Government of **Western Australia**
Department of **Health**

Subacute and Non-acute Data Collection

Data Dictionary

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Links to:	Information Management Policy Framework https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management

Contents

Abbreviations

ABF	Activity Based Funding
AIHW	Australian Institute of Health and Welfare
AMHOCN	Australian Mental Health Outcomes and Classification Network
AN-SNAP	Australian National Subacute and Non-acute Patient
AOS	AROC Online Services
AROC	Australasian Rehabilitation Outcomes Centre
ePalCIS	Electronic Palliative Care Information System
FIM	Functional Independence Measure
GEM	Geriatric Evaluation and Management
HMDC	Hospital Morbidity Data Collection
HMDS	Hospital Morbidity Data System
HoNOS	Health of the Nation Outcome Scales
HoNOS 65+	Health of the Nation Outcome Scales 65+
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
IHPA	Independent Hospital Pricing Authority
PCOC	Palliative Care Outcomes Collaboration
PSOLIS	Psychiatric Services On-line Information System
RUG-ADL	Resource Utilisation Groups - Activities of Daily Living
SANADC	Subacute and Non-acute Data Collection
SMMSE	Standardised Mini-Mental State Examination
UMRN	Unit Medical Record Number
URN	Unit Record Number
WA	Western Australia
webPAS	Web-based Patient Administration System

1. Purpose

The purpose of the *Subacute and Non-acute Data Collection Data Dictionary* is to detail the data elements captured in the Subacute and Non-acute Data Collection (SANADC).

The *Subacute and Non-acute Data Collection Data Dictionary* is a Related Document under MP 0164/21 *Patient Activity Data Policy*.

This data dictionary is to be read in conjunction with this policy and other Related Documents and Supporting Information as follows:

- *Admitted Patient Activity Data Business Rules*
- *Subacute and Non-acute Data Collection Data Specifications*
- *Patient Activity Data Policy Information Compendium*.

2. Background

The use of subacute and non-acute data by the Department of Health is dependent on high quality data that is valid, accurate and consistent.

3. Recording of data

Data that is submitted to the SANADC must be recorded in accordance with the Data Definitions (Section 4).

4. Data definitions

The following section provides specific information about data elements captured in the SANADC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the SANADC and caution should be taken if these data elements are compared with those of other data collections.

Where relevant, related national definitions have been referenced. The Department of Health Western Australia acknowledges the assistance of the Australian Institute of Health and Welfare (AIHW) for services provided in relation to METeOR, Australia's repository for national metadata standards for the health, community services, early childhood, homelessness and housing assistance sectors, which is owned by the AIHW.

Account Number

Field name:	accnt
Source Data Element(s):	[Account Number] – ePalCIS, PSOLIS, webPAS
Definition:	An identifier of an episode of care.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(11)]
Permitted values:	Alphanumeric combination up to 12 characters

Guide for use

Collection of this data element is mandatory.

Account number must be a unique number for every admitted episode of care.

If a patient changes care type within an admitted episode, each admitted instance for a specific care type must be assigned a unique account number.

Examples

A patient is admitted on 1 January 2021 and discharged on 15 February 2021. During this admission, the patient has the following care type changes generating three unique account numbers corresponding to the care type:

Admission Date	Separation Date	Care Type	Account Number
01012021	03012021	Acute	1234567
03012021	29012021	Rehabilitation	1234568
29012021	15022021	Maintenance	1234569

Related national definition

N/A

Revision history

N/A

Admission Date

Field name:	adm
Source Data Element(s):	[Admission Date] – webPAS [Episode Start Date] – ePalCIS [Episode Begin Date] – AOS
Definition:	The date on which an admitted patient commences an episode of care that can be formal or statistical.
Requirement status:	Mandatory
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of this data element is mandatory.

Admission date can be the date of formal admission or the date the patient changes from one care type to another, commonly called a statistical admission or care type change.

Formal Admission

A formal admission is an administrative process that initiates a record of the patient's treatment accommodation within a hospital.

The admission date for a formal admission will be the date the hospital commenced treatment and accommodation of the patient.

Statistical Admission

A statistical admission is an administrative process that occurs within an episode of care and captures the commencement of a particular type of care (care type).

The admission date for a statistical admission will be the date the patient commenced a particular care type.

Often patients move between care types (acute → subacute → non-acute) with a single hospital stay. When this occurs, there will only be one formal admission date but there can be many statistical admission dates depending on how many care type changes have occurred.

Examples

	Admission Date
A patient is admitted into a rehabilitation ward on 10 March 2021	10032021
A patient is statistically admitted to a palliative care unit (e.g. change in care type from acute care to palliative care) on 18 July 2021	18072021

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/695137

Revision history

N/A

Assessment Date

Field name:	ax_date
Source Data Element(s):	[Assessment Date] – PSOLIS, webPAS, AOS [Date/Time of Phase Change] – ePalCIS
Definition:	The date upon which the relevant clinical assessment was performed.
Requirement status:	Mandatory
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of this data element is mandatory.

Assessment date refers to the date on which the patient was assessed against the functional tool associated with the patient's subacute/non-acute care type.

Rehabilitation and GEM patients must be assessed against the FIM™ instrument.

Psychogeriatric patients must be assessed against the HoNOS 65+ scale.

Palliative and maintenance patients must be assessed against the RUG-ADL tool.

Assessment date must be on or after the admission date and before the separation date.

The timing of assessments is important because a person's capacity changes upon commencement of a program of subacute and/or non-acute care.

To achieve an accurate base measure it is important that the initial measurement is done in a timely manner. Similarly, it is important that discharge assessments are done within a time frame that allows the change in capacity of the person to be measured.

For patients who move back and forth between care types (e.g. acute → subacute → acute → subacute), there will be more than one assessment date recorded corresponding to each episode of subacute/non-acute care.

For palliative care episodes, there must be a RUG-ADL assessment date reported for each phase of care.

For rehabilitation and GEM patients assessed against the FIM™ instrument, the assessment must be completed within 72 hours of admission unless the patient has been admitted for assessment only.

Examples

	Assessment Date
A patient is admitted into a rehabilitation ward on the 10 March 2021 and undergoes a FIM™ assessment the following day	11032021

A patient is statistically admitted to a maintenance care ward (e.g. change in care type from acute care to maintenance care) on 23 October 2021 and undergoes a RUG-ADL assessment on the same day	23102021

Related national definition

N/A

Revision history

N/A

Assessment Only

Field name:	ax_only
Source Data Element(s):	[Assessment Only] – ePalCIS, PSOLIS, webPAS
Definition:	An indicator of whether an episode of admitted patient care resulted in the patient undergoing a clinical assessment only, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Yes 2 – No 8 – Unknown 9 – Not stated/inadequately described

Guide for use

Collection of this data element is mandatory.

This data element facilitates the classification of subacute and non-acute episodes into AN-SNAP groups which are then used to inform activity based funding.

