

Public Hospital Services File Format

Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2023-2024 v1.0



Public Hospital Services – File Format 2023–2024 v1.0

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An electronic version of this document is available at
<http://qheps.health.qld.gov.au/hsu/datacollections.htm>

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Public Hospital Services File Format 2023-2024 Collection Year

Introduction

This document specifies the file format for the electronic submission of admitted patient data by facilities providing public hospital services. This data is submitted to the Statistical Services Branch (SSB), Queensland Department of Health for the Queensland Hospital Admitted Patient Data Collection (QHAPDC).

A record must be provided for each admitted patient, including newborn babies, from facilities permitted to admit patients.

All boarders and posthumous organ procurement donors are also included in the scope of the QHAPDC.

There are 13 files specified in this document: Header, Patient, Admission, Activity, Morbidity, Mental Health, Elective Admissions, Sub and Non-Acute Patient, Palliative Care, Department of Veterans' Affairs, Workers' Compensation, Australasian Rehabilitation Outcomes Centre and Telehealth Inpatient Details.

The following standard should be used when naming the files:

ffffctyyctyynnn.filetype

| | |
|----------|--|
| ffff | five-digit facility number (zero filled from the left) |
| ctyyctyy | collection year to which the data relates |
| nnn | data extract number for collection year |
| filetype | HDR for the Header File |
| | PAT for the Patient File |
| | ADM for the Admission File |
| | ACT for the Activity File |
| | MOR for the Morbidity File |
| | MEN for the Mental Health File |
| | EAS for the Elective Admission File |
| | SNP for the Sub and Non-Acute Patient File |
| | PAL for the Palliative Care File |
| | DVA for the Department of Veterans' Affairs File |
| | WCP for the Workers' Compensation File |
| | ARC for the Australasian Rehabilitation Outcomes Centre File |
| | TID for the Telehealth Inpatient Details File |

The 1st admission file for ABC Hospital (facility number 99999) for collection year 2023-2024 would be named:

9999920232024001.ADM

Data for multiple months or a partial month can be supplied in the one extract file. The data extract number for a collection year must begin at '001' and be contiguous throughout the collection year.

Public Facility File Format

Header file

The header file contains an extraction details record (the facility and period for which data has been extracted, and the date the extraction took place) and file details records (the number and type of records on each file).

The extraction details record is the first record on the Header File. There should be only one extraction details record in the Header File.

For each file extracted, there must be a file details record on the Header File.

EXTRACTION DETAILS RECORD

| | | | |
|-------------------|---------|---------------------------------|--|
| Record Identifier | 1 char | E = Extraction details | |
| Facility Number | 5 num | Must be a valid facility number | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| Extract Date | 8 date | Date data extracted | CTYYMMDD |

FILE DETAILS RECORD

| | | | |
|-------------------|--------|--|--|
| Record Identifier | 1 char | F = File details | |
| File Type | 3 char | PAT = Patient ADM = Admission ACT = Activity MOR = Morbidity MEN = Mental Health EAS = Elective Admission Surgery SNP = Sub and Non-Acute Patient PAL = Palliative Care DVA = Department of Veterans' Affairs WCP = Workers' Compensation ARC = Australasian Rehabilitation Outcome Centre TID = Telehealth Inpatient Details | |
| Record Type | 1 char | N = New | |
| Number of Records | 6 num | Number of new records | Right adjusted and zero filled from left; zero if null |
| Record Type | 1 char | A = Amendment | |

| FILE DETAILS RECORD | | | |
|---------------------|--------|------------------------------|--|
| Number of Records | 6 num | Number of amendment records | Right adjusted and zero filled from left; zero if null |
| Record Type | 1 char | D = Deletion | |
| Number of Records | 6 num | Number of deletion records | Right adjusted and zero filled from left; zero if null |
| Record Type | 1 char | U = Up to Date | |
| Number of Records | 6num | Number of up to date records | Right adjusted and zero filled from left; zero if null |
| Filler | 2 | Blank | |

An example of a header file is:

```

E99999202307012023073120230820
FPATN000420A000020D0000000U00007
FADMN000420A000124D000001U000007
FACTN000080A000000D000010U000008
FMORN001000A000000D000005U000009
FMENN000020A000000D000001U000001
FEASN000005A000000D000002U000002
FSNPN000010A000002D000001U000003
FPALN000008A000001D000002U000004
FDVAN000003A000001D000001U000005
FWCPN000002A000001D000001U000001
FARC�000000A000000D000000U000000
FTIDN000007A000002D000001U000001

