGY1 and PGY2) (also referred to as Hospital Medical Officers). – Registered Nurses and Midwives in Graduate Nurse (or Midwifery) Programs (GNP/GMP). – Enrolled Nurses (formerly 'Division 2') in their first year post-qualification. • Allied health professionals in their first two years post-qualification (generally employed at Grade 1 level). Where internship programs exist (e.g. Pharmacy), this would include the internship year and the first year post-internship. Vocational/postgraduate – defined as learners enrolled in formal programs of study, usually undertaken to enable specialty practice. Examples include registrars in specialist medical training programs; nurses and allied health professionals enrolled in Graduate Certificate, Graduate Diploma or Masters courses

Improvement	For the purpose of the risk assessment, improvement is calculated annually compared to previous year's survey results.
Frequency of reporting and data collection	Performance is assessed throughout the calendar year and reported annually at health service level. Data is submitted by health service as per the BPCLE Framework reporting requirements associated with the Training and Development Grant.

Indicator	**Percentage of learners feeling safe at the organisation**	
Numerator	The number of learners that rated their feeling of safety favourably (i.e. agree or strongly agree on the 5-point Likert scale of: strongly disagree – disagree – neither agree nor disagree – agree – strongly agree) to the statement: I feel safe at this organisation	
Denominator	The total number of learners that responded to the statement	
Risk Flag	80%	
Achievement	Over 80%	Achieved
	Equal to or under 80%	Not achieved

Indicator	**Percentage of learners having a sense of wellbeing at the organisation**	
Numerator	The number of learners that rate their sense of personal wellbeing favourably (i.e. agree or strongly agree on a 5-point Likert scale of strongly disagree – disagree – neither agree nor disagree – agree – strongly agree) to the statement: I had an overall sense of wellbeing while in this organisation	
Denominator	The total number of learners that responded to the statement	
Risk Flag	80%	
Achievement	Over 80%	Achieved
	Equal to or under 80%	Not achieved

Indicator	**Percentage of learners who reported experiencing or witnessing bullying at the organisation**	
Numerator	The number of learners that indicate a 'yes' answer to the statement: I personally experienced bullying or witnessed bullying of others in this organisation.	
Denominator	The total number of learners that responded to the statement	
Risk Flag	20%	
Achievement	Under 20%	Achieved
	Equal to or over 20%	Not achieved

Timely access to care

Emergency care

Indicator	Percentage of patients transferred from ambulance to ED within 40 minutes	
Description	Timely reception of ambulance patients in emergency departments (EDs) is essential to delivering responsive and safe emergency care, and good performance impacts positively on patient outcomes, patient flow in the ED and ambulance response times. This indicator monitors the percentage of patients who were transferred from paramedic care to hospital emergency care within 40 minutes of ambulance arrival. .	
Calculating performance	Ambulance patient transfer time is the total time from ambulance arrival at the hospital ('at destination time') to the physical transfer of the patient and handover of care to hospital staff ('ambulance handover complete'). This indicator captures the percentage of cases where ambulance patient transfer time is less than or equal to 40 minutes. This indicator includes patients who arrive by ambulance to the ED but excludes patients arriving by Non-Emergency Patient Transport. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).	
Numerator	Patients arriving by emergency ambulance who are transferred within 40 minutes to the ED	
Denominator	All patients arriving by emergency ambulance who are transferred to the ED	
Statewide target	90%	
Achievement	Greater than or equal to 90%	Achieved
	Less than 90%	Not achieved
Improvement	Improvement is calculated based on same time last year performance.	
Frequency of reporting and data collection	This indicator is measured at the campus level. Performance is monitored and assessed monthly. Quarterly and annual results are also generated. From 1 July 2016, this indicator will be calculated using data submitted by health services via the VEMD. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on VEMD data submission timelines.	

Indicator	**Percentage of triage category 1 emergency patients seen immediately**	
Description	Triage category 1 patients have a condition that is clinically assessed as immediately life threatening and requires immediate intervention. The clinical benchmark is 100 per cent due to the high clinical needs of patients. The aim of this indicator is to ensure the treatment of patients occurs within appropriate clinical benchmark times. All patients attending emergency departments (EDs) are triaged or assessed for urgency. The Australasian College of Emergency Medicine has identified five triage categories and defines the desirable time by when treatment should commence for patients in each category.	
Calculating performance	A patient is categorised as having been seen immediately if the time to treatment, as defined in the VEMD manual, is less than or equal to one minute. Time to treatment equals b – a, where: • 'a' is arrival date and time • 'b' is the date and time of the initiation of patient management (either by a doctor, a mental health practitioner or a nurse, whichever is earliest). • This indicator excludes those presentations with a departure status code of: • 10 – Left after advice regarding treatment options • 11 – Left at own risk without treatment • 30 – Referred to collocated clinic. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up). Improvement is calculated based on same time last year performance. **Performance breach notification:** If a category 1 ED patient was not seen immediately and the event has been verified and confirmed as accurate, the patient will be regarded as a breach for the purposes of performance and a departmental notification procedure must be initiated by the health service. For further details about the performance breach notification process, health services can refer to the 2017-18 PMF or by contacting their respective health service leads / regional manager.	
Numerator	Number of triage category 1 emergency patients seen immediately	
Denominator	Total number of triage category 1 emergency patients	
Statewide target	100%	
Achievement	Equal to 100%	Achieved
	Less than 100%	Not achieved

Frequency of reporting and data collection	Performance is monitored and assessed monthly. Quarterly and annual results are also generated. Data is submitted by health services via the VEMD. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on VEMD data submission timelines. This indicator is measured at the campus level.

Indicator	**Percentage of triage category 1 to 5 emergency patients seen within clinically recommended time**	
Description	All patients attending emergency departments (EDs) are triaged or assessed for urgency. The Australasian College of Emergency Medicine has identified five triage categories and defines the desirable time by when treatment should commence for patients in each category. The aim of this indicator is to ensure the treatment of patients occurs within appropriate clinical benchmark times.	
Calculating performance	A patient is categorised as having been seen within clinically appropriate time where the time to treatment is as defined in the VEMD manual. Time to treatment equals b – a, where: • 'a' is arrival date and time • 'b' is the date and time of the initiation of patient management (either by a doctor, a mental health practitioner or a nurse, whichever is earliest). • This indicator excludes those presentations with a departure status code of: • 10 – Left after advice regarding treatment options • 11 – Left at own risk without treatment • 30 – Referred to collocated clinic. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).	
Numerator	Number of triage category 1 to 5 emergency patients seen within desirable times	
Denominator	Total number of triage category 1 to 5 emergency patients	
Statewide target	80%	
Achievement	Greater than or equal to 80%	Achieved
	Less than 80%	Not achieved
Improvement	Improvement is calculated based on same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Quarterly and annual results are also generated. Data is expected to be submitted by health services via the VEMD. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on VEMD data submission timelines. This indicator is measured at the campus level.	

Indicator	**Percentage of emergency patients with a length of stay in the ED of less than four hours**	
Description	This indicator measures the effectiveness of hospital processes and patient flow. The measure aims to encourage more timely management of emergency department (ED) patients who are admitted to the hospital, referred to another hospital or discharged within four hours.	
Calculating performance	This indicator is measured at the campus level and excludes patients referred to a collocated clinic. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).	
Numerator	Number of patients with an ED length of stay of less than or equal to four hours (240 minutes).	
Denominator	Total number of patients presenting to the ED	
Statewide target	81%	
Achievement	Greater than or equal to 81%	Achieved
	Less than 81%	Not achieved
Improvement	Improvement is calculated based on same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Quarterly and annual results are also generated. Data is submitted by health services via the VEMD. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on VEMD data submission timelines.	

Indicator	**Number of patients with a length of stay in the ED greater than 24 hours**	
Description	This indicator measures the timely transfer of emergency patients to an inpatient bed or discharged home. It reflects the effectiveness of hospital patient flow processes and discharge planning.	
Calculating performance	This indicator is measured at the campus level and excludes patients whose status is dead on arrival. **Performance breach notification**: As of 2017, if a patient has exceeded 24hrs length of stay in ED and the event verified as accurate, the patient will be regarded as a breach for the purposes of performance and a departmental notification procedure must be initiated by the health service. For further details about the performance breach notification process, health services can refer to the 2017-18 PMF or by contacting their respective health service leads / regional manager.	
Numerator	Number of patients with an emergency department length of stay of greater than 24 hours (1,440 minutes), regardless of departure status code	
Statewide target	0 patients	
Achievement	0 patients	Achieved
	Greater than or equal to 1 patient	Not achieved
Improvement	Improvement is calculated based on same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Quarterly and annual results are also generated. Data is submitted by health services via the VEMD. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on VEMD data submission timelines.	

Elective surgery

Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients. Elective surgery services should be provided in accordance with the *Elective surgery access policy* (2009). HealthVic Surgical services <www.health.vic.gov.au/surgery/policies>.

Indicator	**Percentage of elective surgery patients admitted within clinically recommended time**	
Description	All elective surgery patients are allocated an urgency category that indicates the desirable timeframe for admissions due to their clinical condition. There are three urgency categories: • urgency category 1 patients – admission within 30 days is desirable • urgency category 2 patients – admission within 90 days is desirable • urgency category 3 patients – admission within 365 days is desirable. This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.	
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 and with a readiness status of R (ready for surgery) are used to assess this indicator. • A removal in the Elective Surgery Information System (ESIS) is counted when the reason for removal is either: • W – Admitted to the intended campus and has received the awaited procedure • S – Admitted to another campus arranged by ESAS and has received the awaited procedure • X – Admitted to another campus arranged by this campus/health service and has received the awaited procedure under other contract or similar arrangement • Y – Procedure received at intended campus, not planned at admission (excludes emergency admission) • M – Admitted to the intended campus or any campus with the health service and has received the awaited procedure as an emergency admission A broader range of removal codes is used for this indicator compared with the indicator that measures the number of patients admitted. This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up).	
Numerator	Number of patients admitted within clinically recommended timeframes, aggregated across all urgency categories	
Denominator	Total number of patients admitted	
Statewide target	94%	
Achievement	Greater than or equal to 94%	Achieved
	Less than 94%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	

Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted by health services via ESIS. Refer to *Department of Health and Human Services policy and funding guidelines 2017* for further information on ESIS data submission timelines.

