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

Subacute and Non-acute Data Collection

Data Specifications

July 2022

Owner:	Department of Health, Western Australia
Contact:	Information and Performance Governance
Approved by:	Rob Anderson, Assistant Director General, Purchasing and System Performance
Links to:	Information Management Policy Framework https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management

Contents

Abbreviations

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
HMDS	Hospital Morbidity Data System
HoNOS	Health of the Nation Outcome Scales
ICT	Information and Communications Technology
IHPA	Independent Hospital Pricing Authority
PAS	Patient Administration System
PSOLIS	Psychiatric Services On-line Information System
RUG-ADL	Resource Utilisation Groups - Activities of Daily Living
SANA	Subacute and Non-acute
SANADC	Subacute and Non-acute Data Collection
SMMSE	Standardised Mini-Mental State Examination
UMRN	Unit Medical Record Number
WA	Western Australia
webPAS	Web-based Patient Administration System

1. Purpose

The purpose of the *Subacute and Non-acute Data Collection Data Specifications* is to outline the requirements for Health Service Providers and Contracted Health Entities to report subacute and non-acute patient activity to the Department of Health.

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

These data specifications are 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 Dictionary*
- *Patient Activity Data Policy Information Compendium*.

2. Background

Subacute and non-acute patient activity data must be recorded in approved Patient Administration Systems (PAS) in an accurate and timely manner so that the data are available and can be accessed for inclusion into the Subacute and Non-acute Data Collection (SANADC).

The SANADC includes data collected routinely during admitted subacute and non-acute episodes of care but also captures additional clinical information that varies according to the episode care type.

For reliability purposes, all demographic, admission, discharge and morbidity information for subacute and non-acute episodes are sourced directly from the Hospital Morbidity Data System (HMDS) after they have been through the HMDS data quality cycle.

To enable the coding of subacute and non-acute episodes to the Australian National Subacute and Non-acute Patient (AN-SNAP) classification sites are required to submit additional clinical assessment data items for each episode of care. As per the table below, the additional data items required depends on the age of the patient and the care type, with all data items to be collected on admission.

Care type	FIM™ scores	Impairment code	SMMSE	HoNOS 65+ scores	RUG-ADL scores	Phase(s) of care
Adult episodes						
Rehabilitation	✓	✓				
GEM	✓		✓			
Psychogeriatric				✓		
Palliative					✓	✓
Maintenance					✓	
Paediatric episodes						
Rehabilitation		✓				
Palliative						✓

3. Contact details requirements

Data providers must complete the contact details form (Appendix A) and provide contact details for two people who can be contacted in the event of data submission queries or issues:

- ICT technical contact – for data load/extract issues
- Information management contact – for data queries

4. Submission of data

Data must be submitted to the SANADC in accordance with the data submission schedule (Section 5) and data element listing (Section 6) outlined below, unless otherwise agreed to with the SANADC Custodian.

Files must be submitted in accordance to the SANA data file structure (Appendix B).

5. Data submission schedule

Data must be made available for the relevant reporting period as per the schedule set below:

PAS	Reporting Period	Provided to SANADC	Notes
webPAS	Monday - Sunday	Monday, 1am	All care types
AOS	Monday - Sunday	Monday, 1am	Rehabilitation
PSOLIS	Monday - Sunday	Monday, 1am	Psychogeriatric
ePalCIS	Monday - Sunday	Monday, 1am	Palliative

Data providers that use an alternate information system are required to submit data monthly or on request by the Department in an electronic format that is compliant with these specifications and the *Subacute and Non-acute Data Collection Data Dictionary*.

6. Data element listing

Data providers must ensure that data is made available as per the specifications in the following appendices:

- Appendix C – Rehabilitation data elements
- Appendix D – GEM data elements
- Appendix E – Psychogeriatric data elements
- Appendix F – Palliative data elements
- Appendix G – Maintenance data elements

7. Data quality and validation correction process

Data providers are responsible for the quality of data provided. Data quality validations are undertaken by the Quality and Assurance Team at the Department of Health to ensure that data is compliant with reporting specifications, and the five data quality principles:

- relevance
- accuracy
- timeliness
- coherence
- interpretability

Data validation and errors will be distributed to the reporting hospital via dashboards, spreadsheets or ad hoc communication.