```

The details provided in the above example are:

Extraction details

| | |
|-------------------|-----------------------------|
| Facility | 99999 – ABC Hospital |
| Extraction period | 1 July 2023 to 31 July 2023 |
| Extraction date | 20 August 2023 |

File details

Patient file

| | |
|-----|-------------|
| 420 | New records |
| 20 | Amendments |
| 0 | Deletions |
| 7 | Up to Date |

Admission file

| | |
|-----|-------------|
| 420 | New records |
| 124 | Amendments |
| 1 | Deletions |
| 7 | Up to Date |

Activity file

| | |
|----|-------------|
| 80 | New records |
| 0 | Amendments |
| 10 | Deletions |
| 8 | Up to Date |

Morbidity file

| | |
|------|-------------|
| 1000 | New records |
| 0 | Amendments |
| 5 | Deletions |
| 9 | Up to Date |

Mental Health file

| | |
|----|-------------|
| 20 | New records |
| 0 | Amendments |
| 1 | Deletions |
| 1 | Up to Date |

Elective Admission file

| | |
|---|-------------|
| 5 | New records |
| 0 | Amendments |
| 2 | Deletions |
| 2 | Up to Date |

Sub and Non-Acute Patient file

| | |
|----|-------------|
| 10 | New records |
| 2 | Amendments |
| 1 | Deletions |
| 3 | Up to Date |

Palliative Care file

| | |
|---|-------------|
| 8 | New records |
| 1 | Amendments |

| | |
|--|-------------|
| 2 | Deletions |
| 4 | Up to Date |
| Department of Veterans' Affairs file | |
| 3 | New records |
| 1 | Amendments |
| 1 | Deletions |
| 5 | Up to Date |
| Workers' Compensation file | |
| 2 | New records |
| 1 | Amendments |
| 1 | Deletions |
| 1 | Up to Date |
| Australasian Rehabilitation Outcomes Centre file | |
| 0 | New records |
| 0 | Amendments |
| 0 | Deletions |
| 0 | Up to Date |
| Telehealth Inpatient Details | |
| 7 | New records |
| 2 | Amendments |
| 1 | Deletions |
| 1 | Up to Date |

Patient File

The header record is the first record on the file. There is only one header record, followed by the patient details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type PAT = Patient | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 238 | Blank | |

| PATIENT DETAILS RECORDS | | | |
|---|---------|--|--|
| Record Identifier | 1 char | N = New A = Amendment U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by the facility | Right adjusted and zero filled from left |
| Family Name | 24 char | First 24 characters of the patients family name | Left adjusted |
| First Given Name | 15 char | First 15 characters of the patients first given name | Left adjusted, blank if null |
| Second Given Name | 15 char | First 15 characters of the patients second given name | Left adjusted, blank if null |
| Address of Usual Residence | 40 char | Number and street of usual residential address of the patient Note: For HBCIS this data is captured from the 'Address Line' where the 'Address Type' value is equal to 'P' – Permanent. | Blank if null |
| Location (Suburb/Town) of Usual Residence | 40 char | The location associated with the permanent address. | Left adjusted |

PATIENT DETAILS RECORDS

| | | | |
|-----------------------------------|--------|---|---------------|
| Postcode of Usual Residence | 4 num | <p>Australian postcode associated with the permanent address</p> <p>Supplementary codes as below (note that for Australian External Territory addresses, the actual postcode should be used).</p> <p>9301 = Papua New Guinea</p> <p>9302 = New Zealand</p> <p>9399 = Overseas other (not PNG or NZ)</p> <p>9799 = At sea</p> <p>9989 = No fixed address</p> <p>0989 = Not stated or unknown</p> | |
| State of Usual Residence | 1 num | <p>State associated with the permanent address (note that for Australian External Territory addresses, the actual state id should be used)</p> <p>0 = Overseas</p> <p>1 = New South Wales</p> <p>2 = Victoria</p> <p>3 = Queensland</p> <p>4 = South Australia</p> <p>5 = Western Australia</p> <p>6 = Tasmania</p> <p>7 = Northern Territory</p> <p>8 = Australian Capital Territory</p> <p>9 = Not stated/Unknown/No fixed address/At sea</p> | |
| Filler | 4 | Blank | |
| Sex | 1 num | <p>1 = Male</p> <p>2 = Female</p> <p>3 = X</p> | |
| Date of Birth | 8 date | <p>Full date of birth of the patient</p> <p>Where DD is unknown use 15</p> <p>Where MM is unknown use 06</p> <p>Where YY is unknown estimate year</p> | CTYYMMDD |
| Estimated Date of Birth Indicator | 1 char | <p>A flag to indicate whether any component of a reported date of birth is estimated.</p> <p>1 = Estimated</p> | Blank if null |
| Marital Status | 1 num | <p>1 = Never married</p> <p>2 = Married (registered and de facto)</p> <p>3 = Widowed</p> <p>4 = Divorced</p> | |

