Activity based funding: Emergency department care DSS 2013-2014

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Identifying and definitional attributes

Metadata item type: Data Set Specification

METEOR identifier: 497500

Registration status: Independent Hospital Pricing Authority, Superseded 01/03/2013

DSS type: Data Set Specification (DSS)

Scope: The scope of this DSS is emergency care provided in **emergency departments** in **activity based funded** hospitals.

These emergency departments must meet the following criteria:

- Purposely designed and equipped area with designated assessment, treatment and resuscitation areas.
- Ability to provide resuscitation, stabilisation and initial management of all emergencies.
- Availability of medical staff in the hospital 24 hours a day
- Designated emergency department nursing staff and nursing unit manager 24 hours per day 7 days per week.

The scope also includes services where a patient is awaiting transit, had a pre-arranged admission, did not wait or died on arrival. Patients with Department of Veterans' Affairs or compensable funding source are also included in the scope of the collection.

The care provided to patients in emergency departments is, in most instances, recognised as being provided to non-admitted patients. Patients being treated in emergency departments may subsequently become admitted. The care provided to non-admitted patients who are treated in the emergency department prior to being admitted is included in this DSS.

Excluded from scope are:

- Care provided to patients who are being treated in an emergency department site as an admitted patient (e.g. in an observation unit, short-stay unit, emergency department ward or awaiting a bed in an admitted patient ward of the hospital).
- Care provided to patients in General Practitioner co-located units.

Collection and usage attributes

Statistical unit: Emergency department stay.

Collection methods: **National reporting arrangements**

State and territory health authorities provide the data to the Independent Hospital Pricing Authority (IHPA) for national collection, on a quarterly basis as required under national health reform arrangements.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Quarterly data collection commencing 1 July each year.

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Comments: *Scope links with other metadata sets*

Episodes of care for admitted patients are reported through the Admitted patient care NMDS.

Some previous data element concepts are available in the METeOR glossary. Glossary items are available online through links in the relevant metadata items. In addition, links to the glossary terms that are relevant to this data set specification are listed below.

Activity based funding

Emergency department

Urgency related groups

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

Supersedes Emergency department care activity based funding DSS 2012-2013
Independent Hospital Pricing Authority, Superseded 31/10/2012

Has been superseded by Non-admitted patient emergency department care NMDS 2013-14
Health!, Superseded 11/04/2014

Metadata items in this Data Set Specification

Seq No.	Metadata item	Obligation	Max occurs
-	Address—Australian postcode, Australian postcode code (Postcode datafile) {NNNN}	Mandatory	1
-	Emergency department stay—additional diagnosis, code X[X(8)] ***Conditional obligation:*** Only required to be reported when at least one additional diagnosis is present for the emergency department stay.	Conditional	2
-	Emergency department stay—diagnosis classification type, code N.N ***Conditional obligation:*** Only required to be reported when a principal diagnosis and/or at least one additional diagnosis has been reported	Conditional	1
-	Emergency department stay—physical departure date, DDMMYYYY	Mandatory	1
-	Emergency department stay—physical departure time, hhmm	Mandatory	1
-	Emergency department stay—presentation date, DDMMYYYY	Mandatory	1
-	Emergency department stay—presentation time, hhmm	Mandatory	1

Seq No.	Metadata item	Obligation	Max occurs
-	Emergency department stay—principal diagnosis, code X[X(8)] ***Conditional obligation:*** The reporting of this data element is optional for those attendances where the value recorded for non-admitted patient emergency department service episode - episode end status is reported as: • 4 - Did not wait to be attended by a health care professional; • 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; • 7 - Dead on arrival, emergency department clinician certified death.	Conditional	1
-	Emergency department stay—transport mode (arrival), code N	Mandatory	1
-	Emergency department stay—type of visit to emergency department, code N	Mandatory	1
-	Emergency department stay—urgency related group major diagnostic block, code N[AA]	Mandatory	1
-	Emergency department stay—urgency related group, URG (v1.3) code [X]N[N]	Mandatory	1
-	Emergency department stay—waiting time (to commencement of clinical care), total minutes NNNNN ***Conditional obligation:*** This data item is to be recorded if the patient has one of the following non-admitted patient emergency department service episode - episode end status values reported: • 1 - Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward); • 2 - Non-admitted patient emergency department service episode completed—departed without being admitted or referred to another hospital; • 3 - Non-admitted patient emergency department service episode completed—referred to another hospital for admission; • 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; • 6 - Died in emergency department as a non-admitted patient; • 7 - Dead on arrival, emergency department clinician certified the death of the patient.	Conditional	1
-	Episode of care—funding eligibility indicator (Department of Veterans' Affairs), code N	Mandatory	1
-	Establishment—organisation identifier (Australian), NNX[X]NNNNN	Mandatory	1

