

Section 9 - APET

Victorian Admitted Episodes Dataset (VAED) manual
28th edition 2018-19

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To receive this publication in an accessible format, please phone (03) 9096 8595, using the National Relay Service 13 36 77 if required, or email

HDSS.helpdesk@dhhs.vic.gov.au

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Introduction

The Admitted Patient Entry and Transmission (APET) software was developed for small Victorian hospitals requiring a simple data entry system in order to submit data to the Victorian Admitted Episodes Dataset (VAED). Facilities enter episode and diagnosis data into the system via the internet. APET generates a transmission file that is emailed to the HDSS help desk. The file is dropped in the hospital's Managed File Transfer (MFT) home directory for processing. Control Reports are generated when a VAED submission is processed. These reports enable the hospital to verify that data submitted has been received and to facilitate addition or amendment of missing or incorrect information. Control Reports must be retrieved from your MFT account's \pickup folder.

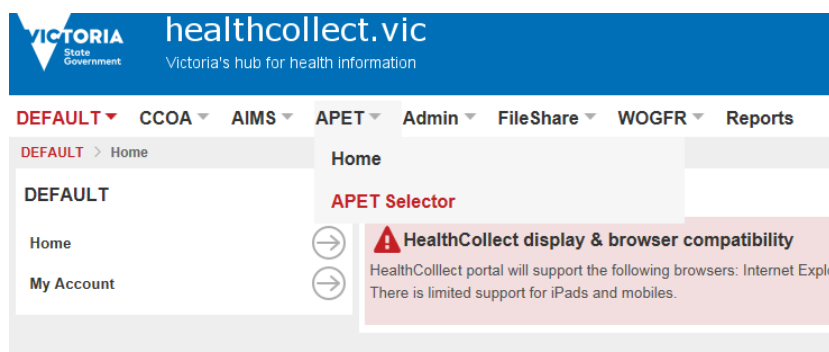
Accessing APET

The facility's hospital code identifies the data entered in the APET database. Access to the APET system is restricted by a user login and password, arranged via the HDSS help desk.

Access to the AIMS and APET website is gained via the same website:

To access APET:

- Enter the address (HealthCollect Home page)
<https://www.healthcollect.vic.gov.au/desktopdefault.aspx?ReturnUrl=%2f>
- Logon to the HealthCollect site using the allocated login and password codes
- Click on APET Selector which should expand to reveal the entry screen for your facility



Note: The system will automatically log you out if no activity has been recorded after one hour

Data submission timelines

A facility may submit data to the VAED database as frequently as desired but must meet the minimum data submission timelines for public hospitals set out in the *Department of Health and Human Services Policy and funding guidelines*. Monthly deadlines for public and private hospitals are set out in Section 1 of the VAED manual and any changes to deadlines are published in the HDSS Bulletin.

Contacts

For general assistance using APET, HDSS Bulletin subscriptions and queries relating to the VAED:

HDSS help desk (03) 9096 8595

Email hdss.helpdesk@dhhs.vic.gov.au

Abbreviations and acronyms

ACHI	Australian Classification of Health Interventions
APET	Admitted Patient Entry and Transmission system
DVA	Department of Veterans' Affairs
E5	Episode Record
DCU	Data Collections Unit – responsible for data collections and HDSS help desk
DRG	Diagnosis Related Group
FIM	FIM™ Score
FYTD	Financial Year-To-Date
H5	Header Record
HDSS	Health Data Standards & Systems (old unit name) - retained for use on HDSS help desk, HDSS website, HDSS Bulletin and HDSS forum
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
J5	Extra Episode Record (public hospitals only)
MFT	Managed File Transfer
MTD	Month-To-Date (month of the transmission start and end dates)
P5	Palliative Record (public hospitals only)
RUG ADL	Resource Utilisation Groups – Activities of Daily Living Score
S5	Subacute Record (public hospitals only)
TAC	Transport Accident Commission
T5	Trailer Record
DHHS	Department of Health and Human Services
U5	Trailer Record
UR Number	Unit Record Number
V5	Department of Veterans Affairs or Transport Accident Commission Record (public hospitals only)
VAED	Victorian Admitted Episode Dataset
X5	Diagnosis Record
YTD	Year-To-Date

About APET

Drop down menus and system validation

Drop-down menus on the forms display a choice of valid codes that can be selected. Code descriptors are provided. Refer to Sections 3 Data definitions and 4 Business rules for further information. Contact HDSS help desk for assistance.