Permitted value definitions

1 – Yes

This code is used when the patient undergoes a clinical assessment only and no further treatment or intervention is provided.

These episodes are usually of short duration, normally less than 24 hours.

2 – No

This code is used when the patient undergoes a clinical assessment and further treatment is provided that is consistent with the minimum requirements for the care type as defined in the *Admitted Patient Activity Data Business Rules*.

8 – Unknown

This code is used when it is not known whether the episode of admitted care resulted in the patient undergoing a clinical assessment only.

9 – Not stated/inadequately described

This code is used when it is has not been reported whether the patient was seen for assessment only.

If valid value = 1 – Yes (patient assessed by clinical team but no further treatment or intervention provided) then the applicable assessment is not mandatory.

An episode of care is regarded as ‘assessment only’ if a patient was seen for clinical assessment only and no treatment or further intervention was planned by the assessing

clinical team.

Where a patient is ‘assessment only’ the clinical team must assess whether the patient qualifies for the subacute or non-acute care type allocation based on *Admitted Patient Activity Data Business Rules* admission criteria.

If valid value = 2 – No (patient assessed by clinical team and further treatment or intervention was provided) then the applicable assessment is mandatory.

Examples

	Assessment Only
A patient is admitted to a rehabilitation ward and examined by clinicians, but no further treatment is required	1 – Yes
A patient is admitted to a palliative care unit for ongoing care and a RUG-ADL assessment performed	2 – No

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/550492

Revision history

N/A

Care Type

Field name:	epicar
Source Data Element(s):	[Care Type] – ePalCIS, PSOLIS, , webPAS
Definition:	The clinical intent and purpose of the treatment being delivered.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NN
Permitted values:	21 – Acute care 22 – Rehabilitation care 23 – Palliative care 24 – Psychogeriatric care 25 – Maintenance care 26 – Newborn 27 – Organ procurement 28 – Boarder 29 – Geriatric Evaluation and Management 32 – Mental health care

Guide for use

Collection of this data element is mandatory.

Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management (GEM) and psychogeriatric care.

Non-acute care comprises the defined care type of maintenance.

Permitted value definitions

21 – Acute care

Care in which the primary clinical purpose or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

Acute care excludes care which meets the definition of mental health care.

22 – Rehabilitation care

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is always:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

Rehabilitation care excludes care which meets the definition of mental health care.

23 – Palliative care

Care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- delivered under the management of or informed by a clinician with specialised expertise in palliative care, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

Palliative care excludes care which meets the definition of mental health care.

24 – Psychogeriatric care

Care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related organic brain impairment or a physical condition.

Psychogeriatric care is always:

- delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Psychogeriatric care is not applicable if the primary focus of care is acute symptom control.

Psychogeriatric care excludes care which meets the definition of mental health care.

25 – Maintenance care

Care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.

Maintenance care excludes care which meets the definition of mental health care.

26 – Newborn care

Initiated when the patient is born in hospital or is nine days old or less at the time of admission, and continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders

- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type
- patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

27 – Organ procurement

Organ procurement is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

28 – Boarder

A boarder is a person who is receiving food and/or accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and/or care.

Boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

29 – Geriatric evaluation and management

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric evaluation and management is always:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Geriatric evaluation and management excludes care which meets the definition of mental health care.

32 – Mental health care

Care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient’s mental disorder. Mental health care:

- is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;
- is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and
- may include significant psychosocial components, including family and carer support.

For detailed admission criteria and rules concerning the application of care types see *Admitted Patient Activity Data Business Rules.*

Examples

	Care Type
A patient is admitted for respite care (maintenance) in an acute hospital setting whilst their usual carer is away on holidays.	25
A patient was admitted to a hospice and managed by a palliative care specialist for palliative care of bony metastases and carcinoma of the lung.	23
A young patient with multiple sclerosis is admitted with a treatment goal to improve functioning and meets the admission criteria for a rehabilitation admission.	22
A patient with Alzheimer's disease is admitted under a psychogeriatric team for behaviour modification.	24
A patient is admitted to the geriatric assessment unit due to multiple falls and the family is having difficulty in managing them at home.	29

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/584408

Revision history

N/A

Establishment Code

Field name:	hosp
Source Data Element(s):	[Establishment Code] – ePalCIS, PSOLIS, webPAS [Establishment ID] – AOS
Definition:	A unique four-digit number that is assigned by Department of Health (WA) to hospitals and other health related locations or establishments.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNNN
Permitted values:	Refer to the Establishment Code List

Guide for use

Collection of this data element is mandatory.

An establishment refers to an authorised/accredited physical location where patients can receive health care and stay overnight. This includes acute hospitals, residential aged care and nursing homes, rehabilitation and residential mental health facilities.

For the purposes of reporting and other business requirements, virtual hospitals, same-day clinics, surgeries, nursing posts, detention centres or prisons may also be assigned an establishment code.

Establishment codes are assigned by the Department of Health and a list of valid establishments is provided in the Establishment Code List .

Examples

	Establishment
A patient is admitted to Albany Hospital.	201
A patient is admitted to St John of God Health Care Murdoch.	640

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/269975

Revision history

N/A

FIM™ Score

Field name:	item1 – item18
Source Data Element(s):	[FIM Score] – AOS, webPAS
Definition:	An assessment of the severity of patient disability.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

Guide for use

Collection of FIM™ score is conditional – the collection of this data element is mandatory for patients with a care type of rehabilitation or GEM.

The FIM™ is a clinical assessment tool applied to patients receiving rehabilitation or GEM care to provide a basic indicator of disability severity. The functional ability of these patients can change during the care process and therefore the FIM™ instrument is useful in measuring the level of change and effectiveness of care.

FIM™ is comprised of 18 items, grouped into 2 subscales - motor and cognition.

The motor subscale includes:

- Eating
- Grooming
- Bathing
- Dressing, upper body
- Dressing, lower body
- Toileting
- Bladder management
- Bowel management
- Transfers - bed/chair/wheelchair
- Transfers - toilet

- Transfers - bath/shower
- Walk/wheelchair
- Stairs

The cognition subscale includes:

- Comprehension
- Expression
- Social interaction
- Problem solving
- Memory

Each item is scored on a seven-point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task associated with that item.

The total score for the FIM™ motor subscale (the sum of the individual motor subscale items) will be a value between 13 and 91.

The total score for the FIM™ cognition subscale (the sum of the individual cognition subscale items) will be a value between 5 and 35.

The total score for the FIM™ instrument (the sum of the motor and cognition subscale scores) will be a value between 18 and 126.

Patient function is assessed using the FIM™ instrument at the start of an episode of care and at the end of an episode of care.

The FIM™ on admission must be completed within 72 hours of the start of the admitted episode. Timely completion of the FIM™ on admission will be assessed using the assessment date.

Where a FIM™ on separation is recorded, this must be completed within 72 hours prior to the end of the admitted episode.