Indicator	**Percentage of urgency category 1 elective surgery patients admitted within 30 days**	
Description	Urgency category 1 elective surgery patients are patients for whom admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it might become an emergency.	
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 and with a readiness status of R (ready for surgery) are used to assess this indicator. A removal in ESIS is counted when the reason for removal is either: • W – Admitted to the intended campus and has received the awaited procedure • S – Admitted to another campus arranged by ESAS and has received the awaited procedure • X – Admitted to another campus arranged by this campus/health service and has received the awaited procedure under other contract or similar arrangement • Y – Procedure received at intended campus, not planned at admission (excludes emergency admission) • M – Admitted to the intended campus or any campus with the health service and has received the awaited procedure as an emergency admission A broader range of removal codes is used for this indicator compared with the indicator that measures the number of patients admitted. This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up). This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used. **Performance breach notification** If a category 1 elective surgery patient is overdue and the event has been verified and confirmed as accurate, the patient will be regarded as a breach for the purposes of performance and a departmental notification procedure must be initiated by the health service. For further details about the performance breach notification process, health services can refer to the 2017-18 PMF or by contacting their respective health service leads / regional manager.	
Numerator	Number of urgency category 1 patients admitted within 30 days	
Denominator	Total urgency category 1 patients admitted	
Statewide target	100%	
Achievement	Equal to 100%	Achieved
	Less than 100%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	

Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted by health services via ESIS. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on ESIS data submission timelines.

Indicator	Number of patients on the elective surgery waiting list	
Description	Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients. This indicator measures the number of patients waiting for elective surgery as at the end of the reporting period and is measured at the health service level. Where health services have multiple campuses, the aggregate for all campuses is used.	
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 and with a readiness status of R (ready for care) are used to assess this indicator. This indicator is expressed as a whole number. Agreed individual health service quarterly targets take into account external factors impacting on service capacity such as peaks in emergency demand and seasonal fluctuations. Notional monthly targets are used to assist with monitoring performance.	
Numerator	Number of patients, for all urgency categories, waiting for elective surgery at the end of the reporting period	
Specific health service target	As agreed in the Statement of Priorities	
Achievement	Target achieved	Achieved
	Target not achieved	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed quarterly based on performance against phased targets, compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted by health services via ESIS. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on ESIS data submission timelines.	

Indicator	Reduce long waiting elective surgery patients	
Description	Percentage of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category	
Calculating performance	Only records assigned a principal procedure code of less than 500 are used to assess this indicator. The measure considers the 'total' waiting list at a health service, not only patients who are 'ready for surgery'. 'Total number of patients on the waiting list' means all patients with readiness status of R,S,F,C or P. Proportional improvement (under the Achievement section below) denotes the incremental performance improvement required to achieve the KPI should the statewide target not be achieved at 30 June 2017. This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used. **Example:** At 30 June 2017, Health Service A has: • 100 patients on the Elective Surgery Waiting List who have waited longer than clinically recommended time for their given urgency category (regardless of their current readiness status). • 1000 patients on the Elective Surgery Waiting List (regardless of readiness status). Therefore, 10% of patients had waited longer than clinically recommended time. At June 30 2018, Health Service A has: • 85 patients on the Elective Surgery Waiting List who have waited longer than clinically recommended time for their given urgency category (regardless of their current readiness status) • 1000 patients on the Elective Surgery Waiting List (regardless of readiness status) Therefore, Health Service A had 8.5% of patients who had waited longer than clinically recommended time at this time Health Service A did not achieve the state wide target (less than 5%), however did achieve a 15% proportional improvement (10% vs 8.5%), therefore meeting this KPI in 2017-18	
Numerator	Total number of patients on the Elective Surgery Waiting List (regardless of readiness status) who have waited longer than clinically recommended times (>30 'ready for care days' for category 1, >90 'ready for care days' for category 2, >365 'ready for care days' for category 3).	
Denominator	Total number of patients on the Elective Surgery Waiting List (regardless of readiness status).	
Statewide target	5%	
Achievement	Less than or equal to 5% OR if state wide target not met, at least 15% proportional improvement from prior year as calculated at 30 June 2017	Achieved
	Greater than 5% AND less than 15% proportional improvement from prior year as calculated at 30 June 2017	Not achieved

Improvement	The 15% proportional improvement from prior year (as indicated under the achievement section) is different to improvement achieved for the purpose of the risk assessment. The former denotes an alternative level of achievement calculated at the end of year and reflected in the Annual Report against the SOP targets. Quarterly improvement for the purpose of the performance risk assessment is the proportional reduction in overdue patients compared to previous quarter. As such, for Q1 2017 this will be compared to Q4 2016; Q2 2017 to Q1 217 and so on.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data is submitted by health services via ESIS.

Indicator	Number of patients admitted from the elective surgery waiting list
Description	This indicator measures the stocks and flows of elective surgery patients and assists the understanding of the demand management of elective surgery patients. Individual targets are negotiated with each health service. Targets for the number of patients admitted from the waiting list during each month are set at the health service level, rather than individual hospital level. The phased targets set for individual health services reflect peaks in emergency demand and seasonal capacity limitations. To enable this indicator to be monitored on a monthly basis health services provide the department with phased monthly targets.
Calculating performance	The number of patients during the reporting period who have been admitted for the awaited procedure, or related procedure, that addresses the clinical condition for which they were added to the elective surgery waiting list. Only records assigned an ESIS principal prescribed procedure code of less than 500 are used to assess this indicator. Within ESIS data, a removal is counted as a planned admission if the removal date falls within the quarter being reported and the reason for removal is either: • W – Admitted to the intended campus and has received the awaited procedure • S – Admitted to another campus arranged by ESAS and has received the awaited procedure • X – Admitted to another campus arranged by this campus/health service and has received the awaited procedure under other contract or similar arrangement Planned admissions have a narrower range of removal codes than the codes used for the indicators dealing with the percentage of patients removed within time. This indicator is expressed as a whole number.
Numerator	Number of admitted patients
Target	Specific health service target as agreed in the Statement of Priorities
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed quarterly based on performance against phased targets, compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed monthly. In addition to monthly monitoring, a performance result is generated annually based on the full year data. Data is submitted by health services via ESIS. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information on ESIS data submission timelines.

Specialist clinics

Specialist clinic performance indicators aim to encourage improved performance in managing access for patients who need these clinics. Management of patient referrals to specialist clinics, including allocation of appointments should be provided in accordance with the Specialist clinics in Victorian public hospitals: access policy (2015).

Indicator	**Proportion of urgent patients referred by a GP or external specialist who attended a first appointment in the waiting period - URGENT**	
Description	The indicator monitors the proportion of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days of referral.	
Calculating performance	Outpatient stream referrals that have been clinically prioritised as urgent are used to assess this indicator. The indicator includes all patients referred from either a GP or external Specialist, who attended a first appointment during, or had a first appointment booked date before the end of the reporting period. This indicator includes those patients with a scheduled appointment but did not attend. The waiting time for a first appointment is the number of days between the Referral in Received Date and the Contact Date/Time or First Appointment Booked Date, whichever occurs first. For details on the technical specifications of this business rule refer to the department's specialist clinics website at HealthVic Data and performance for specialist clinics <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/data-and-performance>	
Numerator	The number of urgent patients referred by a GP or external Specialist, who waited 30 calendar days or less for a first appointment, or first appointment booked date before the end of the reporting period.	
Denominator	The number of all urgent patients referred by a GP or external Specialist, who attended a first appointment or had a first appointment booked date before the end of the reporting period.	
Statewide target	100%	
Achievement	Equal to 100%	Achieved
	Less than 100%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	

Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted by health services via VINAH. Submission date: Health services are encouraged to submit data as often as desired, so long as a minimum of one submission is made for each reference month no later than 5pm on the 10th day of the following reference month. Clean date: All errors are to be cleared by the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday. End of financial year consolidation: All errors for 2017–18 must be corrected and resubmitted before consolidation of the VINAH database on the date advised in the Department of Health and Human Services policy and funding guidelines 2017.	

Indicator	**Proportion of routine patients referred by a GP or external specialist who attended a first appointment in the waiting period - ROUTINE**
Description	The indicator monitors the proportion of routine patients referred by a GP or external specialist who attended a first appointment within 365 days of referral. Outpatient stream referrals that have been clinically prioritised as routine are used to assess this indicator. The indicator includes all patients referred from either a GP or external Specialist, who attended a first appointment during, or had a first appointment booked date before the end of the reporting period. This indicator includes those patients with a scheduled appointment but did not attend.
Calculating performance	The waiting time for a first appointment is the number of days between the Referral in Received Date and the Contact Date/Time or First Appointment Booked Date, whichever occurs first. For details on the technical specifications of this business rule refer to the department's specialist clinics website at HealthVic Data and performance for specialist clinics <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/data-and-performance>
Numerator	The number of routine patients referred by a GP or external Specialist, who waited 365 calendar days or less for a first appointment, or first appointment booked date before the end of the reporting period.
Denominator	The number of all routine patients referred by a GP or external Specialist, who attended a first appointment or had a first appointment booked date before the end of the reporting period.
Statewide target	90%

Achievement	Equal to or above 90%	Achieved
	Less than 90%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted by health services via VINAH. Submission date: Health services are encouraged to submit data as often as desired, so long as a minimum of one submission is made for each reference month no later than 5pm on the 10th day of the following reference month. Clean date: All errors are to be cleared by the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday. End of financial year consolidation: All errors for 2017–18 must be corrected and resubmitted before consolidation of the VINAH database on the date advised in the Victorian health policy and funding guidelines 2017–18 .	