PATIENT DETAILS RECORDS

| | | | |
|--------------------------------------|--------|---|--|
| | | 5 = Separated 9 = Not stated/unknown | |
| Country of Birth | 4 num | Country of birth of patient | Right adjusted and zero filled from left |
| Indigenous Status | 1 num | 1 = Aboriginal but not Torres Strait Islander origin 2 = Torres Strait Islander but not Aboriginal origin 3 = Both Aboriginal and Torres Strait Islander origin 4 = Neither Aboriginal nor Torres Strait Islander origin 9 = Not stated/unknown | |
| Filler | 2 | Blank | |
| Occupation | 4 | Currently not required | Blank if null |
| Labour Force Status | 1 | Currently not required | Blank if null |
| Medicare Eligibility | 1 num | 1 = Eligible 2 = Not eligible 9 = Not stated/unknown | |
| Medicare Number | 11 num | Medicare number of the patient The eleventh digit is the number that precedes the patient's name on the card (the sub numerate). If a sub numerate cannot be supplied, the eleventh digit of the Medicare number should be provided as zero. | Blank if not available or if null |
| Australian South Sea Islander Status | 1 char | Denotes whether the patient is of Australian South Sea Islander origin 1 = Yes 2 = No 9 = Not stated/unknown | |

| | | | |
|--|---------|---|------------------------------|
| Contact for Feedback Indicator | 1 char | Indicates whether or not the patient consents to be contacted by Queensland Health, or its agent, to obtain feedback on the services provided at the facility. Y = Yes N = No U = Unable to obtain | |
| Telephone Number – Home | 20 char | The patient's home contact telephone number | Left adjusted, blank if null |
| Telephone Number – Mobile | 20 char | The patient's mobile contact telephone number | Left adjusted, blank if null |
| Telephone Number – Business or Work | 20 char | The patient's business or work contact telephone number | Left adjusted, blank if null |
| Hospital Insurance Health Fund Code | 6 char | The health insurance fund of which the patient is currently a member for their hospital insurance | Left adjusted, blank if null |
| Hospital Insurance Health Fund Description | 50 char | When health fund code is 'Other' - a description of the health insurance fund of which the patient is currently a member for their hospital insurance is required | Left adjusted, blank if null |

Admission File

The header record is the first record on the file. There is only one header record, followed by the admission details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type ADM = Admission | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 139 | Blank | |

| ADMISSION DETAILS RECORDS | | | |
|---------------------------|---------|---|--|
| Record Identifier | 1 char | N = New A = Amendment D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by the facility | Right adjusted and zero filled from left |
| Admission Date | 8 date | Date of admission to the facility | CTYYMMDD |
| Admission Time | 4 num | Time of admission to the facility (0000 to 2359) | HHMM (24-hour clock) |
| Account Class | 12 char | Facility-specific account codes (HBCIS only) | Left adjusted, blank if null |
| Chargeable Status | 1 num | 1 = Public 2 = Private shared 3 = Private single | |

ADMISSION DETAILS RECORDS

| | | | |
|------------------------------|--------|--|---------------------------------------|
| Care Type | 2 num | 01 = Acute care 05 = Newborn care 06 = Other admitted patient care 07 = Organ procurement-posthumous 08 = Hospital boarder 09 = Geriatric evaluation and management 10 = Psychogeriatric care 11 = Maintenance care 12 = Mental health care 20 = Rehabilitation care 30 = Palliative care | Right adjusted, zero filled from left |
| Compensable Status | 1 num | 1 = Workers' Compensation Queensland 2 = Workers' Compensation (Other) 3 = Compensable third party 4 = Other compensable 5 = Department of Veterans' Affairs 6 = Motor Vehicle (QLD) 7 = Motor Vehicle (Other) 8 = None of the above 9 = Department of Defence | |
| Band | 2 char | Classification to categorise same day procedures into the Commonwealth Bands. 1A = Band 1A 1B = Band 1B 2 = Band 2 3 = Band 3 4 = Band 4 | Left adjusted, blank if null. |
| Source of Referral/ Transfer | 2 num | 01 = Private medical practitioner (excl. Psychiatrist) 02 = Emergency department – this hospital 03 = Outpatient department – this hospital 06 = Episode change 09 = Born in hospital 15 = Private psychiatrist 16 = Correctional facility 17 = Law enforcement agency 18 = Community service 19 = Routine readmission not requiring referral 14 = Other health care establishment | Right adjusted, zero filled from left |