Assessment is complete when the last item of the FIM™ assessment is scored and the time stamp must be the date on which this occurs. Even if the recording of this date happens on a day subsequent to the day the last item of the assessment was completed, the date recorded must be the date the last item of the FIM™ assessment was scored.

For statistical separations from episodes with a care type of rehabilitation or GEM to episodes with a care type of rehabilitation or GEM the separation FIM™ of the prior episode may be repeated as the admission FIM™ of the subsequent episode.

For FIM™ on separation for patients who die in hospital, assign a score of 1 for each item, resulting in a total FIM™ on separation score of 18.

FIM™ on admission and FIM™ on separation are not required for patients aged 17 years and under at the time of admission.

FIM™ score must be captured in accordance with Australasian Rehabilitation Outcomes Centre (AROC) data collection requirements.

Examples

	FIM™
A 68-year-old patient is admitted to hospital with a care type of GEM.	Collected
A 93-year-old patient is admitted to hospital with a care type of palliative.	Not collected
A 19-year-old admitted patient's care type is changed from acute to rehabilitation.	Collected
An 84-year-old admitted patient's care type is changed from maintenance to GEM.	Collected

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/495857

Revision history

N/A

HoNOS 65+ Score

Field name:	item1 – item12
Source Data Element(s):	[HoNOS 65+ Score] – PSOLIS
Definition:	A variant of the HoNOS designed for use with adults aged 65 years and older. It is a 12-item clinician-rated measure designed specifically for use in the assessment of older adult consumer outcomes in mental health services.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No problems within the period rated 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem 8 – Unknown

Guide for use

Collection of Health of the Nation Outcome Scale 65+ (HoNOS 65+) is conditional – this data element only needs to be collected for persons aged 65 years and older when the admitted episode care type is psychogeriatric.

HoNOS 65+ is a 12-item clinician-rated measure to evaluate psychiatric symptoms and psychosocial functioning in an older patient. It is designed to be used by clinicians before and after interventions, so that changes attributable to interventions can be measured.

HoNOS 65+ is answered on an item-specific 4-point scale with higher scores indicating more problems. Each scale is assigned a value between 0 and 4. The 12 scales are as follows:

- behavioural disturbance
- non-accidental self-injury
- problem drinking or drug use
- cognitive problems
- problems related to physical illness or disability
- problems associated with hallucinations and delusions
- problems associated with depressive symptoms
- other mental and behavioural problems

- problems with social or supportive relationships
- problems with activities of daily living
- overall problems with living conditions
- problems with work and leisure activities and the quality of the daytime environment.

The sum of the individual scores of each of the scales (excluding supplementary value 8 ‘Unknown’) represents the total HoNOS 65+ score. The total HoNOS 65+ score ranges from 0 to 48 and represents the overall severity of an individual's psychiatric symptoms.

HoNOS 65+ scores must be captured in accordance with Australian Mental Health Outcomes and Classification Network (AMHOCN) data collection requirements.

Examples

	HoNOS 65+
A 68-year-old patient is admitted to hospital with a care type of psychogeriatric.	Collected
A 73-year-old patient is admitted to hospital with a care type of GEM.	Not collected
A 91-year-old admitted patient’s care type is changed from acute to psychogeriatric.	Collected
An 84-year-old admitted patient’s care type is changed from acute to maintenance.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/730844

Revision history

N/A

Impairment Type

Field name:	aroc_impair
Source Data Element(s):	[Impairment Type] – webPAS [AROC Impairment Code] – AOS
Definition:	The primary reason for a patient undergoing an episode of rehabilitation care.
Requirement status:	Conditional
Data type:	Numeric
Format:	NN**.**NNNN
Permitted values:	Refer to Appendix B: AROC Impairment Types

Guide for use

Collection of impairment type is conditional – this data element only needs to be collected for patients with a care type of rehabilitation.

Impairment codes are used to classify rehabilitation episodes into like clinical groups. The selected code must reflect the primary reason for the episode of rehabilitation care.

Impairment type must be collected within 72 hours of the start of a rehabilitation episode.

This data element is not required where the admission is for assessment only and no further treatment or intervention is provided.

Impairment type must be recorded in accordance with AROC data collection requirements.

Examples

	Impairment Type
An admitted patient is undergoing rehabilitation for *re-conditioning following surgery.*	16.1
An admitted patient is undergoing rehabilitation for *fracture of knee.*	8.141

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/498498

Revision history

N/A

Last Amended

Field name:	last_amended
Source Data Element(s):	[Last Amended] – ePalCIS, PSOLIS, webPAS
Definition:	The date the record was last amended.
Requirement status:	Mandatory
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of this data element is mandatory.

Last amended is system generated and records the date of the most recent change to the episode record.

This data element is used to provide an audit trail of actions performed.

Examples

	Last Amended
A user records a set of RUG-ADL scores on 12 June 2021.	12062021
A user changes an Impairment Type in the system on 5 April 2021.	05042021

Related national definition

N/A

Revision history

N/A

Last Amended By

Field name:	last_amended_by
Source Data Element(s):	[Last Amended By] – ePalCIS, PSOLIS, webPAS
Definition:	The unique employee or user number of the last person to edit the record.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(19)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is mandatory.

Last amended by is system generated and records the employee or user number of the staff member making the most recent change to the episode record.

This data element is used to provide an audit trail of actions performed.

Examples

	Last Amended By
A user records a set of RUG-ADL scores on 12 June 2021 at 10:15 pm.	HE999990
A user changes an Impairment Type in the system on 5 April 2021 at 5:10 am.	HE888880

Related national definition

N/A

Revision history

N/A

Phase End Date

Field name:	pal_phs_end
Source Data Element(s):	[Phase End Date] – webPAS, ePalCIS
Definition:	The date on which an admitted patient completes a phase of palliative care.
Requirement status:	Conditional
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of phase end date is conditional – this data element is mandatory for patients with a care type of palliative.

This data item identifies the time period in which the phase of care occurred and is used in the derivation of length of phase.

Within a palliative care episode there can be many phases. Phases must be reported in date sequence. The SANADC will accept a maximum of eleven phases of care. Any more than eleven phases of care do not contribute to the AN-SNAP classification process.

Phase end date must fall within the admission and separation dates for the episode.

The phase end date is equal to the next phase start date. The last phase end date must always be equal to the episode or care type end date.

Examples

A patient is admitted to a palliative care unit on 12 May 2022 with a phase type of unstable. During the episode of care, four phases of palliative care are recorded, until the episode ends on 21 May 2022. These phases are recorded as follows:

Phase Type	Phase Start Date	Phase End Date
Unstable	12052022	14052022
Stable	14052022	17052022
Deteriorating	17052022	18052022
Terminal	18052022	21052022

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/681040

Revision history

N/A

Phase Start Date

Field name:	pal_phs_start
Source Data Element(s):	[Phase Start Date] – webPAS, ePalCIS
Definition:	The date on which an admitted patient commences a phase of palliative care.
Requirement status:	Conditional
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of phase start date is conditional – this data element is mandatory for patients with a care type of palliative.