Timely response (Ambulance Victoria only)

Indicator	**Percentage of emergency (Code 1) incidents responded to within 15 minutes**	
Description	Statewide response times are an indicator of the provision of accessible and effective ambulance service to communities. Code 1 incidents are potentially life threatening and are time-critical, requiring a lights and sirens response.	
Calculating performance	Response time measures the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the time of the first arrival at the incident scene of an Ambulance Victoria paramedic, a community emergency response team or an ambulance community officer. This indicator applies to all emergency road Code 1 incidents responded to statewide. This indicator excludes: • incidents for which the response time was recorded as > 2 hours or where there are missing time stamps • responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority, NSW Ambulance Service and remote area nurses • responses by air ambulance resources. This indicator is expressed as a percentage to one decimal place.	
Numerator	The sum of all first arrival responses from each emergency road Code 1 incident responded to within 15 minutes	
Denominator	Total number of emergency road Code 1 incidents responded to in that same reporting period	
Statewide target	85%	
Achievement	Equal to or greater than 85%	Achieved
	Less than 85%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Ambulance Victoria submits data to the department monthly.	

Indicator	**Percentage of emergency (Priority Zero) incidents responded to within 13 minutes**	
Description	Percentage of emergency (Priority Zero) cases attended within 13 minutes of the Triple Zero (000) call. Statewide response times are an indicator of the provision of accessible and effective ambulance service to communities. Priority Zero cases are immediately life-threatening emergencies where patient is known or suspected to be in cardiac arrest.	
Calculating performance	Response time measures the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the time of the first arrival at the incident scene of an Ambulance Victoria paramedic, a community emergency response team or an ambulance community officer. This indicator applies to all emergency road Priority Zero incidents responded to statewide. This indicator excludes: • incidents for which the response time was recorded as > 2 hours or where there are missing time stamps • responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority, NSW Ambulance Service and remote area nurses • responses by air ambulance resources. This indicator is expressed as a percentage to one decimal place.	
Numerator	The sum of all first arrival responses from each emergency road Priority Zero incident responded to within 13 minutes	
Denominator	Total number of emergency road Priority Zero incidents responded to in that same reporting period	
Risk flag	85%	
Achievement	Equal to or above 85%	Achieved
	Below 85%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Ambulance Victoria submits data to the department monthly.	

Indicator	**Percentage of emergency Code 1 incidents responded to within 15 minutes in centres with a population greater than 7,500**	
Description	Statewide response times are an indicator of the provision of accessible and effective ambulance service to communities. Code 1 incidents are potentially life threatening and are time-critical, requiring a lights and sirens response.	
Calculating performance	Response time measures the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the time of the first arrival at the incident scene of an Ambulance Victoria paramedic, a community emergency response team or an ambulance community officer. Urban response times are emergency (Code 1) incidents responded to within 15 minutes in centres with a population > 7,500. Urban centres with a population > 7,500 are identified using the Australian Bureau of Statistics resident population statistics and Urban Centre Locality (UCL) boundaries. This indicator applies to all emergency road Code 1 incidents responded to in centres with a population > 7,500. The locations of Code 1 incidents are identified using the *x* and *y* coordinates generated by the ESTA Computer Aided Dispatch (CAD) system. These coordinates are mapped to UCL boundaries to identify those events that fall within the UCLs where the population exceeds 7,500. This indicator excludes: • incidents for which the response time was recorded as > 2 hours or where there are missing time stamps • responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority, NSW Ambulance Service and remote area nurse • responses by air ambulance resources. This indicator is expressed as a percentage to one decimal place.	
Numerator	Number of emergency Code 1 incidents aggregated across all the UCLs with a population > 7,500 responded to within (≤) 15 minutes	
Denominator	Total number of emergency Code 1 incidents across all the UCLs with a population > 7,500 responded to in that same reporting period	
Statewide target	90%	
Achievement	Equal to or greater than 90%	Achieved
	Less than 90%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Ambulance Victoria submits data to the department monthly.	

Indicator	**Percentage of triple zero cases where the caller receives advice or service from another health provider as an alternative to an emergency ambulance response – statewide**	
Description	Low-acuity triple zero (000) cases diverted to the Referral Service may be offered a more appropriate alternative to an emergency ambulance dispatch. A successful referral is when a triple zero call does not result in an emergency ambulance dispatch and is diverted to a non-emergency response or referred to an alternative service provider such as a medical practitioner, nursing service, other health professional service, home self-care or advice. Ambulance Victoria manages call diversion via a Referral Service that performs a secondary triage with the patient, following the primary triage from the Emergency Services Telecommunications Authority (ESTA) call-taker. This indicator applies to all triple zero calls statewide that do not result in an emergency dispatch after triage by the Referral Service.	
Calculating performance	Proportion of triple zero cases where the caller receives advice or service from another health provider or non-emergency ambulance transport as an alternative to emergency ambulance response statewide. This indicator is expressed as a percentage to one decimal place. Improvement is compared to same time last year performance	
Numerator	Total number of cases managed by the Referral Service that did not result in an emergency response	
Denominator	Total number of emergency cases + total number of Referral Service managed cases that did not result in an emergency response	
Statewide target	15%	
Achievement	Equal to or greater than 15%	Achieved
	Less than 15%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Ambulance Victoria submits data to the department monthly.	

Indicator	Average ambulance hospital clearing time	
Description	Clearing time is a key component of total paramedic hospital time that is directly attributable to Ambulance Victoria. This indicator measures the elapsed time from the handover of an emergency patient at a hospital emergency department to completion of all tasks to ensure the ambulance crew is available to respond to another incident. Handover involves a patient being physically transferred to a hospital trolley, bed, chair or waiting area. The ambulance handover completion time (also known as 'off-stretcher time') is recorded in a Patient Care Record (PCR) by a paramedic after agreement with an emergency department clinician. This indicator applies to all emergency transports to a hospital emergency department statewide.	
Calculating performance	The average time for the given period. Off-stretcher time and clearing time are sourced from the PCR. This indicator excludes: • hospital transports where the clearing time was recorded as > 3 hours or where there are missing time stamps • transports by air ambulance resources • non-emergency hospital transports • inter-hospital transports. This indicator is expressed as either minutes to one decimal place or in the following format: MM:SS. Improvement is compared to same time last year performance	
Numerator	The sum of emergency road clearing times	
Denominator	The total number of emergency road clearing times in that same reporting period	
Statewide target	20 minutes	
Achievement	Less than or equal to 20 minutes	Achieved
	Greater than 20 minutes	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is lagged by one month. Ambulance Victoria submits data to the department monthly.	

Forensicare

Admissions to Thomas Embling Hospital (THE)

Indicator	**Number of security patients admitted to Male Acute Units – Security**	
Description	The number of admissions to Forensic acute units where the client is male and on a security order at the time of admission.	
Calculating performance	Performance is assessed quarterly.	
Numerator	The number of admissions to Forensic inpatient units where the client is male and on a security order at the time of admission. Numerator calculation: 1. Select admissions to Forensicare acute units in the applicable time period, where the client is male, and is on a security order (pre Jul'14 – legal stat codes 08,23,24,25,26,27,29, post Jul'14 order codes 105 and 202) at the time of admission. This is based on episode start date. 2. Count the number of admissions per team/campus.	
Denominator	N/A	
Statewide target	80	
Achievement	Equal to or greater than 80	Achieved
	Less than 80	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	CMI/ODS (Mental Health Client Management Information / Operational Data Store). Indicator is reported quarterly.	

Indicator	**Percentage of male security patients admitted to THE within 14 days of certification**
Description	Percentage of male Forensic MAP clients whose security order started, who were transferred to Thomas Embling Hospital within 14 days.
Calculating performance	Performance is assessed quarterly.
Numerator	Total number of male Melbourne Assessment Prison clients who were certified as security during the reference period, and who were transferred to Thomas Embling within 14 days. Numerator calculation: 1. Get male clients who were put on a security order (codes 105 & 202) during the reporting period. Obtain only those clients that were admitted to MAP at the time. Include only those clients that were transferred to Thomas Embling Hospital within 14 days after the security order was made. 2. Count the number of clients per team.

Denominator	Total number of male Melbourne Assessment Prison clients who were certified as security during the reference period. Denominator calculation: 1. Get male clients who were put on a security order (codes 105 & 202) during the reporting period. Obtain only those clients that were admitted to MAP at the time. 2. Count the number of clients per team.	
Statewide target	100%	
Achievement	Equal to 100%	Achieved
	Less than 100%	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	CMI/ODS (Mental Health Client Management Information / Operational Data Store). Indicator is reported quarterly. Data is lagged by 14 days. to allow all transfers occurring within the desired time to be captured.	

Length of stay – Male acute Units – Security

Indicator	**Percentage of security patients discharged to prison within 80 days**	
Description	The number of discharges of male security clients within 80 days, divided by the total number of male security clients, in Forensicare inpatient units.	
Calculating performance	Performance is assessed quarterly.	
Numerator	Total number of discharges within 80 days from Forensicare inpatient units (TEH) in the applicable time period, where the client was male and on a security order. Exclude same day stays. Lagged by 80 days. Calculating Numerator: 1. Select discharges from Forensicare acute units in the applicable time period, where the client was on a security order (order codes 105 and 202) at the time of discharge. a. This is based on episode end date, except in instances where a client was discharged whilst in leave, then take the date sent on leave. b. Calculate length of stay by taking the difference in minutes between the episode start date & time and the end date & time. Convert time difference to days by multiplying by *0.000694444444 (1/60mins/24hrs). c. Exclude those instances where the length of stay is greater than 80. d. Exclude same day stays 2. Count the number of discharges per team.	
Denominator	Total number of occupants in the Forensicare inpatient units (TEH) in the applicable time period, where the client was male and was on a security order (at discharge/end of reporting period). Exclude same day stays. Lagged by 80 days. Calculating Denominator: 1. Select all male clients in Forensicare acute units in the applicable time period. Exclude same day stays. a. Include only those clients on a security order (order codes 105 and 202) at the end of the reporting period, or for those clients that were discharged within the reporting period, at the time of discharge. b. For those clients not discharged within the applicable time period, exclude those clients that have length of stay less than 80 days. 2. Count the number of episodes per team.	
Statewide target	75%	
Achievement	Equal to or greater than 75%	Achieved
	Less than 75%	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	CMI/ODS (Mental Health Client Management Information / Operational Data Store). Indicator is measured quarterly and reported quarterly. Data lagged by 80 days.	