ADMISSION DETAILS RECORDS

| | | | |
|-----------------------------------|--------|--|---|
| | | 20 = Organ procurement 21 = Boarder 23 = Residential aged care service 24 = Admitted patient transferred from another hospital 25 = Non-admitted patient referred from other hospital 29 = Other 30 = Planned Emergency 31 = Residential mental health care facility 32 = Change of reference period 33 = Rapid Access – Outpatient Department – this hospital 34 = Rapid Access – Other QH Facility/service | |
| Transferring from Facility | 5 num | Facility number from which the patient was transferred or referred. Provide facility code if Source of Referral/Transfer is 16, 23, 24, 25,31 or 34 | Right adjusted and zero filled from left; blank if null |
| Hospital Insurance | 1 num | 7 = Hospital insurance 8 = No hospital insurance 9 = Not stated/unknown | |
| Separation Date | 8 date | Date of separation from the facility | CTYYMMDD |
| Separation Time | 4 num | Time of separation from the facility (0000 to 2359) | HHMM (24-hour clock) |
| Mode of Separation | 2 num | 01 = Home/usual residence 04 = Other health care establishment 05 = Died in hospital 06 = Episode change 07 = Discharged at own risk 09 = Non return from leave 12 = Correctional facility 13 = Organ procurement 14 = Boarder 16 = Transferred to another hospital 17 = Medi-Hotel 19 = Other 21 = Residential aged care service, which is not the usual place of residence | Right adjusted and zero filled from left |

ADMISSION DETAILS RECORDS

| | | | |
|------------------------------|---------------|---|---|
| | | 22 = Residential aged care service, which is the usual place of residence 31 = Residential mental health care facility 32 = Change of reference period | |
| Transferring to Facility | 5 num | Facility number to which the patient was transferred Provide facility code if Mode of Separation is 12, 15, 16, 21 or 31 | Right adjusted and zero filled from left, blank if null |
| DRG (version 11.0) | 5 char | Collected if available | Left adjusted, blank if null |
| MDC | 3 char | Collected if available | Left adjusted, blank if null |
| Baby Admission Weight | 4 num | Admission weight in grams for neonates who are under 29 days or weigh less than 2500 grams at time of admission. | Right adjusted and zero filled from left, blank if null |
| Admission Ward | 6 char | Code to describe the admitting ward | Left adjusted |
| Admission Unit | 4 char | Code to describe admitting unit | Blank if null |
| Standard Unit Code | 4 char | Standard code to describe the treating doctor speciality/unit | Left adjusted |
| Treating Doctor at Admission | 6 char | Code to identify the treating doctor at the admission of the episode of care | Left adjusted |
| Planned Same Day | 1 char | Y = Yes, planned to be separated from the hospital on the same day N = No, planned to stay at least one night | |
| Elective Patient Status | 1 char | 1 = Emergency admission 2 = Elective admission 3 = Not assigned | |
| Qualification Status | 1 char | A = Acute U = Unqualified | Blank if null |
| Standard Ward Code | 4 char | Denotes whether the ward is assigned to a Standard Ward Code. CCU4 = Coronary Care Unit Level 4 CCU5 = Coronary Care Unit Level 5 CCU6 = Coronary Care Unit Level 6 CHEM = Chemotherapy CIC4 = Children's Intensive Care Service Level 4 CIC5 = Children's Intensive Care Service Level 5 CIC6 = Children's Intensive Care Service Level 6 DIAL = Renal Dialysis EDSS = Emergency Department Short Stay Unit EMER = Emergency | Blank if null |