The APET system performs simple validation checks, such as those listed below, to ensure only valid codes can be entered into data fields:

- Drop-down lists of VAED code sets with code descriptors
- Field lengths pre-determined
- Validation messages regarding mandatory data items – you cannot save a form until mandatory data items have been entered

Entering date and time in forms

Data entry for dates and times may vary according to your browser. Times 00:00 to 23:59 can be reported to the VAED.

In Internet Explorer select year, month and day from calendar as shown below

Admitted Patient Entry and Transmission System

Year:


Agency:

Edit an Existing Record

Saving data in forms

Click on Save at top left hand corner of form. APET will not allow you to save the form until all mandatory data fields are completed.

Printing forms

Each form (E5, J5, X5, S5, P5 and V5) can be printed by clicking on  at the top right hand corner of the form. Save data before printing.

Data extraction and file processing

APET generates a transmission file in the format required by the VAED processing system. This file is automatically emailed to the HDSS help desk and then dropped into the hospital's MFT home directory for processing.

Your file is processed through the VAED processing system and accepted data is added to a central database. A control report and any request reports selected will be generated. Refer to Sections 6 Request reports and 7 Control reports for further information.

Entering data in APET

APET Main Menu

The Year defaults to the current financial year (use the drop down to select the previous financial year)

Note: Before final consolidation of the VAED for 2017-18, facilities will be able to access the APET system for both the current and previous financial year.

Please ensure that admitted patient data is being entered into the appropriate Year. Complete reporting for 2017-18 before creating a July transmission file for 2018-19.

Separation prior to 1 July 2018 Enter into 2017-18 APET

Separation on or after 1 July 2018 Enter into 2018-19 APET

Admitted Patient Entry and Transmission System

Year:

Agency:

Edit an Existing Record

Unique Key:

Select a Record Type:

- Episode (E5)
- SubAcute (S5)
- Palliative (P5)
- Diagnosis (X5)
- DVA/TAC (V5)
- Extra Episode (J5)

Create a new Episode

Unique Key:

Transmit Episodes

Roll back previous transmissions

From:

To:

From this screen you can:

- Enter a new admitted episode by clicking on New Episode
- Update an existing episode by selecting the appropriate Unique Key, selecting Episode (E5) and clicking on Edit Record
- Enter or update a Diagnosis Record for an existing Episode Record
- Create a Transmission File
- Roll back the extract dates to allow the re-extraction of previously submitted data

Public hospitals can also enter or update the following for an existing Episode Record:

- a DVA/TAC Record (must be included in same transmission as Episode Record)

For an existing Episode Record with a Separation Date:

- an Extra Episode Record

- a Subacute Record
- a Palliative Record

Entering a new episode (E5) record

On the main menu click on New Episode

APET will display an initial nine-character Unique Key, as per system specifications

Users can either opt to allow APET to:

- Allocate a progressive Unique Key to each E5 Record or
- Type in their own Unique Key based on the facility's specifications (numeric only)
- Record the Unique Key on the admission form to enable the appropriate record to be found easily in the APET system.

If the Unique Key has fewer than nine characters it must be right justified and filled with leading zeroes
If you enter anything other than a nine-character value, a validation message will be displayed

Note: The Unique Key identifies the admitted episode. Once you have selected the first Unique Key, APET will automatically allocate subsequent Unique Keys in sequential order.