Indicator	**Percentage of security patients discharged within 21 days of becoming a civil patient**	
Description	Percentage of male Forensic inpatient unit (Thomas Embling Hospital) clients whose security order expired, who were discharged to community within 21 days.	
Calculating performance	Performance is assessed quarterly.	
Numerator	Total number of male Forensicare inpatient (TEH) clients whose security order expired during the reference period, and were subsequently discharged to the community or an area mental health service within 21 days. Numerator calculation: 1. Get male clients admitted to Forensicare acute units who had a security order (code 105 & 202) expire during the reporting period. Include only those clients that were discharged from Forensicare Thomas Embling Hospital within 21 days after the security order expired. a. Obtain all Forensicare acute unit clients who had a security order expire (order codes 105 & 202) b. Include only those who had a civil order to follow, or whose sentinces ended and they are now not on an order ie.(i)Exclude those clients who effectively had their security order renewed (i.e order did not truly expire) & (ii) exclude those that have returned to MAP c. Exclude those who are still in Forensicare 21 days after their security order expired 2. Count the number per team.	
Denominator	Total number of male Forensicare inpatient (TEH) clients whose security order expired during the reference period. Denominator calculation: 1. Get male clients admitted to Forensicare acute units who had a security order (code 105 & 202) expire during the reporting period. a. Obtain all Forensicare acute unit clients who had a security order expire (order codes 105 & 202) b. Include only those who had a civil order to follow, or whose sentences ended and they are now not on an order i.e.(i) Exclude those clients who effectively had their security order renewed (i.e order did not truly expire) & (ii) exclude those that have returned to MAP 2. Count the number per team.	
Statewide target	75%	
Achievement	Equal to or greater than 75%	Achieved
	Less than 75%	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is compared to previous quarter performance.	

Frequency of reporting and data collection	CMI/ODS (Mental Health Client Management Information / Operational Data Store). Indicator is measured quarterly and reported quarterly. Data lagged by 21 days to allow all discharges occurring within the desired time to be captured.

Effective financial management

Indicator	Operating result as a percentage of revenue	
Description	This indicator is a measure of financial sustainability. The agreed SoP target should achieve an operating surplus necessary to maintain or, where necessary, improve the current operating cash position. This requirement aligns with the department's reform priority to increase the financial sustainability and productivity of the health system.	
Calculating performance	This indicator is predicated on the year-to-date (YTD) operating result in the SoP. The variance between the actual YTD result reported in the AIMS F1 and the target which is the YTD budget loaded in the F1 (based on the agreed SoP outcome) is the measured outcome. It is expressed as a percentage and rounded to two decimal places. The indicator excludes consolidated entities (with the exception of Monash Health, which includes Jessie McPherson Private Hospital and Western Health which includes the Foundation). Phased monthly targets are based on the September AIMS F1 submission for the financial year. Changes thereafter are only reported on agreement between the department and the health service regardless of the data submitted in the AIMS F1. The opportunity to prospectively re-phase monthly targets tracking to the agreed annual operating result should be negotiated with the department. Should the phasings require adjusting; these changes will be considered on a quarterly basis and, where agreed, submitted in the F1 by the health service. Note that the department does not support retrospective changes to phased targets.	
Numerator	YTD operating result before capital and depreciation	
Denominator	YTD total revenue	
Target	As agreed in the SoP for each health service	
Achievement	Actual F1 YTD operating as % of revenue is greater than Budgeted F1 YTD operating as % of revenue	Achieved
	Actual F1 YTD operating as % of revenue is less than Budgeted F1 YTD operating as % of revenue	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against phased target result, except for Q1 (no change).	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return) 2017–18* for further information on completing the F1. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information about funding policy changes.	

Indicator	Trade creditors	
Description	This indicator is a short-term liquidity indicator. It represents the average number of days a health service takes to pay creditors. Increasing days beyond the 60-day target may indicate significant cash liquidity issues. NB: In response to feedback from health services, and consistent with outcomes from the benchmarking group, an adjustment to the calculation of this indicator has been made to include account codes related to inter hospital and accrual expenses.	
Calculating performance	Average trade creditors divided by the average daily non-salary operating costs. Trade creditors are defined as account codes between: • 80101 to 80199: Trade creditors – system generated • 80600 to 80649: Creditors – Inter hospital • 81001 to 81099: Accrual expenses. Non-salary operating costs are defined as account codes in the ranges: • 20001 to 38999 (excludes accounts 37036–37040: PPP interest expense) • 12500 to 13211. This indicator is calculated at a health service level and calculation of the indicator does not include controlled entities cost range Z9002–Z9101 and Z9502–Z9600 (with the exception of Monash Health, which includes Jessie McPherson Private Hospital and Western Health which includes the Western Health Foundation). The indicator is expressed as a number of whole days, therefore rounded to the nearest whole number (0.5 is rounded up).	
Numerator	The sum of trade creditors at the end of the previous financial year and trade creditors at the end of the reporting month divided by two	
Denominator	YTD non-salary operating costs divided by the YTD number of days	
Statewide target	60 days	
Achievement	Less than or equal to 60 days	Achieved
	Greater than 61 days	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against prior year's results for the same period.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is expected to be submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return) 2017–18* for further information on completing the F1.	

Indicator	Patient fee debtors	
Description	This indicator is a short-term liquidity indicator. It represents the average number of days a health service takes to collect debts in relation to patient fees. The length of time it takes for private health funds and statutory bodies (such as the TAC) to settle their accounts will influence the result. A fall in days indicates more effective collection.	
Calculating performance	Average patient fees receivable divided by the average daily patient fee revenue. Debts subject to debt recovery plans in relation to receivables/fees for uninsured or under insured overseas visitors are excluded (account codes 71071–71080 for numerator and 50041–50043 for denominator). Patient fees receivable are defined as the following account codes: • 71001 to 71049: Debtors – Private Inpatients • 71071 to 71075: Debtors – Private Inpatients (Uninsured O'S Visitors) • 71100 to 71149: Debtors – Private Outpatients • 71200 to 71249: Debtors – Nursing Home / Hostel • 71300 to 71349: Debtors Diagnostic Billing • 71401 to 71449: Other Patient Debtors – e.g. Day hospital. Patient fees revenue are defined as the following account codes: • 50001 to 50040: Admitted Patient fees – Acute • 50041 to 50043: Admitted Patient fees uninsured debtors • 50051 to 50396: Admitted Patient fees – other • 50446 to 50699: Non-admitted Patient fees • 50751 to 50756: Transport Fees – Ambulance Victoria • 50901 to 50960: Private Practise fees • 59111 to 59149: Private Practise fees. This indicator is calculated at a health service level and calculation of the indicator does not include controlled entities cost range Z9002–Z9100 and Z9502–Z9600 (with the exception of Monash Health, which includes Jessie McPherson Private Hospital and Western Health, which includes the Western Health Foundation). The indicator is expressed as a number of whole days, therefore rounded to the nearest whole number (0.5 is rounded up).	
Numerator	The sum of patient fees receivable at the end of the previous financial year and the patient fees receivable at the end of the reporting month divided by two	
Denominator	YTD patient fee revenue divided by the YTD number of days	
Statewide target	60 days	
Achievement	Less than or equal to 60 days	Achieved
	Greater than 61 days	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against prior year's results for the same period.	

Frequency of reporting and data collection	Performance is monitored and assessed monthly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is expected to be submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return) 2017–18* for further information on completing the F1.

Indicator	Public and private WIES	
Description	The year-to-date (YTD) public and private (PP) WIES indicator aims to reinforce the need for health services to manage their activity in line with the published recall policy.	
Calculating performance	In assessing performance, the department recognises that there may be circumstances whereby a health service exceeds the 104% tolerance level without significantly impacting financial viability. These cases are assessed on a case-by-case basis. Phased monthly targets are based on the September F1 submission for the financial year. Changes thereafter are only reported on agreement between the department and the health service regardless of data submitted in the AIMS F1. The phased end-of-year targets (as reported for the F1 activity budget) should reflect the agreed activity targets. YTD activity performance against the target is expressed as a percentage and rounded to two decimal places (0.055 is rounded up).	
Numerator	YTD actual PP WIES	
Denominator	YTD PP WIES target	
Statewide target	100%	
Achievement	Between 100% and104%	Achieved
	Less than 100% or over 104%	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the YTD phased target results, except for Q1 which is assessed against same time last year performance.	
Frequency of reporting and data collection	Performance is monitored and assessed monthly. An annual result is generated based on the YTD result at 30 June 2018 (following final consolidation of VAED). Data is submitted by health services monthly via the AIMS F1. Refer to the *Guidelines for completing the F1 (finance return) 2017–18* for further information on completing the F1. For further information on the funding policy changes and recall policy please refer to the *Department of Health and Human Services policy and funding guidelines 2017*.	