ADMISSION DETAILS RECORDS

| | | | |
|----------------|--------|--|--|
| | | <p>HOME = Hospital in the Home</p> <p>ICU4 = Intensive Care Unit Level 4</p> <p>ICU5 = Intensive Care Unit Level 5</p> <p>ICU6 = Intensive Care Unit Level 6</p> <p>MATY = Maternity</p> <p>MENA = Specialised Mental Health Acute Psychiatric</p> <p>MENN = Specialised Mental Health Non-Acute Psychiatric</p> <p>MENR = Residential Mental Health Care</p> <p>MIXC = Mixed Wards Critical Care</p> <p>MIXG = Mixed Wards Non-Critical Care Service Types</p> <p>NSV4 = Neonatal Service Level 4</p> <p>NSV5 = Neonatal Service Level 5</p> <p>NSV6 = Neonatal Service Level 6</p> <p>OBSV = Observation</p> <p>PAED = Paediatric Services</p> <p>SNAP = Designated SNAP Unit</p> <p>STKU = Stroke Unit</p> <p>SNAP = Sub and Non-Acute Patient</p> <p>TRNL = Transit Lounge</p> <p>VCAR = Virtual Care</p> | |
| Contract Role | 1 char | <p>A = Hospital A (contracting hospital)</p> <p>B = Hospital B (contracted hospital)</p> <p>Identifies whether the hospital is 'Hospital A' – the purchaser of hospital care (contracting hospital) or 'Hospital B' - the provider of an admitted or non-admitted service (contracted hospital)</p> | Blank if null |
| Contract Type | 1 char | <p>1 = B</p> <p>2 = ABA</p> <p>3 = AB</p> <p>4 = (A)B</p> <p>5 = BA</p> <p>Describes the contract arrangement between the contracting hospital ('Hospital A') and the contracted hospital ('Hospital B')</p> | Blank if null |
| Funding Source | 2 char | <p>Expected principal source of funds for the episode.</p> <p>01 = Health service budget (not covered elsewhere)</p> | Right adjusted and zero filled from left |

ADMISSION DETAILS RECORDS

| | | | |
|--|--------|--|-------------------------------|
| | | 02 = Private health insurance 03 = Self-funded 04 = Workers' compensation 05 = Motor vehicle third party personal claim 06 = Other compensation (e.g. Public liability, common law and medical negligence) 07 = Department of Veterans' Affairs 08 = Department of Defence 09 = Correctional facility 10 = Other hospital or public authority (contracted care) 11 = Health service budget (due to eligibility for Reciprocal Health Care) 12 = Other funding source 13 = Health service budget (no charge raised due to hospital decision) 99 = Not known | |
| Incident Date | 8 date | The date the patient was first aware of the symptoms or onset of illness; or had the accident for which hospital treatment as either an admitted or non-admitted patient is being administered Where DD is unknown use 15. Where MM is unknown use 06. Where YY is unknown an estimate must be provided. | CTYYMMDD Blank if null |
| Incident Date Flag | 1 char | Flag to indicate whether the patient's incident date is estimated 1 = Estimated | Blank if null |
| Workcover Queensland (Q-Comp) Consent | 1 char | Indicates whether or not the patient consents to the release of their details to Workcover Queensland (Q-Comp) Y = Yes N = No U = Unable to obtain | |
| Motor Accident Insurance Commission (MAIC) Consent | 1 char | Indicates whether or not the patient consents to the release of their details to the Motor Accident Insurance Commission. Y = Yes N = No U = Unable to obtain | |

ADMISSION DETAILS RECORDS

| | | | |
|---|--------|--|---|
| Department of Veterans' Affairs (DVA) Consent | 1 char | Indicates whether or not the patient consents to the release of their details to the Department of Veterans' Affairs. Y = Yes N = No U = Unable to obtain | |
| Department of Defence Consent | 1 char | Indicates whether a patient consents to the release of their details to the Department of Defence. Y = Yes N = No U = Unable to obtain | |
| Filler | 4 | Filler | Blank |
| Interpreter Required | 1 num | Indicates whether an interpreter service is required by or for the person. 1 = Interpreter needed 2 = Interpreter not needed 9 = Unknown | |
| Religion | 4 num | Currently not required | Blank if null |
| QAS Patient Identification Number (eARF Number) | 12 num | QAS patient identification number provided by the QAS team when delivering a patient to this facility. | Left adjusted, blank if null |
| Purchaser/ Provider Identifier | 5 num | The identifier of the 'other' facility or purchaser involved in the contracted care. Record the Facility ID of the other hospital if contract type = 2, 3, 4, 5 Record the ID of the jurisdiction, HHS or other external purchaser that has purchased the public contracted hospital care if contract type = 1 and contract role = B (Hospital B). | Right adjusted and zero filled from left; blank if null |
| Preferred Language | 6 num | Indicates the patient's preferred language for communicating when receiving health care services | Left adjusted. |