This data item identifies the time period in which the phase of care occurred and is used in the derivation of length of phase.

Within a palliative care episode there can be many phases. Phases must be reported in date sequence. The SANADC will accept a maximum of eleven phases of care. Any more than eleven phases of care do not contribute to the AN-SNAP classification process.

Phase start date must fall within the admission and separation dates for the episode.

The first phase start date must always be equal to the associated admission or care type start date. Subsequent phase start dates must be equal to the previous phase end date.

Examples

A patient is admitted to a palliative care unit on 12 May 2022 with a phase type of unstable. During the episode of care, four phases of palliative care are recorded, until the episode ends on 21 May 2022. These phases are recorded as follows:

Phase Type	Phase Start Date	Phase End Date
Unstable	12052022	14052022
Stable	14052022	17052022
Deteriorating	17052022	18052022
Terminal	18052022	21052022

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/681043

Revision history

N/A

Phase Type

Field name:	pal_phs_type
Source Data Element(s):	[Phase Type] – webPAS, ePalCIS
Definition:	The patient's stage of illness within the episode in terms of the recognised phases of palliative care.
Requirement status:	Conditional
Data type:	Numerical
Format:	N
Permitted values:	1 – Stable 2 – Unstable 3 – Deteriorating 4 – Terminal 9 – Not stated/inadequately described

Guide for use

Collection of phase type is conditional – this data element is mandatory for patients with a care type of palliative.

Permitted value definitions

1 – Stable

The patient symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned. The situation of the family/carers is relatively stable and no new issues are apparent.

2 – Unstable

The patient experiences the development of a new unexpected problem or a rapid increase in the severity of existing problems, either of which requires an urgent change in management or emergency treatment. The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

3 – Deteriorating

The patient experiences a gradual worsening of existing symptoms or the development of new but expected problems.

4 – Terminal

Death is likely in a matter of days and no acute intervention is planned or required.

9 – Not stated/inadequately described

The phase of the illness has not been reported.

An episode of admitted patient palliative care may comprise a single phase or multiple phases, depending on changes in the patient's condition. Phases are not sequential and a patient may move back and forth between phases within the one episode of admitted

patient palliative care.

A palliative care phase must not have the same phase type as the previous or next phase record within an episode.

Each time the phase type changes, a new set of phase start date, phase end date and RUG-ADL on phase change must be reported.

The SANADC will accept up to a maximum of eleven phases of care.

Examples

A patient is admitted to a palliative care unit on 11 May 2022 with a phase type of stable. During the episode of care, five phases of palliative care are recorded, until the episode ends on 21 May 2022. The phases are recorded as follows:

Phase Type	Phase Start Date	Phase End Date
Stable	11052022	12052022
Unstable	12052022	14052022
Stable	14052022	17052022
Deteriorating	17052022	18052022
Terminal	18052022	21052022

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/681029

Revision history

N/A

Record Creation Date

Field name:	created_on
Source Data Element(s):	[Record Creation Date] – ePalCIS, PSOLIS, webPAS
Definition:	The date on which the record was created.
Requirement status:	Mandatory
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of this data element is mandatory.

Record creation date is system generated and records the date each record is created.

Examples

	Record Creation
A user creates a new patient record in ePalCIS on 12 June 2021.	12062021

Related national definition

N/A

Revision history

N/A

RUG-ADL Score

Field name:	item1 – item4
Source Data Element(s):	[RUG-ADL Score] – ePalCIS, webPAS
Definition:	An assessment of patient motor function.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	*Scoring scale for bed mobility, toileting and transfers:* 1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than two persons physical assist 5 – Two or more persons physical assist *Scoring scale for eating:* 1 – Independent or supervision only 2 – Limited assistance 3 – Extensive assistance/total dependence/tube fed

Guide for use

Collection of Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) is conditional – this data element is mandatory for patients with a care type of maintenance or palliative.

The RUG-ADL is a clinical assessment tool that measures the level of functional dependence of a patient for four activities of daily living. The values assigned as part of a RUG-ADL assessment provide an indication of what a person actually does, not what they are capable of doing.

RUG-ADL measures the motor function of a patient for the following four activities of daily living:

- Bed mobility
- Toileting
- Transfers
- Eating

The total of all four RUG-ADL sub-scores is the driver for allocation to an AN-SNAP group.

As a general rule, the higher the total RUG-ADL score, the more dependent and potentially clinically complex the patient is.

Permitted value definitions

Bed Mobility

Ability to move in bed after the transfer into bed has been completed.

1 – Independent or supervision only

Able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.

3 – Limited physical assistance

Able to readjust position in bed, and perform own pressure area relief, with the assistance of one person.

4 – Other than two persons physical assist

Requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief. Still requires the assistance of one person for task.

5 – Two or more persons physical assist

Requires two or more assistants to readjust patient's position in bed, and perform pressure area relief.

Toileting

Includes mobilising to the toilet, adjustment of clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If level of assistance differs between voiding and bowel movement, record the lower performance.

1 – Independent or supervision only

Able to mobilise to toilet, adjusts clothing, cleans self, has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.

3 – Limited physical assistance

Requires hands-on assistance of one person for one or more of the tasks**.**

4 – Other than two persons physical assist

Requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/suppository. Requires assistance of one person for management of the device

5 – Two or more persons physical assist

Requires two or more assistants to perform any step of the task.

Transfers

Includes the transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night.

1 – Independent or supervision only

Able to perform all transfers independently or with prompting of carer. No hands-on assistance required. May be independent with the use of a device.

3 – Limited physical assistance

Requires hands-on assistance of one person to perform any transfer of the day/night.

4 – Other than two persons physical assist

Requires the use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.

5 – Two or more persons physical assist

Requires two or more assistants to perform any transfer of the day/night.

Eating

Includes the tasks of cutting food, bringing food to mouth and chewing and swallowing food. Does not include preparation of the meal.

1 – Independent or supervision only

Able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. No hands-on assistance required. If individual relies on parenteral or gastrostomy feeding that he/she administers him/herself then score 1.

2 – Limited assistance

Requires hands on assistance of one person to set up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).

3 – Extensive assistance/total dependence/tube fed

Needs to be fed meal by assistant, or does not eat or drink full meals by mouth but relies on parenteral/gastrostomy feeding and does not administer feeds by him/herself.

For maintenance care patients, RUG-ADL assessments must be conducted on admission and at discharge.

For palliative care patients, RUG-ADL assessments must be conducted on admission, and daily thereafter, with RUG-ADL scores recorded at each phase change.

A score of 2 is not valid for bed mobility, toileting and transfer items.

The total RUG-ADL score (the sum of the individual scale items) must be a value between 4 and 18.

A person with a total RUG-ADL score of 4 is considered independent.

A person with a total RUG-ADL score of 18 requires the full assistance of two people.

For maintenance care patients, only the first set of RUG-ADL scores performed during the admission are required for reporting.