Indicator	Adjusted current asset ratio
Description	This indicator is a measure of financial liquidity. The generally accepted current asset ratio (CAR) is a financial ratio that measures whether or not an organisation has enough resources to pay its debts over the next 12 months. It compares an organisation's current assets to its current liabilities. The ACAR for hospital performance has been adjusted to include 'Long-Term Investments: Other financial assets' (which excludes Land and Buildings). This recognises the different cash management approaches/strategies employed by health services. For example, health services may move short-term cash assets into longer term investments, which are not recognised by the traditional CAR calculations. Further, the Long Service Leave liability will be adjusted so that only the current portion of the liability is included. This will utilise a factor based on the previous year's full year full year balances. Additionally, the SoP targets will be established. These will recognise the different starting points for health services and focus on achieving performance improvement overtime or maintaining good performance. This aligns with the department's reform priority to increase the financial sustainability and productivity of the health system.
Calculating performance	The variance between the actual ACAR based on the audited 30 June result and the target/benchmark is the measured outcome. Targets are based on a health service's final audited ACAR result for the previous financial year, which will form the 'base' upon which health services will be measured. Health services that have a 'base' of 0.7 or above (that is, their audited ACAR for the previous year was 0.7 or greater) will obtain full achievement of the indicator provided they maintain their ACAR above 0.7 (statewide benchmark). Health services starting with a 'base' below 0.7 will be required to achieve a 3% 'improvement' ('improvement target') from their 'base' in order to. be recognised as having improved from their base point.
Numerator	Current asset and long-term investment is defined as: • accounts 70001 to 73391: cash at bank and on hand, patient trusts, other trusts and short-term investments – cash equivalents • accounts 75001 to'75269: long-term investments
Denominator	All short-term liabilities is defined as accounts 80000 to 86699 Excludes the non-current portion of LSL liability, based on previous year's % of total LSL balance for each health service.
Statewide target	0.7
Achievement	Statewide target achieved OR 3% improvement from health service base target
	Statewide target not achieved OR less than 3% improvement from health service base target
Improvement	For the purpose of the performance risk assessment improvement is assessed against the phased target results, except for Q1 which is assessed against same time last year performance.

Frequency of reporting and data collection	Performance is monitored and assessed monthly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return) 2017–18* for further information on completing the F1. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information about funding policy changes.

Indicator	Days of available cash	
Description	This measure presents the number of days a health service can maintain its operations with unrestricted available cash, ***projected as at 30 June.*** Ideally, health services will project, at the end of the financial year, to have sufficient cash and cash equivalents to cover tied funding obligations and also meet their daily working capital requirements for a period of at least 14 days.	
Calculating performance	The results are derived by dividing the numerator by the denominator and rounded to one decimal place. Health service will be measured against the targets stipulated in the 'Achievement' section below. However, for health services that have finished the previous financial year (June 30) below the targeted 14 days, the June 30 result from the previous year will become a 'base' target upon which health service will assessed against for improvement.	
Numerator	'Total Available Funds': unrestricted cash at the end of June, which is all short- and long-term financial assets less committed funding to present the net available cash (total unrestricted funds) that is available to the health service for its operations Exclude both short-term and long-term: 'Committed Obligations for Internally Managed SPF' 'Others'	
Denominator	'Working capital' – this is equal to total operating expenditure excluding controlled entities as reported in the F1 *Budget Income* worksheet. This is then divided by 365 (total days in year) to arrive at the average daily working capital requirement	
Statewide target	14 days	
Achievement	June End of Year Forecast is equal to or above 14.0 days	Achieved
	June End of Year Forecast is less than 14.0 days	Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the 30 June 2017 base.	
Frequency of reporting and data collection	Projected cash at 30 June is based on the AIMS F1 submission (*Actual cashflow worksheet*) for the financial year. If the *Actual cashflow worksheet* does not provide forecast (out-months) cashflow data through to the end of year, the target will be assessed as not achieved. Performance is monitored and assessed monthly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return) 2017–18* for further information on completing the F1. Refer to the *Department of Health and Human Services policy and funding guidelines 2017* for further information about funding policy changes.	

Attachment A

List of low mortality DRGs (using Version 7 of the DRG Grouper)

DRG	DRG Name
801C	OR Procedures Unrelated to Principal Diagnosis W/O CC
963Z	Neonatal Diagnosis Not Consistent W Age/Weight
A08B	Autologous Bone Marrow Transplant W/O Catastrophic CC
A09B	Kidney Transplant, Age >=17 W/O Catastrophic CC
A11B	Insertion of Implantable Spinal Infusion Device W/O Catastrophic CC
A12Z	Insertion of Neurostimulator Device
B01A	Ventricular Shunt Revision W Catastrophic or Severe CC
B01B	Ventricular Shunt Revision W/O Catastrophic or Severe CC
B03A	Spinal Procedures W Catastrophic or Severe CC
B03B	Spinal Procedures W/O Catastrophic or Severe CC
B04B	Extracranial Vascular Procedures W/O Catastrophic CC
B05Z	Carpal Tunnel Release
B06B	Procs for Cerebral Palsy, Muscular Dystrophy, Neuropathy W/O Cat or Sev CC
B07B	Cranial or Peripheral Nerve and Other Nervous System Procedures W/O CC
B40Z	Plasmapheresis W Neurological Disease, Sameday
B41Z	Telemetric EEG Monitoring
B62Z	Apheresis
B65Z	Cerebral Palsy
B68B	Multiple Sclerosis and Cerebellar Ataxia W/O CC
B69B	TIA and Precerebral Occlusion W/O Catastrophic or Severe CC
B71B	Cranial and Peripheral Nerve Disorders W/O CC
B72B	Nervous System Infection Except Viral Meningitis W/O Cat or Sev CC
B73Z	Viral Meningitis
B75Z	Febrile Convulsions
B76B	Seizures W/O Catastrophic or Severe CC
B77Z	Headache
B79B	Skull Fractures W/O Catastrophic or Severe CC
B80Z	Other head injuries
B81B	Other Disorders of the Nervous System W/O Catastrophic or Severe CC
C01Z	Procedures for Penetrating Eye Injury
C02Z	Enucleations and Orbital Procedures
C03Z	Retinal Procedures

C04Z	Major Corneal, Scleral and Conjunctival Procedures
C05Z	Dacryocystorhinostomy
C10Z	Strabismus Procedures
C11Z	Eyelid Procedures
C12Z	Other Corneal, Scleral and Conjunctival Procedures
C13Z	Lacrimal Procedures
C14Z	Other Eye Procedures
C15A	Glaucoma/Cx Cataract Procedures
C15B	Glaucoma/Cx Cataract Procedures, Sameday
C16Z	Lens Procedures
C60B	Acute and Major Eye Infections W/O CC
C61A	Neurological and Vascular Disorders of the Eye W CC
C61B	Neurological and Vascular Disorders of the Eye W/O CC
C62Z	Hyphaema and Medically Managed Trauma to the Eye
C63Z	Other Disoders of the Eye
D01Z	Cochlear Implant
D02B	Head and Neck Procedures W Malignancy or W Mod CC
D02C	Head and Neck Procedures W/O Malignancy W/O CC
D03Z	Surgical Repair for Cleft Lip and Palate Disorders
D04A	Maxillo Surgery W CC
D04B	Maxillo Surgery W/O CC
D05Z	Parotid Gland Procedures
D06Z	Sinus and Complex Middle Ear Procedures
D10Z	Nasal Procedures
D11Z	Tonsillectomy and/or Adenoidectomy
D12Z	Other Ear, Nose, Mouth and Throat Procedures
D13Z	Myringotomy W Tube Insertion
D14Z	Mouth and Salivary Gland Procedures
D15Z	Mastoid Procedures
D40Z	Dental Extractions and Restorations
D61Z	Dysequilibrium
D62Z	Epistaxis
D63Z	Otitis Media and Upper Respiratory Infections
D64Z	Laryngotracheitis and Epiglottitis
D65Z	Nasal Trauma and Deformity
D66B	Other Ear, Nose, Mouth and Throat Disorders W/O CC

D67A	Oral and Dental Disorders
D67B	Oral and Dental Disorders, Sameday
E01B	Major Chest Procedures W/O Catastrophic CC
E02C	Other Respiratory System OR Procedures W/O CC
E42C	Bronchoscopy, Sameday
E60A	Cystic Fibrosis W Catastrophic or Severe CC
E60B	Cystic Fibrosis W/O Catastrophic or Severe CC
E63Z	Sleep Apnoea
E66C	Major Chest Trauma W/O CC
E67B	Respiratory Signs and Symptoms, <2 Days
E68B	Pneumothorax W/O Catastrophic or Severe CC
E69B	Bronchitis and Asthma W/O CC
E70A	Whooping Cough and Acute Bronchiolitis W CC
E70B	Whooping Cough and Acute Bronchiolitis W/O CC
E72Z	Respiratory Problems Arising from Neonatal Period
E73C	Pleural Effusion W/O CC
E75C	Other Respiratory System Disorders
F01B	Implantation or Replacement of AICD, Total System W/O Catastrophic CC
F03B	Cardiac Valve Procs W CPB Pump W Invasive Cardiac Inves W/O Cat CC
F04B	Cardiac Valve Procs W CPB Pump W/O Invasive Cardiac Inves W/O Cat CC
F05B	Coronary Bypass W Invasive Cardiac Investigation W/O Catastrophic CC
F06B	Coronary Bypass W/O Invasive Cardiac Investigation W/O Catastrophic CC
F07C	Other Cardtor/Vasc Procedures +PMP W/O CC
F10B	Interventional Coronary Procedures Admitted for AMI W/O Catastrophic CC
F12B	Implantation or Replacement of Pacemaker, Total System W/O Catastrophic CC
F13B	Amputation, Upper Limb and Toe, for Circulatory Disorders W/O Cat or Sev CC
F14B	Vascular Procs, Except Major Reconstruction, W/O CPB Pump W Sev or Mod CC
F14C	Vascular Procs, Except Major Reconstruction, W/O CPB Pump W/O CC
F15B	Interventional Coronary Procs, Not Adm for AMI W Stent Implant W/O Cat/Sev CC
F16B	Interventional Coronary Procs, Not Adm for AMI W/O Stent Implant W/O CC
F17B	Insert/Replace PM Genertr - CSCC
F18B	Other Pacemaker Procedures W/O CC
F20Z	Vein Ligation and Stripping
F41B	Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves W/O Cat or Sev CC
F42B	Circulatory Disorders, Not Adm for AMI W Invasive Cardiac Inves W/O Cat/Sev CC
F42C	Circulatory Disorders, Not Adm for AMI W Invasive Cardiac Inves, Sameday