It is the responsibility of health care providers, administrative, clinical coding and clerical staff to complete and correct data validations within required timeframes as communicated by the Department of Health.

Some examples of data quality validations may include:

- patient demographics
- reporting of blank or incorrect values
- availability of sufficient information to enable reporting to the Independent Hospital Pricing Authority.

8. Glossary

The following definition(s) are relevant to this document.

Term	Definition
Contracted Health Entity	As per section 6 of the *Health Services Act 2016*, a non-government entity that provides health services under a contract or other agreement entered into with the Department Chief Executive Officer on behalf of the State, a Health Service Provider or the Minister
Custodian	A custodian manages the day-to-day operations of the information asset(s), and implements policy on behalf of the Steward and Sponsor.
Data Collection	Refer to Information Asset
Data Specifications	Data Specifications mandate the list of data elements, format and submission schedule for each information asset.
Health Service Provider	As per section 6 of the *Health Services Act 2016*, a Health Service Provider established by an order made under section 32(1)(b)
Information asset	A collection of information that is recognised as having value for the purpose of enabling the WA health system to perform its clinical and business functions, which include supporting processes, information flows, reporting and analytics.
Information Management Policy Framework	The Information Management Policy Framework specifies the information management requirements that all Health Service Providers must comply with in order to ensure effective and consistent management of health, personal and business information across the WA health system.
Patient Activity Data Business Rules	Patient Activity Data Business Rules mandate the rules, scope and criteria to be used when recording health service patient activity data and reporting to the Department of Health.
WA health system	Pursuant to section 19(1) of the *Health Services Act 2016*, means the Department of Health, Health Service Providers, and to the extent that Contracted Health Entities provide health services to the State, the Contracted Health Entities.

9. References

These data specifications should be read in conjunction with the information linked below:

Subacute and Non-acute Care

Australian National Subacute and Non-acute Patient Classification Version 5.0

Subacute and Non-acute Care Data Set Specifications

Appendix A – Contact details form

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

Subacute and Non-acute Data Collection
Data Provider Contact Details Form

The purpose of this form is to collect contact information for persons providing data to the Subacute and Non-acute Data Collection.

Name of Data Provider or Feeder System	Click or tap here to enter text.
Date	Click or tap here to enter text.

ICT Technical Contact

Please provide details for the person to contact regarding technical queries (e.g. data loading, extract issues)

Name	Click or tap here to enter text.
Position	Click or tap here to enter text.
Organisation	Click or tap here to enter text.
Email	Click or tap here to enter text.
Phone	Click or tap here to enter text.

Information Management Contact

Please provide contact details for the person to contact regarding data queries (e.g. queries relating to data interpretation)

Name	Click or tap here to enter text.
Position	Click or tap here to enter text.
Organisation	Click or tap here to enter text.
Email	Click or tap here to enter text.
Phone	Click or tap here to enter text.

Please submit this form to sana.data@health.wa.gov.au

Appendix B – SANA data file structure

Subacute care in this data file is identified as admitted episodes in rehabilitation care, geriatric evaluation and management care, psychogeriatric care and palliative care.

Non-acute care in this data file is identified as admitted episodes in maintenance care.

The submission file is to be provided in .csv format.

Data included in Item 1 to Item 18 below is dependent on the care type of the episode being reported. These data items contain the scores of the clinical assessment tool being used. The data items used, by assessment measure, are as follows:

- FIMTM Score: Item 1 to Item 18 (excluding Item 8a)
- HoNOS 65+ Score: Item 1 to Item 12 (including Item 8a)
- RUG-ADL Score: Item 1 to Item 4

Data items for the palliative care type are reported for each phase of care in a palliative care episode.

A maximum of eleven phases of care changes within a palliative care episode may be reported, with the last phase being the phase at the end of the episode.