The screenshot shows the APET Episode (E5) form. At the top, the Unique Key is 000000144, Patient ID is 111111112, Admission Date is 2015-07-01, and Separation Date is 2015-07-01. The Admission Details section includes fields for Admission Time (09:11), Intended Duration of Stay (1: Intended same day), Sex (2: Female), Marital Status (5: Married), Locality (CROYDON), Postcode (3136), Date of Birth (1958-04-01), DOB Accuracy Code (AAE: Day & Month are Accurate; Year is not known but estimated), Country of Birth (1101: Australia), Indigenous Status (1: Aboriginal but not Torres Strait Islander origin), Preferred Language (8941: Wiradjuri), and Interpreter Required (2: No). It also has dropdowns for Admission Type (P: Elective admission), Admission Source (H: Admission from private residence/accom), Transfer Source, Hospital Insurance Status (2: Hospital Insurance), Medicare Number, Medicare Suffix (C-U), Admission Criteria (B: Day-only Automatically Admitted Procedures), Care Type (4: Oth care (Acute) including Qualified newborn), Mental Health Patient ID, and Mother UR. The Separation Details section includes Account Class on Separation (MP: Public: Eligible), ACAS Status, Leave with Permission Days MTD, FYTD, and Total, Contract/Spoke Identifier, Mental Health Legal Status (9: Not applicable), Separation Mode (H: Sep to private residence/accommodation), Transfer Destination, Carer Availability, Contract Type, Program Identifier (06: Competitive Elective Surgery Funding Initiative (CESFI)), Accommodation Type on Sep (3: Same Day accom), Leave without Permission Days MTD, FYTD, and Total, Contract Leave Days MTD, FYTD, and Total, Separation Time (17:00), Intention to Re-Admit (9: No plan to re-adm within 28 days), Separation Referral (X: No referral or support services arranged before discharge), Funding Arrangement, and Contract Role. The Status Segments section shows a table with one row: Account Class (MP: Public: Eligible), Accommodation Type (3: Same Day accom), Qualification Status (X: Not applicable), Patient Days MTD (1), Patient Days FYTD (1), and Patient Days Total (1).

Entering episode details

- Enter the Patient Identifier, Admission Date and Separation Date (if the patient has been separated)
Note: The Patient Identifier (or UR Number) is a ten character value; leading zeroes must be used to fill the designated field length. For example, a Patient Identifier of '12345' must be entered as '0000012345'
- Enter values for all data items relevant to your facility. Some data items are compulsory and you will not be able to save the form until those items have been entered.

E5 Status segment details

Status Segments						
Add						
Account Class	Accommodation Type	Qualification Status	Patient Days MTD	Patient Days FYTD	Patient Days Total	
MP : Public: Eligible	1 : Overnight accom: shared room	X : Not applicable	0	0	0	

- Status segments are used to report combinations of Account Class, Accommodation Type and Qualification Status (N and U for newborn episodes, X for all others) during the episode
- At least one status segment must be entered for each episode. Enter the Account Class, Accommodation Type and Qualification Status applicable at the time the patient was admitted.
- Enter the appropriate month-to-date, financial year-to-date and total Patient Days, for this combination of Account Class, Accommodation Type and Qualification Status.
- A patient may have more than one status segment during their stay. For example, if a patient moves from a shared to a private room, the number of days spent in each accommodation type will be reported in two status segments.
- Click on Add to enter an additional status segment
- An incorrect status segment can be overwritten with the correct information or deleted by clicking on the minus sign at the right hand side of the status segment details.
- Click Save when all data is entered. The record will be automatically flagged for inclusion in the next data transmission file

Counting patient days

- Patient days for a multi-day patient are calculated by subtracting the Admission Date from the Separation Date and deducting total leave days (with or without permission)
- For same-day patients (admitted and separated on the same date), patient days = 1 day
- For overnight patients, patient days = 1 day
- The Admission Date is always counted as a patient day
- The Separation Date is not counted