F63B	Venous Thrombosis W/O Catastrophic or Severe CC
F64B	Skin Ulcers in Circulatory Disorders W/O Catastrophic or Severe CC
F67B	Hypertension W/O Catastrophic or Severe CC
F68B	Congenital Heart Disease W/O CC
F69B	Valvular Disorders W/O Catastrophic or Severe CC
F72B	Unstable Angina W/O Catastrophic or Severe CC
F73B	Syncope and Collapse W/O Catastrophic or Severe CC
F74Z	Chest Pain
G01B	Rectal Resection W/O Catastrophic CC
G02B	Major Small and Large Bowel Procedures W/O Catastrophic CC
G03B	Stomach, Oesophageal and Duodenal Procedures W/O Malignancy W Sev or Mod CC
G03C	Stomach, Oesophageal and Duodenal Procedures W/O Malignancy W/O CC
G04B	Peritoneal Adhesiolysis W Severe or Moderate CC
G04C	Peritoneal Adhesiolysis W/O CC
G05B	Minor Small and Large Bowel Procedures W Severe or Moderate CC
G05C	Minor Small and Large Bowel Procedures W/O CC
G06Z	Pyloromyotomy
G07A	Appendicectomy W Malignancy or Peritonitis or W Catastrophic or Severe CC
G07B	Appendicectomy W/O Malignancy or Peritonitis W/O Cat or Sev CC
G10B	Hernia Procedures W/O CC
G11Z	Anal and Stomal Procedures
G12C	Other Digestive System OR Procedures W/O CC
G46B	Complex Endoscopy W/O Catastrophic CC
G46C	Complex Endoscopy, Sameday
G47B	Gastroscopy W/O Catastrophic CC
G47C	Gastroscopy, Sameday
G48B	Colonoscopy W/O Catastrophic or Severe CC
G48C	Colonoscopy, Sameday
G63Z	Uncomplicated Peptic Ulcer
G64B	Inflammatory Bowel Disease W/O CC
G66Z	Abdominal Pain and Mesenteric Adenitis
G67B	Oesophagitis and Gastroenteritis W/O Catastrophic or Severe CC
G70B	Other Digestive System Disorders W/O Catastrophic or Severe CC
H01B	Pancreas, Liver and Shunt Procedures W/O Catastrophic CC
H02C	Major Biliary Tract Procedure W SCC
H05B	Hepatobiliary Diagnostic Procedures W/O Catastrophic CC

H06B	Other Hepatobiliary and Pancreas OR Procedures W/O Catastrophic CC
H07B	Open Cholecystectomy W/O Closed CDE W/O Catastrophic CC
H08A	Laparoscopic Cholecystectomy W Closed CDE or W Cat or Sev CC
H08B	Laparoscopic Cholecystectomy W/O Closed CDE W/O Cat or Sev CC
H43B	ERCP Procedures W/O Catastrophic or Severe CC
H62B	Disorders of Pancreas, Except Malignancy W/O Catastrophic or Severe CC
H64B	Disorders of the Biliary Tract W/O CC
I01B	Bilateral and Multiple Major Joint Proc of Lower Limb W/O Revision W/O Cat CC
I02B	Skin Grafts W/O Cat or Sev CC, Excluding Hand
I03B	Hip Replacement W/O Catastrophic CC
I04A	Knee Replacement W Catastrophic or Severe CC
I04B	Knee Replacement W/O Catastrophic or Severe CC
I05A	Other Joint Replacement W Catastrophic or Severe CC
I05B	Other Joint Replacement W/O Catastrophic or Severe CC
I06Z	Spinal Fusion for Deformity
I08B	Other Hip and Femur Procedures W/O Catastrophic CC
I09B	Spinal Fusion W/O Catastrophic CC
I10B	Other Back and Neck Procedures W/O Catastrophic or Severe CC
I11Z	Limb Lengthening Procedures
I12B	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W Sev or Mod CC
I12C	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W/O CC
I13B	Humerus, Tibia, Fibula and Ankle Procedures W/O CC, Age >=17
I15Z	Cranio-Facial Surgery
I16Z	Other Shoulder Procedures
I17A	Maxillo-Facial Surgery W CC
I17B	Maxillo-Facial Surgery W/O CC
I18Z	Other Knee Procedures
I19A	Other Elbow and Forearm Procedures W CC
I19B	Other Elbow and Forearm Procedures W/O CC
I20Z	Other Foot Procedures
I21Z	Local Excision and Removal of Internal Fixation Devices of Hip and Femur
I23Z	Local Excision and Removal of Internal Fixation Devices, Except Hip and Femur
I24Z	Arthroscopy
I25B	Bone and Joint Diagnostic Procedures Including Biopsy W/O CC
I27B	Soft Tissue Procedures W/O Catastrophic or Severe CC
I28B	Other Musculoskeletal Procedures W/O CC

I29Z	Knee Reconstructions, and Revisions of Reconstructions
I30Z	Hand Procedures
I31B	Revision of Hip Replacement not for Infect/Inflam of Joint Prosth W/O Cat CC
I32B	Revision of Knee Replacement not for Infect/Inflam of Joint Prosth W/O Cat CC
I32C	Knee Revision W/O CSCC
I61B	Distal Femoral Fractures W/O CC
I63B	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh W/O CC
I64B	Osteomyelitis W/O Catastrophic or Severe CC
I66B	Inflammatory Musculoskeletal Disorders W/O Catastrophic or Severe CC
I67B	Septic Arthritis W/O Catastrophic or Severe CC
I68B	Non-surgical Spinal Disorders W/O CC
I68C	Non-surgical spinal Disorders, Same day
I69B	Bone Diseases and Arthropathies W/O Catastrophic or Severe CC
I71B	Other Musculotendinous Disorders W/O Catastrophic or Severe CC
I72B	Specific Musculotendinous Disorders W/O Catastrophic or Severe CC
I73B	Aftercare of Musculoskeletal Implants or Prostheses W/O Cat or Sev CC
I74Z	Injuries to Forearm,Wrist, Hand and Foot
I75B	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle W/O CC
I76B	Other Musculoskeletal Disorders W/O Catastrophic or Severe CC
I77B	Fractures of Pelvis W/O Catastrophic or Severe CC
J01A	Microvas Tiss Transf for Skin, Subcut Tiss & Breast Dsrds W Cat or Sev CC
J01B	Microvas Tiss Transf for Skin, Subcut Tiss & Breast Dsrds W/O Cat or Sev CC
J06Z	Major Procedures for Breast Disorders
J07Z	Minor Procedures for Breast Disorders
J08B	Other Skin Grafts and Debridement Procedures W/O CC
J09Z	Perianal and Pilonidal Procedures
J10Z	Plastic OR Procedures for Skin, Subcutaneous Tissue and Breast Disorders
J11Z	Other Skin, Subcutaneous Tissue and Breast Procedures
J12B	Lower Limb Procs W Ulcer/Cellulitis W/O Cat CC W Skin Graft/Flap Repair
J12C	Lower Limb Procs W Ulcer/Cellulitis W/O Cat CC W/O Skin Graft/Flap Repair
J13B	Lwr Limb Procs W/O Ulcer/Cellulitis W/O (Skin Grafts and Sev CC) W/O Cat CC
J14Z	Major Breast Reconstructions
J60C	Skin Ulcers, Sameday
J63A	Non-Malignant Breast Disorders
J63B	Non-Malignant Breast Disorders, Sameday
J64B	Cellulitis W/O Catastrophic or Severe CC

J65B	Trauma to Skin, Subcutaneous Tissue and Breast W/O Cat or Sev CC
J67A	Minor Skin Disorders
J67B	Minor Skin Disorders, Sameday
J68B	Major Skin Disorders W/O Catastrophic or Severe CC
J68C	Major Skin Disorders, Sameday
K01B	OR Procedures for Diabetic Complications W/O Catastrophic CC
K02B	Pituitary Procedures W/O CC
K03Z	Adrenal Procedures
K04A	Major Procedures for Obesity W CC
K04B	Major Procedures for Obesity W/O CC
K05B	Parathyroid Procedures W/O Catastrophic or Severe CC
K06A	Thyroid Procedures W Catastrophic or Severe CC
K06B	Thyroid Procedures W/O Catastrophic or Severe CC
K07Z	Obesity Procedures
K08Z	Thyroglossal Procedures
K09B	Other Endocrine, Nutritional and Metabolic OR Procs W Severe or Moderate CC
K09C	Other Endocrine, Nutritional and Metabolic OR Procs W/O CC
K40B	Endoscopic and Investigative Procs for Metabolic Disorders W/O Cat CC
K40C	Endoscopic and Investigative Procs for Metabolic Disorders, Sameday
K60B	Diabetes W/O Catastrophic or Severe CC
K62B	Miscellaneous Metabolic Disorders W/O Catastrophic or Severe CC
K63B	Inborn Errors of Metabolism W/O Catastrophic or Severe CC
K64B	Endocrine Disorders W/O Catastrophic or Severe CC
L02B	Operative Insertion of Peritoneal Catheter for Dialysis W/O Cat or Sev CC
L03B	Kidney, Ureter and Major Bladder Procedures for Neoplasm W Sev CC
L03C	Kidney, Ureter and Major Bladder Procedures for Neoplasm W/O Cat or Sev CC
L04B	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm W/O Cat CC
L04C	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Sameday
L05B	Transurethral Prostatectomy for Urinary Disorder W/O Cat or Sev CC
L06B	Minor Bladder Procedures W/O Catastrophic or Severe CC
L07B	Other Transurethral Procedures W/O CC
L08A	Urethral Procedures W CC
L08B	Urethral Procedures W/O CC
L09B	Other Procedures for Kidney and Urinary Tract Disorders W Sev CC
L09C	Other Procedures for Kidney and Urinary Tract Disorders W/O Cat or Sev CC
L40Z	Ureteroscopy