Position	Data Element	Data Type	Format	Length	Requirement
1	Account Number	String	X[X(11)]	12	Mandatory
2	UMRN	String	X[X(9)]	10	Mandatory
3	Admission Date	Date	DDMMYYYY	8	Mandatory
4	Separation Date	Date	DDMMYYYY	8	Mandatory
5	Establishment Code	Numeric	N(4)	4	Mandatory
6	Care Type	Numeric	NN	2	Mandatory
7	Assessment Date	Date	DDMMYYYY	8	Mandatory
8	Assessment Only	Numeric	N	1	Mandatory
9	Impairment Type	Numeric	NN.NNNN	7	Conditional
10	Item 1	Numeric	N	1	Conditional
11	Item 2	Numeric	N	1	Conditional
12	Item 3	Numeric	N	1	Conditional
13	Item 4	Numeric	N	1	Conditional
14	Item 5	Numeric	N	1	Conditional
15	Item 6	Numeric	N	1	Conditional
16	Item 7	Numeric	N	1	Conditional
17	Item 8	Numeric	N	1	Conditional
18	Item 8a	String	A	1	Conditional
19	Item 9	Numeric	N	1	Conditional
20	Item 10	Numeric	N	1	Conditional
21	Item 11	Numeric	N	1	Conditional
22	Item 12	Numeric	N	1	Conditional
23	Item 13	Numeric	N	1	Conditional
24	Item 14	Numeric	N	1	Conditional
25	Item 15	Numeric	N	1	Conditional
26	Item 16	Numeric	N	1	Conditional

Position	Data Element	Data Type	Format	Length	Requirement
27	Item 17	Numeric	N	1	Conditional
28	Item 18	Numeric	N	1	Conditional
29	SMMSE Completed	Numeric	N	1	Conditional
30	SMMSE Assessment Date	Date	DDMMYYYY	8	Conditional
31	SMMSE 1	Numeric	N	1	Conditional
32	SMMSE 2	Numeric	N	1	Conditional
33	SMMSE 3	Numeric	N	1	Conditional
34	SMMSE 4	Numeric	N	1	Conditional
35	SMMSE 5	Numeric	N	1	Conditional
36	SMMSE 6	Numeric	N	1	Conditional
37	SMMSE 7	Numeric	N	1	Conditional
38	SMMSE 8	Numeric	N	1	Conditional
39	SMMSE 9	Numeric	N	1	Conditional
40	SMMSE 10	Numeric	N	1	Conditional
41	SMMSE 11	Numeric	N	1	Conditional
42	SMMSE 12	Numeric	N	1	Conditional
43	Phase Start Date	Date	DDMMYYYY	8	Conditional
44	Phase End Date	Date	DDMMYYYY	8	Conditional
45	Phase Type	Numeric	N	1	Conditional
46	Type of Maintenance Care	Numeric	NN	2	Conditional
47	Record Creation Date	Date	DDMMYYYY	8	Mandatory
48	Last Amended	Date	DDMMYYYY	8	Mandatory
49	Last Amended By	String	X[X(19)]	20	Mandatory

Appendix C – Rehabilitation data elements

Data Element	Data Type	Format	Permitted Values
Account Number	String	X[X(11)]	Alphanumeric combination up to 12 characters
Admission Date	Date	DDMMYYYY	Valid date
Assessment Date	Date	DDMMYYYY	Valid date
Assessment Only	Numeric	N	1 – Yes 2 – No 8 – Unknown 9 – Not stated/inadequately described
Care Type	Numeric	NN	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
Establishment Code	Numeric	N(4)	Valid establishment code. Refer to Establishment Code List
FIM™ Score	Numeric	N	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
Impairment Type	Numeric	NN.NNNN	Refer to *Appendix B: AROC Impairment Types* within the SANADC Data Dictionary.
Last Amended	Date	DDMMYYYY	Valid date
Last Amended By	String	X[X(19)]	Alphanumeric combination
Record Creation Date	Date	DDMMYYYY	Valid date
Separation Date	Date	DDMMYYYY	Valid date
UMRN	String	X[X(9)]	Alphanumeric combination