August transmission file with header dates 1/8/2018 – 31/8/2018

Admission Date	Separation Date	MTD (patient days in August)	YTD (patient days in July & August)	Total Days (total patient days for episode)
29/07/2018	02/08/2018	1	4	4
28/06/2018	07/07/2018	0	6	9
27/08/2018	Remaining in	5	5	5
04/08/2018	04/08/2018	1	1	1

For further information about status segments and counting patient days refer to Section 4 Business rules *Reporting history of code changes* and *Length of Stay*

Patients remaining in hospital

Patients remaining in hospital at the end of August, as above, can be identified through the census report (reports received after each submission).

You must edit the Episode (E5) record for this patient for inclusion in your September transmission and update the status segment(s) to reflect the appropriate patient day counts.

- Select the appropriate Unique Key
- Select Episode (E5)
- Select Edit Record
- Add separation details if applicable
- Update status segment details as required and click Save

Entering Diagnosis (X5) Details

Diagnosis (X5) records must be created once the patient has been separated. The E5 Record must be completed prior to entering the X5 Record.

From the main menu select the appropriate Unique Key from the drop down menu.

- Select Diagnosis (X5)
- Select Edit Record and the X5 Record form (as displayed below) will appear.

Agency: A Sample Campus (9999)

Diagnosis Record (X5)

Unique Key 000000150 Patient ID 0000333666 Admission Date 2018-07-01 Separation Date 2018-07-01

Admission Details

Admission Weight	<input type="text"/>
Duration ICU Stay	<input type="text"/>
Duration MV in ICU	<input type="text"/>
Hospital DRG	<input type="text"/>
Duration Cardiac/Coronary Care Unit	<input type="text"/>
Duration NIV in ICU	<input type="text"/>
Procedure Start Date	<input type="text"/>
Procedure Start Time	<input type="text"/>
Care Plan Documented Date	<input type="text"/>
Proceduralist ID	<input type="text"/>

Diagnosis Codes	Procedure Codes
<input type="button" value="Add"/>	<input type="button" value="Add"/>
<input type="text"/>	

- Enter the ICD-10-AM diagnosis code with appropriate prefix. Refer to Section 3 Diagnosis codes for information about diagnosis codes and prefixes.
- Click on Add to enter additional diagnosis codes
- Enter ACHI procedure codes in a similar manner
- Enter any other data relevant and click Save. The record will be automatically flagged for inclusion in the next data transmission file.

Editing a Record

Once a record has been edited and the alterations saved, the record will be automatically flagged for inclusion in the next data transmission file.

- Open the applicable form, as per previous instructions for entering data
- Make the necessary amendments and click Save

Note: The Patient Identifier (Unit Record Number) cannot be edited after a record has been saved on APET. If an incorrect Patient Identifier has been entered, the record will need to be deleted and re-entered with the correct unit record number. See instructions below on how to delete a record. Separate instructions apply depending on whether or not the record has been included in a transmission file.

Entering data in S5, P5 and J5 Records – public hospitals only

The E5 Record must be completed prior to entering data in the S5, P5 or J5 Records for separated patients.

S5 record shown below

- From the main menu select the appropriate Unique Key from the drop down menu.
- Select Subacute (S5)
- Select Edit Record and the S5 Record form (as displayed below) will appear
- Enter data and click Save

Save Delete

SubAcute (S5)

Unique Key 000000148 Patient ID 0000999999 Admission Date 2017-07-01 Separation Date

Admission Details

Functional Assessment Date on Admission	<input type="text"/>	Onset Date	<input type="text"/>
Functional Assessment Date on Separation	<input type="text"/>	Impairment Code	--None Selected--
FIM Score on Admission	<input type="text"/>	FIM Score on Separation	<input type="text"/>

Entering a New DVA/TAC (V5) Record – public hospitals only

The E5 Record admission details (as a minimum) must be completed prior to entering the V5 Record.