L41Z	Cystourethroscopy for Urinary Disorder, Sameday
L42Z	ESW Lithotripsy
L61Z	Haemodialysis
L63B	Kidney and Urinary Tract Infections W/O Catastrophic or Severe CC
L64Z	Urinary Stones and Obstruction
L65B	Kidney and Urinary Tract Signs and Symptoms W/O Catastrophic or Severe CC
L66Z	Urethral Stricture
L67B	Other Kidney and Urinary Tract Disorders W/O Catastrophic or Severe CC
L68Z	Peritoneal Dialysis
M01A	Major Male Pelvic Procedures W Catastrophic or Severe CC
M01B	Major Male Pelvic Procedures W/O Catastrophic or Severe CC
M02B	Transurethral Prostatectomy for Reproductive System Disorder W/O Cat/Sev CC
M03Z	Penis Procedures
M04Z	Testes Procedures
M05Z	Circumcision
M06B	Other Male Reproductive System OR Procedures W/O CC
M40Z	Cystourethroscopy for Male Reproductive System Disorder, Sameday
M61Z	Benign Prostatic Hypertrophy
M62Z	Male Reproductive System Inflammation
M63Z	Male Sterilisation Procedures
M64Z	Other Male Reproductive System Disorders
N01Z	Pelvic Evisceration and Radical Vulvectomy
N04A	Hysterectomy for Non-Malignancy W Catastrophic or Severe CC
N04B	Hysterectomy for Non-Malignancy W/O Catastrophic or Severe CC
N05A	Oophorectomy and Complex Fallopian Tube Procs for Non-Malig W Cat or Sev CC
N05B	Oophorectomy and Complex Fallopian Tube Procs for Non-Malig W/O Cat or Sev CC
N06A	Female Reproductive System Reconstruction Procedures W CSCC
N06B	Female Reproductive System Reconstruction Procedures W/O CSCC
N07Z	Other Uterus and Adnexa Procedures
N08Z	Endoscopic and Laparoscopic Procedures, Female Reproductive System
N09Z	Other Vagina, Cervix and Vulva Procedures
N10Z	Diagnostic Curettage and Diagnostic Hysteroscopy
N11Z	Other Female Reproductive System OR Procedures
N12B	Uterus and Adnexa Procedures for Malignancy W/O Catastrophic CC
N61Z	Female Reproductive System Infections
N62Z	Menstrual and Other Female Reproductive System Disorders

O01A	Caesarean Delivery W Catastrophic CC
O01B	Caesarean Delivery W Severe CC
O02A	Vaginal Delivery W OR Procedures W Catastrophic or Severe CC
O02B	Vaginal Delivery W OR Procedures W/O Catastrophic or Severe CC
O03A	Ectopic Pregnancy W CC
O03B	Ectopic Pregnancy W/O CC
O04A	Postpartum and Post Abortion W OR Procedures W Catastrophic or Severe CC
O04B	Postpartum and Post Abortion W OR Procedures W/O Catastrophic or Severe CC
O05Z	Abortion W OR Procedures
O60Z	Vaginal Delivery
O61Z	Postpartum and Post Abortion W/O OR Procedures
O63Z	Abortion W/O OR Procedures
O64Z	False Labour
O66Z	Antenatal and Other Obstetric Admissions
P63Z	Neonate, AdmWt 1000-1249g
P64Z	Neonate, AdmWt 1250-1499g
P65B	Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Major Problem
P65C	Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Other Problem
P65D	Neonate, AdmWt 1500-1999g W/O Significant OR Proc W/O Problem
P66A	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Multiple Major Problems
P66B	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Major Problem
P66C	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Other Problem
P66D	Neonate, AdmWt 2000-2499g W/O Significant OR Proc W/O Problem
P67A	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Mult Major Probs
P67B	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Major Problem
P67C	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Other Problem
P67D	Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W/O Problem
Q02B	Blood and Immune System Disorders W Other OR Procedures W/O Cat or Sev CC
Q60B	Reticuloendothelial and Immunity Disorders W/O Catastrophic or Severe CC
Q60C	Reticuloendothelial and Immunity Disorders, Sameday
Q61B	Red Blood Cell Disorders W/O Catastrophic or Severe CC
R01B	Lymphoma and Leukaemia W Major OR Procedures W/O Catastrophic or Severe CC
R02C	Other Neoplastic Disorders W Major OR Procedures W/O CC
R03B	Lymphoma and Leukaemia W Other OR Procedures W/O Catastrophic or Severe CC
R04B	Other Neoplastic Disorders W Other OR Procedures W/O CC
R61C	Lymphoma and Non-Acute Leukaemia, Sameday

R63Z	Chemotherapy
R64Z	Radiotherapy
S60Z	HIV, Sameday
T01B	Infectious and Parasitic Diseases W OR Procedures W Severe or Moderate CC
T01C	Infectious and Parasitic Diseases W OR Procedures W/O CC
T61B	Postoperative and Post-Traumatic Infections W/O Catastrophic or Severe CC
T62B	Fever of Unknown Origin W/O CC
T63Z	Viral Illnesses
T64C	Other Infectious and Parasitic Diseases W/O CC
U40Z	Mental Health Treatment W ECT, Sameday
U60Z	Mental Health Treatment W/O ECT, Sameday
U61Z	Schizophrenia Disorders
U62A	Paranoia & Acute Psyc Disorders, Involuntary Admission or W Cat or Sev CC
U62B	Paranoia & Acute Psyc Disorders W/O Cat or Sev CC
U63Z	Major Affective Disorders
U64Z	Other Affective and Somatoform Disorders
U65Z	Anxiety Disorders
U66Z	Eating and Obsessive-Compulsive Disorders
U67Z	Personality Disorders and Acute Reactions
U68Z	Childhood Mental Disorders
V60Z	Alcohol Intoxication and Withdrawal
V61Z	Drug Intoxication and Withdrawal
V62A	Alcohol Use Disorder and Dependence
V62B	Alcohol Use Disorder and Dependence, Sameday
V63Z	Opioid Use and Dependence
V64Z	Other Drug Use and Dependence
W02B	Hip, Femur & Lower Limb Procs for Mult Significant Trauma W/O Cat or Sev CC
W03Z	Abdominal Procedures for Multiple Significant Trauma
W04A	Multiple Significant Trauma W Other OR Procs W Catastrophic or Severe CC
W04B	Multiple Significant Trauma W Other OR Procs W/O Catastrophic or Severe CC
X02A	Microvascular Tiss Transfer or (Skin Graft W Cat/Sev CC) for Injuries to Hand
X02B	Skin Graft for Injuries to Hand W/O Catastrophic or Severe CC
X04B	Other Procedures for Injuries to Lower Limb W/O Catastrophic or Severe CC
X05A	Other Procedures for Injuries to Hand W CC
X05B	Other Procedures for Injuries to Hand W/O CC
X06B	Other Procedures for Other Injuries W/O Catastrophic or Severe CC

X07B	Skin Graft for Injuries Excl Hand W/O Microvascular Tiss Trans W/O Cat/Sev CC
X60B	Injuries W/O Catastrophic or Severe CC
X61Z	Allergic Reactions
X62B	Poisoning/Toxic Effects of Drugs and Other Substances W/O Cat or Sev CC
X63B	Sequelae of Treatment W/O Catastrophic or Severe CC
Y02A	Skin Grafts for Other Burns W Catastrophic or Severe CC
Y02B	Skin Grafts for Other Burns W/O Catastrophic or Severe CC, Emergency
Y03Z	Other OR Procedures for Other Burns
Y60Z	Burns, Transferred to Acute Facility <5 Days
Y62B	Other Burns W/O CC
Z01B	Other Contacts W Health Services W OR Procedures, Sameday
Z40Z	Other Contacts W Health Services W Endoscopy, Sameday
Z60B	Rehabiliation, W CCC
Z60C	Rehabilitation, W/O CCC
Z61B	Signs and Symptoms, Sameday
Z63B	Other Follow Up After Surgery or Medical Care W/O Catastrophic CC
Z64B	Other Factors Influencing Health Status, Sameday

Attachment B

ICD-10-AM codes for trauma, immuno-compromised state or cancer relating to death in low mortality DRG measure

Notes

1. **Hierarchical representation**.

Where codes are presented at a three or four character level, they include all codes classifiable to that level. For example, *S01 Open wound of head* includes all of the following:

- S01.0 Open wound of scalp
- S01.1 Open wound of eyelid and periocular area
- S01.2 Open wound of nose
- S01.20 Open wound of nose, part unspecified
- S01.21 Open wound of nose, external skin
- S01.22 Open wound of nares (nostril)
- S01.23 Open wound of nasal septum
- S01.29 Open wound of other and multiple parts of nose etc.

2. **Aetiology and manifestation convention - the 'dagger and asterisk' system**.