For palliative care patients, a set of RUG-ADL scores is required for each time a patient changes phase of care type.

Within a given palliative care episode, a patient can have up to eleven phases of care.

Where more than eleven phases of palliative care occur, all RUG-ADL scores captured after the eleventh change are omitted and only the details of the final (i.e. the eleventh) RUG-ADL assessment is reported.

RUG-ADL scores must be captured in accordance with Palliative Care Outcomes Collaboration (PCOC) data collection requirements.

Examples

	RUG-ADL
A 43-year-old patient is admitted to hospital with a care type of palliative.	Collected
An 82-year-old patient is admitted to hospital with a care type of maintenance.	Collected
A 91-year-old admitted patient's care type is changed from acute to GEM.	Not collected
A 50-year-old admitted patient's care type is changed from acute to palliative.	Collected
An 84-year-old admitted patient's care type is changed from acute to maintenance.	Collected

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/495909

Revision history

N/A

Separation Date

Field name:	sep
Source Data Element(s):	[Separation Date] – webPAS [Episode End Date] – ePalCIS, AOS
Definition:	The date on which an admitted patient completes an episode of care.
Requirement status:	Mandatory
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of this data element is mandatory.

The patient can be formally or statistically discharged from hospital.

Formal Separation/Discharge

A formal separation/discharge is an administrative process that ceases a record of the patient's treatment and accommodation within a hospital.

The separation date for a formal separation/discharge will be the date the hospital completed treatment and accommodation of the patient.

If an admitted patient is on leave but does not return after seven days the patient is then formally discharged on the seventh day, and the preceding days are counted as leave days.

Statistical Separation/Discharge

A statistical separation/discharge is an administrative process that occurs within an episode of care and captures the end date the patient received a particular type of care (care type).

The separation date for a statistical discharge will be the date the patient completed a particular care type.

Often subacute and non-acute patients move between care types (acute → subacute → non-acute) with a single hospital stay. When this occurs there will only be one formal separation date but there can be many statistical separation dates depending on how many care type changes have occurred.

If a patient dies in hospital, the separation date is the date of death.

Examples

	Separation Date
A patient is discharged from a rehabilitation ward on 10 March 2021	10032021

A patient is statistically discharged from an acute ward (e.g. change in care type from acute care to palliative care) on 18 July 2021	18072021

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/270025

Revision history

N/A

SMMSE Assessment Date

Field name:	smmse_date
Source Data Element(s):	[SMMSE Assessment Date] – webPAS
Definition:	The date on which an admitted GEM patient undergoes the SMMSE clinical assessment.
Requirement status:	Conditional
Data type:	Date
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of Standardised Mini-Mental State Examination (SMMSE) assessment date is conditional – this data element only needs to be collected for admitted patients with a care type of GEM who have undergone the SMMSE assessment.

SMMSE assessment date is only required to be reported where the care type is GEM.

This data element is only required if an SMMSE has actually been performed during the GEM episode of care.

Not all GEM episodes of care will have a SMMSE performed.

Examples

	SMMSE Assessment Date
A patient is admitted to a GEM ward on 10 March 2021 and undergoes an SMMSE the following day	11032021

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/681420

Revision history

N/A

SMMSE Completed

Field name:	smmse_comp
Source Data Element(s):	[SMMSE Completed] – webPAS
Definition:	Code identifying whether an admitted GEM patient has undergone an SMMSE clinical assessment.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Yes 2 – No 9 – Unknown

Guide for use

Collection of Standardised Mini-Mental State Examination (SMMSE) completed is conditional – this data element is mandatory for admitted patients with a care type of GEM.

SMMSE completed is only required to be reported where the care type is GEM.

Not all GEM episodes of care will have a SMMSE performed.

Examples

	SMMSE Completed
A patient is admitted to a GEM ward on 10 March 2021 and undergoes an SMMSE the following day	1 – Yes
A patient is admitted to a GEM ward on 22 August 2021 and no SMMSE is undertaken	2 – No

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/681420

Revision history

N/A

SMMSE Score

Field name:	smmse1 – smmse12
Source Data Element(s):	[SMMSE Score] – webPAS
Definition:	The person's degree of cognitive ability to process thoughts and respond appropriately and safely, as represented by a score-based code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – Score of 0 1 – Score of 1 2 – Score of 2 3 – Score of 3 4 – Score of 4 5 – Score of 5 7 – Not applicable – item has been omitted 8 – Unknown 9 – Not stated/inadequately described

Guide for use

Collection of Standardised Mini-Mental State Examination (SMMSE) score is conditional – this data element only needs to be collected for admitted patients with a care type of GEM who have undergone the SMMSE assessment. Not all GEM episodes of care will have a SMMSE performed. SMMSE is designed to screen and measure cognitive impairment. It consists of twelve questions which assess a range of cognitive domains, requiring vocal and physical actions (such as memory recall and drawing) in response to reading and listening to commands.

Each question in the SMMSE has a maximum score:

Question	Cognitive Domain	Max.Score
1	Orientation – time	5
2	Orientation – place	5
3	Memory – immediate	3
4	Language/attention	5
5	Memory – short	3
6	Language/memory – long	1
7	Language/memory – long	1
8	Language/abstract thinking/verbal fluency	1

9	Language		1
10	Language/attention/comprehension		1
11	Attention/comprehension/follow commands/constructional		1
12	Attention/comprehension/construction/follow commands		3
		Total score	30

Scores above 1 are not permissible for questions 6–11.

Scores above 3 are not permissible for questions 3 and 12.

Scores above 5 are not permissible for questions 1, 2 and 4.

The final SMMSE score is a sum of the 12 questions and can range from a minimum of 0 to a maximum of 30.

The SMMSE can be adjusted for non-cognitive disabilities.

As outlined in the SMMSE guidelines, if a question cannot be modified or adjusted then the question is omitted, reducing the maximum obtainable score from 30. The formula — (Actual score x 30) / Maximum obtainable score) — is used to readjust the score to be comparable with unadjusted scores.

Only one array of SMMSE scores (i.e. twelve individual scores) per GEM episode are required to be reported.

If multiple sets of SMMSE scores are recorded in the patient's record, the set of scores (i.e. twelve individual scores) which demonstrate the lowest level of cognitive ability recorded during the GEM episode must be reported.

SMMSE scores must be captured in accordance with Independent Hospital Pricing Authority (IHPA) data collection requirements.

Examples

	SMMSE	SMMSE Score
An 82-year-old patient is admitted to hospital with a care type of GEM and an SMMSE assessment is performed.	Collected	27
A 91-year-old admitted patient's care type is changed from acute to GEM and an SMMSE assessment is performed.	Collected	15
A 67-year-old admitted patient's care type is changed from acute to GEM. No SMMSE assessment is performed.	Not collected	

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/681420

Revision history

N/A

Type of Maintenance Care

Field name:	main_type
Source Data Element(s):	[Type of Maintenance Care] – webPAS
Definition:	The type of maintenance care provided to an admitted patient during an episode of care, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	NN
Permitted values:	1 – Convalescent 2 – Respite 3 – Nursing home type 8 – Other 98 – Unknown 99 – Not stated/inadequately described

Guide for use

Collection of type of maintenance care is conditional – this data element only needs to be collected for admitted patients with a care type of maintenance.