Appendix D – GEM data elements

Data Element	Data Type	Format	Permitted Values
Account Number	String	X[X(11)]	Alphanumeric combination up to 12 characters
Admission Date	Date	DDMMYYYY	Valid date
Assessment Date	Date	DDMMYYYY	Valid date
Assessment Only	Numeric	N	1 – Yes 2 – No 8 – Unknown 9 – Not stated/inadequately described
Care Type	Numeric	NN	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
Establishment Code	Numeric	N(4)	Valid establishment code. Refer to Establishment Code List
FIM™ Score	Numeric	N	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
Last Amended	Date	DDMMYYYY	Valid date
Last Amended By	String	X[X(19)]	Alphanumeric combination
Record Creation Date	Date	DDMMYYYY	Valid date
Separation Date	Date	DDMMYYYY	Valid date
SMMSE Completed	Numeric	N	1 – Yes 2 – No 9 – Unknown
SMMSE Assessment Date	Date	DDMMYYYY	Valid date
SMMSE Score	Numeric	N	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
UMRN	String	X[X(9)]	Alphanumeric combination

Appendix E – Psychogeriatric data elements

Data Element	Data Type	Format	Permitted Values
Account Number	String	X[X(11)]	Alphanumeric combination up to 12 characters
Admission Date	Date	DDMMYYYY	Valid date
Assessment Date	Date	DDMMYYYY	Valid date
Assessment Only	Numeric	N	1 – Yes 2 – No 8 – Unknown 9 – Not stated/inadequately described
Care Type	Numeric	NN	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
Establishment Code	Numeric	N(4)	Valid establishment code. Refer to Establishment Code List
HoNOS 65+ Score	Numeric	N	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
Last Amended	Date	DDMMYYYY	Valid date
Last Amended By	String	X[X(19)]	Alphanumeric combination
Record Creation Date	Date	DDMMYYYY	Valid date
Separation Date	Date	DDMMYYYY	Valid date
UMRN	String	X[X(9)]	Alphanumeric combination

Appendix F – Palliative data elements

Data Element	Data Type	Format	Permitted Values
Account Number	String	X[X(11)]	Alphanumeric combination up to 12 characters
Admission Date	Date	DDMMYYYY	Valid date
Assessment Only	Numeric	N	1 – Yes 2 – No 8 – Unknown 9 – Not stated/inadequately described
Care Type	Numeric	NN	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
Establishment Code	Numeric	N(4)	Valid establishment code. Refer to Establishment Code List
Last Amended	Date	DDMMYYYY	Valid date
Last Amended By	String	X[X(19)]	Alphanumeric combination
Record Creation Date	Date	DDMMYYYY	Valid date
Separation Date	Date	DDMMYYYY	Valid date
UMRN	String	X[X(9)]	Alphanumeric combination
The variables below are required to be recorded for each palliative phase			
Assessment Date	Date	DDMMYYYY	Valid date
Phase End Date	Date	DDMMYYYY	Valid date
Phase Start Date	Date	DDMMYYYY	Valid date
Phase Type	Numeric	N	1 – Stable 2 – Unstable 3 – Deteriorating 4 – Terminal 9 – Not stated/inadequately described
RUG-ADL Score	Numeric	N	*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

Appendix G – Maintenance data elements

Data Element	Data Type	Format	Permitted Values
Account Number	String	X[X(11)]	Alphanumeric combination up to 12 characters
Admission Date	Date	DDMMYYYY	Valid date
Assessment Date	Date	DDMMYYYY	Valid date
Care Type	Numeric	NN	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
Establishment Code	Numeric	N(4)	Valid establishment code. Refer to Establishment Code List
Last Amended	Date	DDMMYYYY	Valid date
Last Amended By	String	X[X(19)]	Alphanumeric combination
Record Creation Date	Date	DDMMYYYY	Valid date
RUG-ADL Score	Numeric	N	*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
Separation Date	Date	DDMMYYYY	Valid date
Type of Maintenance Care	Numeric	NN	1 – Convalescent 2 – Respite 3 – Nursing home type 8 – Other 98 – Unknown 99 – Not stated/inadequately described
UMRN	String	X[X(9)]	Alphanumeric combination

Appendix H – Summary of revisions

Date Released	Author	Approval	Amendment
1 July 2021	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created.
1 July 2022	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. Superseded QoCR system references replaced by AOS. Superseded AN-SNAP Version 4.0 references replaced by AN-SNAP Version 5.0.

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