| | | | |
|--|--------|---|---|
| Length of Stay in an Intensive Care Unit | 7 num | The total amount of time spent by an admitted patient in an approved intensive care unit (Adult Intensive Care Unit ICU6 or Children's Intensive Care Service Level 6 - CIC6) Format HHHHHMM H = Hours, M = Minutes | Right adjusted and zero filled from left; blank if null |
| Duration of continuous ventilatory support | 7 num | The total amount of time an admitted patient has spent on continuous ventilatory support (i.e. invasive ventilation) Format HHHHHMM H = Hours, M = Minutes | Right adjusted and zero filled from left; blank if null |
| Criteria Led Discharge Type | 2 num | The discipline of the clinician who initiated the separation 01 = Not CLD – Authorised (Admitting) Practitioner 02 = Junior Doctor – CLD 03 = Nurse – CLD 04 = Midwife – CLD 05 = Nurse Practitioner – CLD 06 = Physiotherapist – CLD 07 = Occupational Therapist – CLD 08 = Social Worker – CLD 09 = Psychologist – CLD 10 = Speech Pathologist – CLD 11 = Dietitian – CLD 12 = Pharmacist – CLD 99 = Other – CLD | Right adjusted and zero filled from left. |
| Smoking Status | 1 num | Indicates the smoking status of the patient 1 = Reported as a current smoker within the last 30 days. 2 = Reported not a smoker 9 = Not reported | Blank if null |
| Smoking Pathway Completed | 1 char | Indicates whether a Smoking Cessation Clinical Pathway has been completed Y = Yes P = Partial N = No | Must not be null if smoking status = 1 |
| Treating Doctor at Separation | 6 char | Code to identify the treating doctor at separation of the episode of care | Left adjusted |

Activity File

The header record is the first record on the file. There is only one header record, followed by the activity details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type ACT = Activity | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 25 | Blank | |

| ACTIVITY DETAILS RECORDS | | | |
|--------------------------|---------|--|--|
| Record Identifier | 1 char | N = New D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (eg. Unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |
| Activity Code | 1 char | A | Account class variation |
| | | L | Leave episode |
| | | W | Ward/unit transfer |
| | | C | Contract status |
| | | N | Not ready for surgery |
| | | E | Elective surgery items |
| | | Q | Qualification status |
| | | S | Sub and non-acute patient items |
| | | T | Nursing home type |

ACTIVITY DETAILS RECORDS

| | | | | |
|------------------|--|--------------------------------------|--|--|
| | | B | Mother's patient identifier of baby born in hospital | |
| Activity Details | | See below table/s for record details | | |

Activity Details if Activity Code = A (Account Class Variation)

| | | | |
|--------------------|---------|--|------------------------------|
| Account Class | 12 char | Facility-specific account codes (HBCIS only) | Left adjusted, blank if null |
| Filler | 2 | Blank | |
| Chargeable Status | 1 num | 1 = Public 2 = Private shared 3 = Private single | |
| Compensable Status | 1 num | 1 = Workers' Compensation Queensland 2 = Workers' Compensation (Other) 3 = Compensable Third Party 4 = Other Compensable 5 = Department of Veterans' Affairs 6 = Motor Vehicle (Qld) 7 = Motor Vehicle (Other) 8 = None of the above 9 = Department of Defence | |
| Filler | 2 | Blank | |
| Date of Change | 8 date | Date that change to account class occurred | CTYYMMDD |
| Time of Change | 4 num | Not currently required | Blank if null |

Activity Details if Activity Code = L (Leave Episode)

| | | | |
|--------------------------|--------|--------------------------------------|----------------------|
| Date of Starting Leave | 8 date | Date the patient went on leave | CTYYMMDD |
| Time of Starting Leave | 4 num | Time the patient started leave | HHMM (24-hour clock) |
| Date Returned from Leave | 8 date | Date the patient returned from leave | CTYYMMDD |
| Time Returned from leave | 4 num | Time the patient returned from leave | HHMM (24-hour clock) |
| Filler | 6 | Blank | |