Type of maintenance care must be recorded at the start of the admitted episode.

Permitted value definitions

1 – Convalescent

Following assessment and/or treatment, the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include:

- patients awaiting the completion of home modifications essential for discharge
- patients awaiting the provision of specialised equipment essential for discharge
- patients awaiting rehousing
- patients awaiting supported accommodation such as hostel or group home bed
- patients for whom community services are essential for discharge but are not yet available.

2 – Respite

An episode where the primary reason for admission is the short-term unavailability of the patient's usual care. Examples may include:

- admission due to carer illness or fatigue
- planned respite due to carer unavailability

- short term closure of care facility
- short term unavailability of community services.

3 – Nursing home type

The patient does not have a current acute care certificate and is awaiting placement in a residential aged care facility.

8 – Other

Any other reason the patient may require a maintenance episode other than those already stated.

98 – Unknown

It is not known what type of maintenance care the patient is receiving.

99 – Not stated/inadequately described

The type of maintenance care has not been reported.

Examples

	Type of Maintenance Care
A patient is admitted to hospital with a maintenance care type and receives respite care	2 – Respite
A patient's care type is changed from acute to maintenance and receives convalescent care	1 – Convalescent

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/496467

Revision history

N/A

Unit Medical Record Number (UMRN)

Field name:	umrn
Source Data Element(s):	[UMRN] – ePalCIS, PSOLIS, webPAS [Patient Identifier] – AOS
Definition:	The same identifier retained by the hospital for the patient for all events within that particular hospital.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(9)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is mandatory.

Alternate names for UMRN are patient or client identifier, and unit record number (URN).

UMRN can be alphanumeric or numeric up to a maximum of 10 characters and must be a unique number for every patient in an establishment.

The year number should not form any part of the UMRN.

The same patient identifier must be retained by the hospital for all admissions within a particular hospital.

Examples

	UMRN
A patient is admitted to a rehabilitation ward with a UMRN of L2309999.	L2309999
A patient is transferred to a palliative care unit and assigned a URN of 21999.	21999

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/290046

Revision history

N/A

Appendix A – AN-SNAP V5 Classification

The Independent Hospital Pricing Authority (IHPA) is responsible for the implementation of a nationally consistent activity-based funding (ABF) system for subacute and non-acute care. The Australian National Subacute and Non-Acute Patient (AN-SNAP) classification system was selected by IHPA as the ABF classification system to be used for subacute and non-acute care.

AN-SNAP Version 5 applies to episodes of admitted patient hospital care (same day and overnight). It does not classify non-admitted care because IHPA does not use AN-SNAP to price non-admitted subacute care. Patients are classified on the basis of setting, care type, phase of care, assessment of functional impairments, age and other measures.

AN-SNAP Version 5 was released in December 2021 and has been used to price subacute and non-acute services from 2022-23. More information about the classification can be found here.

AN-SNAP V5 Classification			
Class	**Episode Setting**	**Episode Type**	**Description**
5AZ1	Admitted	Adult rehabilitation	Weighted FIM Motor score 13-18, Brain, Spine, MMT, Burns, Age >= 59
5AZ2	Admitted	Adult rehabilitation	Weighted FIM Motor score 13-18, Brain, Spine, MMT, Burns, Age 18 - 58
5AZ3	Admitted	Adult rehabilitation	Weighted FIM Motor score 13-18, All other impairments, Age >= 79
5AZ4	Admitted	Adult rehabilitation	Weighted FIM Motor score 13-18, All other impairments, Age 18 - 78
5AA1	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 63 - 91, FIM Cognition 30 - 35
5AA2	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 63 - 91, FIM Cognition 21 - 29
5AA3	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 63 - 91, FIM Cognition 5 - 20
5AA4	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 44 - 62, FIM Cognition 18 - 35
5AA5	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 44 - 62, FIM Cognition 5 - 17
5AA6	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 19 - 43, Age >= 80
5AA7	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 19 - 43, Age 67 - 79
5AA8	Admitted	Adult rehabilitation	Stroke, Weighted FIM Motor 19 - 43 Age 18 - 66
5AB1	Admitted	Adult rehabilitation	Brain dysfunction, FIM Cognition 27 - 35 Weighted FIM Motor 59 - 91
5AB2	Admitted	Adult rehabilitation	Brain dysfunction, FIM Cognition 27 - 35 Weighted FIM Motor 19 - 58
5AB3	Admitted	Adult rehabilitation	Brain dysfunction, FIM Cognition 19 - 26 Weighted FIM Motor 50 - 91
5AB4	Admitted	Adult rehabilitation	Brain dysfunction, FIM Cognition 19 - 26 Weighted FIM Motor 19 - 49
5AB5	Admitted	Adult rehabilitation	Brain dysfunction, FIM Cognition 5 - 18 Weighted FIM Motor 39 - 91
5AB6	Admitted	Adult rehabilitation	Brain dysfunction, FIM Cognition 5 - 18 Weighted FIM Motor 19 - 38
5AC1	Admitted	Adult rehabilitation	Neurological conditions, Weighted FIM Motor 70 - 91
5AC2	Admitted	Adult rehabilitation	Neurological conditions, Weighted FIM Motor 50 - 69
5AC3	Admitted	Adult rehabilitation	Neurological conditions, Weighted FIM Motor 19 - 49
5AD1	Admitted	Adult rehabilitation	Spinal cord dysfunction, Weighted FIM Motor 55 - 91
5AD2	Admitted	Adult rehabilitation	Spinal cord dysfunction, Weighted FIM Motor 37 - 54
5AD3	Admitted	Adult rehabilitation	Spinal cord dysfunction, Weighted FIM Motor 19 - 36