Seq No.	Metadata item	Obligation	Max occurs
-	Non-admitted patient emergency department service episode—clinical care commencement date, DDMMYYYY ***Conditional obligation:*** This data item is to be recorded if the patient has one of the following non-admitted patient emergency department service episode - episode end status values reported: • 1 - Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward); • 2 - Non-admitted patient emergency department service episode completed—departed without being admitted or referred to another hospital; • 3 - Non-admitted patient emergency department service episode completed—referred to another hospital for admission; • 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; • 6 - Died in emergency department as a non-admitted patient; • 7 - Dead on arrival, emergency department clinician certified the death of the patient.	Conditional	1
-	Non-admitted patient emergency department service episode—clinical care commencement time, hhmm ***Conditional obligation:*** This data item is to be recorded if the patient has one of the following non-admitted patient emergency department service episode - episode end status values reported: • 1 - Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward); • 2 - Non-admitted patient emergency department service episode completed—departed without being admitted or referred to another hospital; • 3 - Non-admitted patient emergency department service episode completed—referred to another hospital for admission; • 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; • 6 - Died in emergency department as a non-admitted patient; • 7 - Dead on arrival, emergency department clinician certified the death of the patient.	Conditional	1
-	Non-admitted patient emergency department service episode—episode end date, DDMMYYYY	Mandatory	1
-	Non-admitted patient emergency department service episode—episode end status, code N	Mandatory	1
-	Non-admitted patient emergency department service episode—episode end time, hhmm	Mandatory	1
-	Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN	Mandatory	1

Seq No.	Metadata item	Obligation	Max occurs
-	Non-admitted patient emergency department service episode—triage category, code N ***Conditional obligation:*** This data item is to be recorded if the patient has one of the following nonemergency department stay - type of visit to emergency department values reported: • 1 - Emergency department presentation; • 2 - Return visit, planned; • 3 - Pre-arranged admission; • 4 - Patient in transit.	Conditional	1
-	Non-admitted patient emergency department service episode—triage date, DDMMYYYY ***Conditional obligation:*** This data item is to be recorded if the patient has one of the following nonemergency department stay - type of visit to emergency department values reported: • 1 - Emergency department presentation; • 2 - Return visit, planned; • 3 - Pre-arranged admission; • 4 - Patient in transit.	Conditional	1
-	Non-admitted patient emergency department service episode—triage time, hhmm ***Conditional obligation:*** This data item is to be recorded if the patient has one of the following nonemergency department stay - type of visit to emergency department values reported: • 1 - Emergency department presentation; • 2 - Return visit, planned; • 3 - Pre-arranged admission; • 4 - Patient in transit.	Conditional	1
-	Patient—compensable status, code N	Mandatory	1
-	Person—area of usual residence, geographical location code (ASGC 2011) NNNNN	Mandatory	1
-	Person—area of usual residence, statistical area level 2 (SA2) code (ASGS 2011) N(9)	Mandatory	1
-	Person—country of birth, code (SACC 2011) NNNN	Mandatory	1
-	Person—date of birth, DDMMYYYY	Mandatory	1
-	Person—Indigenous status, code N	Mandatory	1
-	Person—person identifier, XXXXXX[X(14)]	Mandatory	1
-	Person—sex, code N	Mandatory	1