Activity Details if Activity Code = W (Ward/Unit Transfer)

| | | | |
|---------------------------|--------|--|----------------------|
| Admission Ward | 6 char | Ward that the patient was transferred to | |
| Admission Unit | 4 char | Unit that the patient was transferred to | Blank if null |
| Standard Unit Code | 4 char | Standard unit that the patient was transferred to | |
| Date of Transfer | 8 date | Date the patient transferred | CTYYMMDD |
| Time of Transfer | 4 num | Time the patient transferred | HHMM (24-hour clock) |
| Standard Ward Code | 4 char | <p>Denotes whether the ward is assigned to a Standard Ward Code.</p> <p>CCU4 = Coronary Care Unit Level 4</p> <p>CCU5 = Coronary Care Unit Level 5</p> <p>CCU6 = Coronary Care Unit Level 6</p> <p>CHEM = Chemotherapy</p> <p>CIC4 = Children's Intensive Care Service Level 4</p> <p>CIC5 = Children's Intensive Care Service Level 5</p> <p>CIC6 = Children's Intensive Care Service Level 6</p> <p>DIAL = Renal Dialysis</p> <p>EDSS = Emergency Department Short Stay Unit</p> <p>EMER = Emergency</p> <p>HOME = Hospital in the Home</p> <p>ICU4 = Intensive Care Unit Level 4</p> <p>ICU5 = Intensive Care Unit Level 5</p> <p>ICU6 = Intensive Care Unit Level 6</p> <p>MATY = Maternity</p> <p>MENA = Specialised Mental Health Acute Psychiatric</p> <p>MENN = Specialised Mental Health Non-Acute Psychiatric</p> <p>MENR = Residential Mental Health Care</p> <p>MIXC = Mixed Wards Critical Care</p> <p>MIXG = Mixed Wards Non-Critical Care Service Types</p> <p>NSV4 = Neonatal Service Level 4</p> <p>NSV5 = Neonatal Service Level 5</p> <p>NSV6 = Neonatal Service Level 6</p> <p>OBSV = Observation</p> <p>PAED = Paediatric Services</p> <p>SNAP = Designated SNAP Unit</p> | Blank if null |

| | | | |
|--|--|--|--|
| | | STKU = Stroke Unit SNAP = Sub and Non-Acute Patient TRNL = Transit Lounge VCAR = Virtual Care | |
|--|--|--|--|

Activity Details if Activity Code = C (Contract Status)

| | | | |
|-------------------------------|--------|--|----------|
| Date Transferred For Contract | 8 date | Date the patient transferred for a contract service | CTYYMMDD |
| Date returned From Contract | 8 date | Date the patient returned from a contract service | CTYYMMDD |
| Facility Contracted To | 5 num | Facility number for the facility performing the contracted service | |
| Filler | 9 | Blank | |

Activity Details if Activity Code = N (Not Ready for Surgery)

| | | | |
|---------------------------------|--------|---|---------------------------------------|
| Entry Number | 3 num | The unique Waiting List placement number | Right adjusted, zero filled from left |
| Date Not Ready For Surgery | 8 date | Date the patient was not ready for surgery | CTYYMMDD |
| Time Not Ready For Surgery | 4 num | Not currently required | Blank if null |
| Last Date Not Ready For Surgery | 8 date | Last date the patient was not ready for surgery | CTYYMMDD |
| Last Time Not Ready For Surgery | 4 num | Not currently required | Blank if null |
| Filler | 3 | Blank | |

Activity Details if Activity Code = E (Elective Surgery Items)

| | | | |
|------------------|-------|---|---------------------------------------|
| Entry Number | 3 num | The unique Waiting List placement number | Right adjusted, zero filled from left |
| Urgency Category | 1 num | Clinical urgency classification from field 20 of the Waiting List Entry screen 1 = Elective Surgery – Category 1 2 = Elective Surgery – Category 2 3 = Elective Surgery – Category 3 4 = Other – Category 1 5 = Other – Category 2 6 = Other – Category 3 | |

| | | | |
|------------------------------|--------|--|---------------|
| | | 9 = Surveillance Procedure | |
| Accommodation (intended) | 1 char | Currently not required | Blank if null |
| Site Procedure Indicator | 3 char | Currently not required | Blank if null |
| National Procedure Indicator | 2 num | Currently not required | Blank if null |
| Planned Length of Stay | 3 char | Currently not required | Blank if null |
| Planned Admission Date | 8 date | Currently not required | Blank if null |
| Date of Change | 8 date | Date that change to elective surgery item occurred | CTYYMMDD |
| Filler | 1 | Blank | |

Activity Details if Activity Code = Q (Qualification Status)

| | | | |
|----------------------|--------|---|---------------|
| Qualification Status | 1 char | A = Acute U = Unqualified | |
| Date of Change | 8 date | Date that the change of qualification status occurred | CTYYMMDD |
| Time of Change | 4 num | Currently not required | Blank if null |
| Filler | 17 | Blank | |

All changes of qualification status must be provided. If more than one change of qualification status occurs on a single day, then the final qualification status for that day should be provided.