ICD-10-AM uses the dagger and asterisk system to differentiate between aetiology and manifestation. Codes for aetiology (underlying cause) are annotated by a dagger symbol (†) and manifestation codes by an asterisk (*) symbol. In the list of codes below, both the aetiology and manifestation codes are given where relevant. For example:

- B59† Pneumocystosis (J17.3*)

ICD-10-AM 8th edition trauma diagnosis codes

Injuries to the head (S001–S09)

- S01 Open wound of head
- S02 Fracture of skull and facial bones
- S03 Dislocation, sprain and strain of joints and ligaments of head
- S04 Injury of cranial nerves
- S05 Injury of eye and orbit
- S06 Intracranial injury
- S07 Crushing injury of head
- S08 Traumatic amputation of part of head
- S09 Other and unspecified injuries of head

Injuries to the neck (S11–S19)

- S11 Open wound of neck
- S12 Fracture of neck
- S13 Dislocation, sprain and strain of joints and ligaments at neck level
- S14 Injury of nerves and spinal cord at neck level
- S15 Injury of blood vessels at neck level

- S16 Injury of muscle and tendon at neck level
- S17 Crushing injury of neck
- S18 Traumatic amputation at neck level
- S19 Other and unspecified injuries of neck

Injuries to the thorax (S21–S29)

- S21 Open wound of thorax
- S22 Fracture of rib(s), sternum and thoracic spine
- S23 Dislocation, sprain and strain of joints and ligaments of thorax
- S24 Injury of nerves and spinal cord at thorax level
- S25 Injury of blood vessels of thorax
- S26 Injury of heart
- S27 Injury of other and unspecified intrathoracic organs
- S28 Crushing injury of thorax and traumatic amputation of part of thorax
- S29 Other and unspecified injuries of thorax

Injuries to the abdomen, lower back, lumbar spine and pelvis (S31–S39)

- S31 Open wound of abdomen, lower back and pelvis
- S32 Fracture of lumbar spine and pelvis
- S33 Dislocation, sprain and strain of joints and ligaments of lumbar spine and pelvis
- S34 Injury of nerves and lumbar spinal cord at abdomen, lower back and pelvis level
- S35 Injury of blood vessels at abdomen, lower back and pelvis level
- S36 Injury of intra-abdominal organs
- S37 Injury of urinary and pelvic organs
- S38 Crushing injury and traumatic amputation of part of abdomen, lower back & pelvis
- S39 Other and unspecified injuries of abdomen, lower back and pelvis

Injuries to the shoulder and upper arm (S41–S49)

- S41 Open wound of shoulder and upper arm
- S42 Fracture of shoulder and upper arm
- S43 Dislocation, sprain and strain of joints and ligaments of shoulder girdle
- S44 Injury of nerves at shoulder and upper arm level
- S45 Injury of blood vessels at shoulder and upper arm level
- S46 Injury of muscle and tendon at shoulder and upper arm level
- S47 Crushing injury of shoulder and upper arm
- S48 Traumatic amputation of shoulder and upper arm
- S49 Other and unspecified injuries of shoulder and upper arm

Injuries to the elbow and forearm (S51–S59)

- S51 Open wound of forearm
- S52 Fracture of forearm
- S53 Dislocation, sprain and strain of joints and ligaments of elbow
- S54 Injury of nerves at forearm level
- S55 Injury of blood vessels at forearm level
- S56 Injury of muscle and tendon at forearm level
- S57 Crushing injury of forearm
- S58 Traumatic amputation of forearm
- S59 Other and unspecified injuries of forearm

Injuries to the wrist and hand (S61–S69)

- S61 Open wound of wrist and hand
- S62 Fracture at wrist and hand level
- S63 Dislocation, sprain and strain of joints and ligaments at wrist and hand level
- S64 Injury of nerves at wrist and hand level
- S65 Injury of blood vessels at wrist and hand level
- S66 Injury of muscle and tendon at wrist and hand level
- S67 Crushing injury of wrist and hand
- S68 Traumatic amputation of wrist and hand
- S69 Other and unspecified injuries of wrist and hand

Injuries to the hip and thigh (S71–S79)

- S71 Open wound of hip and thigh
- S72 Fracture of femur
- S73 Dislocation, sprain and strain of joint and ligaments of hip
- S74 Injury of nerves at hip and thigh level
- S75 Injury of blood vessels at hip and thigh level
- S76 Injury of muscle and tendon at hip and thigh level
- S77 Crushing injury of hip and thigh
- S78 Traumatic amputation of hip and thigh
- S79 Other and specified injuries of hip and thigh

Injuries to the knee and lower leg (S81–S89)

- S81 Open wound of lower leg
- S82 Fracture of lower leg, including ankle
- S83 Dislocation, sprain and strain of joints and ligaments of knee
- S84 Injury of nerves at lower leg level
- S85 Injury of blood vessels at lower leg level
- S86 Injury of muscle and tendon at lower leg level
- S87 Crushing injury of lower leg
- S88 Traumatic amputation of lower leg
- S89 Other and unspecified injuries of lower leg

Injuries to the ankle and foot (S91–S99)

- S91 Open wound of ankle and foot
- S92 Fracture of foot, except ankle
- S93 Dislocation, sprain and strain of joints and ligaments at ankle and foot level
- S94 Injury of nerves at ankle and foot level
- S95 Injury of blood vessels at ankle and foot level
- S96 Injury of muscle and tendon at ankle and foot level
- S97 Crushing injury of ankle and foot
- S98 Traumatic amputation of ankle and foot
- S99 Other and unspecified injuries of ankle and foot

Injuries involving multiple body regions (T01–T07)

- T01 Open wounds involving multiple body regions
- T02 Fractures involving multiple body regions
- T03 Dislocations, sprains and strains involving multiple body regions

- T04 Crushing injuries involving multiple body regions
- T05 Traumatic amputations involving multiple body regions
- T06 Other injuries involving multiple body regions, not elsewhere classified
- T07 Unspecified multiple injuries

Injuries to unspecified part of trunk, limb or body region (T08–T14)

- T08 Fracture of spine, level unspecified
- T09 Other injuries of spine and trunk, level unspecified
- T10 Fracture of upper limb, level unspecified
- T11 Other injuries of upper limb, level unspecified
- T12 Fracture of lower limb, level unspecified
- T13 Other injuries of lower limb, level unspecified
- T14 Injury of unspecified body region

Burns (T20–T31)

Burns of external body surface, specified by site (T20–T25)

- T20 Burn of head and neck
- T21 Burn of trunk
- T22 Burn of shoulder and upper limb, except wrist and hand
- T23 Burn of wrist and hand
- T24 Burn of hip and lower limb, except ankle and foot
- T25 Burn of ankle and foot

Burns of eye and internal organs (T26–T28)

- T26 Burn of eye and adnexa
- T27 Burn of respiratory tract
- T28 Burn of other internal organs

Burns of multiple and unspecified body regions (T29–T31)

- T29 Burns of multiple body regions
- T30 Burn, body region unspecified
- T31 Burns classified according to extent of body surface involved

Frostbite (T34–T35)

- T34 Frostbite with tissue necrosis
- T35 Frostbite involving multiple body regions and unspecified frostbite

Certain early complications of trauma (T79)

- T79 Certain early complications of trauma, not elsewhere classified

Other complications of trauma not elsewhere classified (T89)

- T89 Other specified complications of trauma

ICD-10-AM 8th edition immunocompromised state diagnosis codes

Human immunodeficiency virus [HIV] disease (B20–B24)

- B20 Human immunodeficiency virus [HIV] disease resulting in infectious and parasitic diseases
- B21 Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms
- B22 Human immunodeficiency virus [HIV] disease resulting in other specified diseases
- B23 Human immunodeficiency virus [HIV] disease resulting in other conditions

- B24 Unspecified human immunodeficiency virus [HIV] disease

Protozoal diseases (B59)

- B59† Pneumocystosis (J17.3*)

Other diseases of blood and blood-forming organs (D70–D73)

- D70 Agranulocytosis
- D71 Functional disorders of polymorphonuclear neutrophils
- D72 Other disorders of white blood cells
- D73 Diseases of spleen

Certain disorders involving the immune mechanism (D80-D89)

- D80 Immunodeficiency with predominantly antibody defects
- D81 Combined immunodeficiencies
- D82 Immunodeficiency associated with other major defects
- D83 Common variable immunodeficiency
- D84 Other immunodeficiencies
- D86 Sarcoidosis
- D89 Other disorders involving the immune mechanism, not elsewhere classified

Malnutrition (E40–E43)

- E40 Kwashiorkor
- E41 Nutritional marasmus
- E42 Marasmic kwashiorkor
- E43 Unspecified severe protein-energy malnutrition

Hypertensive diseases (I12–I13)

- I12 Hypertensive kidney disease
- I13 Hypertensive heart and kidney disease

Other

- K91.2 Postprocedural malabsorption, not elsewhere classified
- M35.9 Systemic involvement of connective tissue, unspecified
- N18 Chronic kidney disease
- N19 Unspecified kidney failure
- T86 Failure and rejection of transplanted organs and tissues
- Z49 Care involving dialysis
- Z94 Transplanted organ and tissue status
- Z99.2 Dependence on kidney dialysis

ICD-10-AM 8th edition immunocompromised state intervention codes (square brackets indicate ACHI block)

- 13706-00 [802] Allo bm/sc trnsplnt rel don wo invitro
- 13706-06 [802] Allo bm/sc trnsplnt rel don w invitro
- 13706-07 [802] Autolgs bm/stem cel trnsplnt wo invitro
- 13706-08 [802] Autolgs bm/stem cell trnsplnt w invitro
- 13706-09 [802] Allo bm/sc trnsplnt oth don wo invitro
- 13706-10 [802] Allo bm/sc trnsplnt oth don w invitro
- 14203-01 [1906] Direct living tissue implantation

- 36503-00 [1058] Kideny transplantation
- 90172-00 [555] Sequential single lung trnsplnt bil
- 90172-01 [555] Other transplantation of lung
- 90205-00 [660] Heart transplantation
- 90205-01 [660] Heart and lung transplantation
- 90317-00 [954] Transplantation of liver
- 90324-00 [981] Transplantation of pancreas

ICD-10-AM 8th edition cancer diagnosis codes

- C00–C96 Malignant neoplasms (except C44 Other malignant neoplasms of skin)
- Z85 Personal history of malignant neoplasm