AN-SNAP V5 Classification			
Class	**Episode Setting**	**Episode Type**	**Description**
5AE1	Admitted	Adult rehabilitation	Amputation of limb
5AH1	Admitted	Adult rehabilitation	Orthopaedic conditions, fractures, Weighted FIM Motor 48 - 91, FIM Cognition 33 - 35
5AH2	Admitted	Adult rehabilitation	Orthopaedic conditions, fractures, Weighted FIM Motor 48 - 91, FIM Cognition 21 - 32
5AH3	Admitted	Adult rehabilitation	Orthopaedic conditions, fractures, Weighted FIM Motor 48 - 91, FIM Cognition 5 - 20
5AH4	Admitted	Adult rehabilitation	Orthopaedic conditions, fractures, Weighted FIM Motor 19 - 47
5A41	Admitted	Adult rehabilitation	Orthopaedic conditions, replacement (knee, hip, shoulder), Weighted FIM Motor 61 - 91
5A42	Admitted	Adult rehabilitation	Orthopaedic conditions, replacement (knee, hip, shoulder), Weighted FIM Motor 45 - 60
5A43	Admitted	Adult rehabilitation	Orthopaedic conditions, replacement (knee, hip, shoulder), Weighted FIM Motor 19 - 44
5A21	Admitted	Adult rehabilitation	Orthopaedic conditions, all other, Weighted FIM Motor 57 - 91
5A22	Admitted	Adult rehabilitation	Orthopaedic conditions, all other, Weighted FIM Motor 41 - 56
5A23	Admitted	Adult rehabilitation	Orthopaedic conditions, all other, Weighted FIM Motor 19 - 40
5A31	Admitted	Adult rehabilitation	Cardiac, Pain syndromes, and Pulmonary, Weighted FIM Motor 66 - 91
5A32	Admitted	Adult rehabilitation	Cardiac, Pain syndromes, and Pulmonary, Weighted FIM Motor 38 - 65
5A33	Admitted	Adult rehabilitation	Cardiac, Pain syndromes, and Pulmonary, Weighted FIM Motor 19 - 37
5AP1	Admitted	Adult rehabilitation	Major Multiple Trauma, Weighted FIM Motor 51 - 91
5AP2	Admitted	Adult rehabilitation	Major Multiple Trauma, Weighted FIM Motor 19 - 50
5AR1	Admitted	Adult rehabilitation	Reconditioning, Weighted FIM Motor 64 - 91, FIM Cognition 29 - 35
5AR2	Admitted	Adult rehabilitation	Reconditioning, Weighted FIM Motor 64 - 91, FIM Cognition 5 - 28
5AR3	Admitted	Adult rehabilitation	Reconditioning, Weighted FIM Motor 48 - 63, FIM Cognition 19 - 35
5AR4	Admitted	Adult rehabilitation	Reconditioning, Weighted FIM Motor 48 - 63, FIM Cognition 5 - 18
5AR5	Admitted	Adult rehabilitation	Reconditioning, Weighted FIM Motor 19 - 47
5A91	Admitted	Adult rehabilitation	All other impairments, Weighted FIM Motor 61 - 91
5A92	Admitted	Adult rehabilitation	All other impairments, Weighted FIM Motor 42 - 60
5A93	Admitted	Adult rehabilitation	All other impairments, Weighted FIM Motor 19 - 41
5J01	Admitted	Adult rehabilitation	Adult Same-Day Rehabilitation
599A	Admitted	Adult rehabilitation	Adult Rehabilitation - Ungroupable
5F01	Admitted	Paediatric rehabilitation	Rehabilitation, Age <= 3
5F02	Admitted	Paediatric rehabilitation	Rehabilitation, Age >= 4, Spinal cord dysfunction
5F03	Admitted	Paediatric rehabilitation	Rehabilitation, Age >= 4, Brain dysfunction
5F04	Admitted	Paediatric rehabilitation	Rehabilitation, Age >= 4, Neurological conditions
5F05	Admitted	Paediatric rehabilitation	Rehabilitation, Age >= 4, All other impairments
5O01	Admitted	Paediatric rehabilitation	Paediatric Same-Day Rehabilitation
599F	Admitted	Paediatric rehabilitation	Paediatric Rehabilitation - Ungroupable
5BS1	Admitted	Adult palliative care	Stable phase, RUG-ADL 4-5
5BS2	Admitted	Adult palliative care	Stable phase, RUG-ADL 6-16
5BS3	Admitted	Adult palliative care	Stable phase, RUG-ADL 17-18

AN-SNAP V5 Classification			
Class	**Episode Setting**	**Episode Type**	**Description**
5BU1	Admitted	Adult palliative care	Unstable phase, First Phase in Episode, RUG-ADL 4-13
5BU2	Admitted	Adult palliative care	Unstable phase, First Phase in Episode, RUG-ADL 14-18
5BU3	Admitted	Adult palliative care	Unstable phase, Not first Phase in Episode, RUG-ADL 4-5
5BU4	Admitted	Adult palliative care	Unstable phase, Not first Phase in Episode, RUG-ADL 6-18
5BD1	Admitted	Adult palliative care	Deteriorating phase, RUG-ADL 4-14
5BD2	Admitted	Adult palliative care	Deteriorating phase, RUG-ADL 15-18, Age >= 75
5BD3	Admitted	Adult palliative care	Deteriorating phase, RUG-ADL 15-18, Age 55-74
5BD4	Admitted	Adult palliative care	Deteriorating phase, RUG-ADL 15-18, Age <= 54
5BT1	Admitted	Adult palliative care	Terminal phase
5K01	Admitted	Adult palliative care	Adult Same-Day Palliative Care
599B	Admitted	Adult palliative care	Adult Palliative Care - Ungroupable
5G01	Admitted	Paediatric palliative care	Phase Type: Not Terminal, Age < 1 year
5G02	Admitted	Paediatric palliative care	Phase Type: Not Terminal, Age >= 1 year, Stable phase
5G03	Admitted	Paediatric palliative care	Phase Type: Not Terminal, Age >= 1 year, Unstable or Deteriorating phase
5G04	Admitted	Paediatric palliative care	Terminal phase
5P01	Admitted	Paediatric palliative care	Paediatric Same-Day Palliative Care
599G	Admitted	Paediatric palliative care	Paediatric Palliative Care - Ungroupable
5CL1	Admitted	Geriatric evaluation and management (GEM)	Frailty Related Index of Comorbidities (FRIC) Score 0 - 1.8, FIM Motor 58 - 91
5CL2	Admitted	Geriatric evaluation and management (GEM)	Frailty Related Index of Comorbidities (FRIC) Score 0 - 1.8, FIM Motor 13 - 57
5CM1	Admitted	Geriatric evaluation and management (GEM)	Frailty Related Index of Comorbidities (FRIC) Score 1.9 - 7.3, FIM Motor 51 - 91
5CM2	Admitted	Geriatric evaluation and management (GEM)	Frailty Related Index of Comorbidities (FRIC) Score 1.9 - 7.3, FIM Motor 13 - 50
5CH1	Admitted	Geriatric evaluation and management (GEM)	Frailty Related Index of Comorbidities (FRIC) Score >= 7.4, FIM Motor 40 - 91
5CH2	Admitted	Geriatric evaluation and management (GEM)	Frailty Related Index of Comorbidities (FRIC) Score >= 7.4, FIM Motor 13 - 39
5L01	Admitted	Geriatric evaluation and management (GEM)	Same-Day GEM
599C	Admitted	Geriatric evaluation and management (GEM)	GEM - Ungroupable
5DL1	Admitted	Psychogeriatric care	Long term care (LOS > 91)
5DS1	Admitted	Psychogeriatric care	LOS =< 91, HoNOS 65+ Total 18 - 48
5DS2	Admitted	Psychogeriatric care	LOS =< 91, HoNOS 65+ Total 0 - 17
5M01	Admitted	Psychogeriatric care	Same-Day Psychogeriatric Care
599D	Admitted	Psychogeriatric care	Psychogeriatric care - Ungroupable
5EL1	Admitted	Non-acute care	Long term care (LOS > 91)
5ES1	Admitted	Non-acute care	Shorter term care (LOS =< 91), Age >= 65, Frailty Related Index of Comorbidities (FRIC) Score 0 - 1.9
5ES2	Admitted	Non-acute care	Shorter term care (LOS =< 91), Age >= 65, Frailty Related Index of Comorbidities (FRIC) Score >= 2
5ES3	Admitted	Non-acute care	Shorter term care (LOS =< 91), Age = 18-64
5ES4	Admitted	Non-acute care	Shorter term care (LOS =< 91), Age =< 17
599E	Admitted	Non-acute care	Non-acute care - Ungroupable
5999	Unknown	Unknown	No valid episode setting or episode type available - Ungroupable