- Select the appropriate Unique Key from the drop down menu.
- Select DVA/TAC (V5)
- Select Edit Record and the DVA/TAC V5 Record form (as displayed below) will appear
- Enter the DVA/TAC Number, Date of Accident (TAC only), Surname and Given Names and click Save

Save Delete

DVA/TAC (V5)

Unique Key 000000148 Patient ID 0000999999 Admission Date 2017-07-01 Separation Date 2017-07-01

Admission Details

DVA/TAC Number	<input type="text"/>	Date of Accident	<input type="text"/>
Surname	<input type="text"/>	Given Name	<input type="text"/>

Deleting a Record

Record submitted to VAED:

If the record has been included in a transmission file and was accepted, it will exist on the VAED processing database. Therefore, a deletion record must be sent in a transmission file to remove it, otherwise it will continue to be counted as an admission in the VAED.

To delete an entire Episode Record and any associated S5, P5, V5 and X5 records from the VAED processing database:

- Open the E5 Record you want to delete
- Enter eleven 9s in the Medicare Number Field
- Click on Save

A deletion record for this record will automatically be included in your next transmission file. This will remove the record from the VAED processing database if it has previously been transmitted and accepted. If the record has been deleted before it was transmitted, you may receive an edit R005 because there is nothing to delete on the database. This error can be ignored.

Deleting other records

- To delete a Sub-Acute (S5) record; open the S5, fill the Impairment field with 9s and Submit.
- To delete a Palliative (P5) record; open the P5, fill the RUG ADL on Admission field with 9s and Submit.
- To delete a Diagnosis (X5) record; open the X5, zero-fill the first diagnosis code and leave the rest of the record blank and Submit
- DVA/TAC (V5) and Extra Episode (J5) records can only be deleted by sending an Episode (E5) record deletion.

Record entered in APET but not submitted to VAED:

Selecting Delete on a form permanently deletes the record from the APET system.

Roll back function

This function allows you to resend data previous submitted to VAED in the next transmission file. This function is commonly used by facilities during testing. All records which have separation dates, or were remaining-in, between the rollback dates selected will be flagged for inclusion in the next transmission file. This is also useful to ensure additional records such as the X5 and S5 are re-triggered after making corrections to the E5.

Roll back previous transmissions

From: 1 July 2018

To: 31 July 2018

Roll Back Transmission File

- From the main menu, select dates required for Roll Back, for example to re-transmit all data for July 2018 to 31 July 2018, select 1 July 2018 to 31 July 2018
- Click on Roll Back Transmission File
- Click on Create Transmission File

Extracting data from APET

Creating a transmission file

- From the Main Menu click on Create Transmission File to generate the transmission file in the correct format for submission to VAED

Agency: A Sample Campus (9999)

Create Transmission File

Admission Details

Transmission Start Date	<input type="text" value="2018-08-01"/>
Transmission End Date	<input type="text" value="2018-08-31"/>
Transmission Number	123

- The Transmission Start Date defaults to the day after the End Date of the previous transmission file:
 - Transmission number 124 will automatically have start date 1/09/2018 and end date 30/09/2018
 - Change dates for transmission 123 back to 1/07/2018 - 31/07/2018 if you want to submit another July file, for example to submit corrections.
- Click on Submit, which generates the Transmission Form for completion. Most of the Transmission Form is completed automatically based on the information held in the APET database and an analysis of the records identified for extraction.
- You may request reports. Refer to Section 6: Request reports for further information about reports available, including the format for the parameters of each request report.
- Select the Request Reports required
- Submit the completed Transmission Form
- APET will generate the extract file and email it to the HDSS Help Desk email. You will receive a message confirming the email has been sent. If a message does not appear, the process has failed.

Note: Do not create a transmission file with today's date or a future Transmission End Date.

Create a 1-31 August transmission early in September.

Make sure the Transmission Start Date and End Date are in the same month

Frequency of data submission

A transmission file should be created at least once per month. However, transmission files may be created more frequently.