Appendix B – AROC Impairment Types

The Australasian Rehabilitation Outcomes Centre (AROC) is a national body that collects and reports data on the specialist medical rehabilitation sector. Data collected for AROC is primarily used to develop a national benchmarking system to improve clinical rehabilitation outcomes, produce information on the efficacy of interventions and develop clinical and management information based on functional outcomes and impairment groupings.

The AROC Impairment Codes specified below provide the list of acceptable values for capture of the subacute data element known as Impairment Type.

More information about the Impairment Codes can be found here.

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
STROKE	
Stroke - haemorrhagic	
1.11	Left Body Involvement (Right Brain)
1.12	Right Body Involvement (Left Brain)
1.13	Bilateral Involvement
1.14	No Paresis
1.19	Other stroke
Stroke - ischaemic	
1.21	Left Body Involvement (Right Brain)
1.22	Right Body Involvement (Left Brain)
1.23	Bilateral Involvement
1.24	No Paresis
1.29	Other stroke
BRAIN DYSFUNCTION	
Non-traumatic brain dysfunction	
2.11	Non traumatic subarachnoid haemorrhage
2.12	Anoxic brain damage
2.13	Other non-traumatic brain dysfunction
Traumatic brain dysfunction	
2.21	Traumatic, open injury
2.22	Traumatic, closed injury
NEUROLOGICAL CONDITIONS	
3.1	Multiple sclerosis
3.2	Parkinsonism
3.3	Polyneuropathy
3.4	Guillain-Barre
3.5	Cerebral palsy
3.8	Neuromuscular disorders
3.9	Other neurologic
SPINAL CORD DYSFUNCTION	
Non-traumatic spinal cord dysfunction	
4.111	Paraplegia, incomplete
4.112	Paraplegia, complete

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
4.1211	Quadriplegia incomplete C1-4
4.1212	Quadriplegia incomplete C5-8
4.1221	Quadriplegia complete C1-4
4.1222	Quadriplegia complete C5-8
4.13	Other non-traumatic spinal cord dysfunction
Traumatic spinal cord dysfunction	
4.211	Paraplegia, incomplete
4.212	Paraplegia, complete
4.2211	Quadriplegia incomplete C1-4
4.2212	Quadriplegia incomplete C5-8
4.2221	Quadriplegia complete C1-4
4.2222	Quadriplegia complete C5-8
4.23	Other traumatic spinal cord dysfunction
AMPUTATION OF LIMB	
Amputation of limb NOT resulting from a trauma	
5.11	Single upper amputation above the elbow
5.12	Single upper amputation below the elbow
5.13	Single lower amputation above the knee
5.14	Single lower amputation below the knee
5.15	Double lower amputation above the knee
5.16	Double lower amputation above/below the knee
5.17	Double lower amputation below the knee
5.18	Partial foot amputation (includes single/double)
5.19	Other amputation
Amputation of limb as a result of trauma	
5.21	Single upper amputation above the elbow
5.22	Single upper amputation below the elbow
5.23	Single lower amputation above the knee
5.24	Single lower amputation below the knee
5.25	Double lower amputation above the knee
5.26	Double lower amputation above/below the knee
5.27	Double lower amputation below the knee
5.28	Partial foot amputation (includes single/double)
5.29	Other amputation
ARTHRITIS	
6.1	Rheumatoid arthritis
6.2	Osteoarthritis
6.9	Other arthritis
PAIN SYNDROMES	
7.1	Neck pain
7.2	Back pain
7.3	Extremity pain
7.4	Headache (includes migraine)
7.5	Multi-site pain

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
7.9	Other pain
ORTHOPAEDIC CONDITIONS	
Fracture	
8.111	Fracture of hip, unilateral (includes #NOF)
8.112	Fracture of hip, bilateral (includes #NOF)
8.12	Fracture of shaft of femur (excludes femur involving knee joint)
8.13	Fracture of pelvis
8.141	Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
8.142	Fracture of leg, ankle, foot
8.15	Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
8.16	Fracture of spine (excludes where the major disorder is pain)
8.17	Fracture of multiple sites
8.19	Other orthopaedic fracture
Post orthopaedic surgery	
8.211	Unilateral hip replacement
8.212	Bilateral hip replacement
8.221	Unilateral knee replacement
8.222	Bilateral knee replacement
8.231	Knee and hip replacement same side
8.232	Knee and hip replacement different sides
8.24	Shoulder replacement or repair
8.25	Post spinal surgery
8.26	Other orthopaedic surgery
Soft tissue injury	
8.3	Soft tissue injury
CARDIAC	
9.1	Following recent onset of new cardiac impairment
9.2	Chronic cardiac insufficiency
9.3	Heart or heart/lung transplant
PULMONARY	
10.1	Chronic obstructive pulmonary disease
10.2	Lung transplant
10.9	Other pulmonary
BURNS	
11	Burns
CONGENITAL DEFORMITIES	
12.1	Spina bifida
12.9	Other congenital
OTHER DISABLING IMPAIRMENTS	
13.1	Lymphoedema
13.3	Conversion disorder
13.9	Other disabling impairments. This classification should rarely be used.
MAJOR MULTIPLE TRAUMA	
14.1	Brain + spinal cord injury

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
14.2	Brain + multiple fracture/amputation
14.3	Spinal cord + multiple fracture/amputation
14.9	Other multiple trauma
DEVELOPMENTAL DISABILITIES	
15.1	Developmental disabilities
RE-CONDITIONING/RESTORATIVE	
16.1	Re-conditioning following surgery
16.2	Re-conditioning following medical illness
16.3	Cancer rehabilitation

Appendix C – Summary of revisions

Date Released	Author	Approval	Amendment
1 July 2021	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created. Adapted from *SANADC Reference Manual 2016/17*
1 July 2022	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. Superseded QoCR system references replaced by AOS. Removed 'Rules' and 'QA / Validations' sections from each data element. Superseded AN-SNAP Version 4.0 explanatory text and classification replaced by AN-SNAP Version 5.0.

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