Activity Details if Activity Code = S (Sub and Non-Acute Items)

| | | | |
|---------------------|--------|--|---|
| SNAP Episode Number | 3 num | The unique SNAP episode number | Right adjusted, zero filled from left |
| ADL Type | 3 char | Measure of physical, psychosocial, vocational and cognitive functions of an individual with a disability | |
| | | FIM | Functional Independence Measure (FIM) |
| | | HON | Health of the Nation Outcomes Scale 65+ (HoNOS 65+) |

| | | | | | |
|-------------|--------|---|--|--|--|
| | | RUG | Resource Utilisation Groups-Activities of Daily Living (RUG-ADL) | | |
| | | SMM | Standardised Mini-Mental State Examination (SMME) | | |
| ADL Subtype | 3 char | For patients assigned a Psychogeriatric care type: ADL Type = HON and record scores for 12 ADL Subtypes and a Total ADL Subtype: | | | |
| | | BEH | Behavioural disturbance | | |
| | | NAS | Non-accidental self-injury | | |
| | | DDU | Problem drinking or drug use | | |
| | | CGP | Cognitive problems | | |
| | | PID | Problems related to physical illness or disability | | |
| | | HAD | Problems associated with hallucinations and delusions | | |
| | | DPS | Problems with depressive symptoms | | |
| | | OMB | Other mental and behavioural problems | | |
| | | SSR | Problems with social or supportive relationships | | |
| | | ADL | Problems with activities of daily living | | |
| | | LVC | Overall problems with living conditions | | |
| | | WLQ | Problems with work and leisure activities and the quality of the daytime environment | | |
| | | TOT | Total | | |
| | | The FIM tool has a cognitive and a motor sub-scale. | | | |
| | | For patients assigned a Rehabilitation or Geriatric Evaluation and Management care type: ADL Type = FIM and record scores for the 13 Motor ADL Subtypes, 5 Cognitive ADL Subtypes and a Total Cognitive and a Total Motor ADL Subtype: | | | |
| | | EAT | Eating | | |
| | | GRM | Grooming | | |
| | | BTH | Bathing | | |
| | | DRU | Dressing upper body | | |
| | | DRL | Dressing lower body | | |
| | | TLT | Toileting | | |
| | | BDR | Bladder management | | |
| | | BWL | Bowel management | | |

| | | | |
|--|--|--|--|
| | | TBC | Transfer (bed/chair/wheelchair) |
| | | TTL | Transfer (toileting) |
| | | TBS | Transfer (bath/shower) |
| | | LWW | Locomotion (walk/wheelchair) |
| | | LST | Locomotion (stairs) |
| | | CMP | Comprehension |
| | | EXP | Expression |
| | | SOC | Social interaction |
| | | PRS | Problem solving |
| | | MEM | Memory |
| | | MOT | Motor (total) |
| | | COG | Cognitive (total) |
| | | <p>The RUG tool requires the collection of the total RUG score when assigning to a Maintenance or Palliative care type.</p> <p>ADL Type = RUG and record 1 ADL Subtype: TOT = Total</p> | |
| | | <p>Reporting of Standardised Mini-Mental State Examination scores is optional for patients assigned a Geriatric Evaluation and Management care type and not required for any other sub and non-acute care type.</p> <p>ADL Type = SMM and record scores for the 12 ADL Subtypes and a Total ADL Subtype:</p> | |
| | | ORT | Orientation – time |
| | | ORP | Orientation – place |
| | | MIM | Memory – immediate |
| | | LAT | Language/attention |
| | | MSH | Memory – short |
| | | LMW | Language memory – long (wristwatch) |
| | | LMP | Language memory – long (pencil) |
| | | LAV | Language/abstract thinking/verbal fluency |
| | | LNG | Language |
| | | LAC | Language/attention/comprehension |
| | | ACD | Attention/comprehension/follow commands/constructional (diagram) |
| | | ACP | Attention/comprehension/construction/follow commands (paper) |
| | | TOT | Total |

| | | | |
|-----------|-------|---|--|
| ADL Score | 3 num | <p>Numerical rating from the ADL tool used as a measurement of different components of functional ability.</p> <p>Where ADL Type is FIM and ADL Subtype is;</p> <ul style="list-style-type: none"> • EAT score must be between 1 and 7 or 999 • GRM score must be between 1 and 7 or 999 • BTH score must be between 1 and 7 or 999 • DRU score must be between 1 and 7 or 999 • DRL score must be between 1 and 7 or 999 • TLT score must be between 1 and 7 or 999 • BDR score must be between 1 and 7 or 999 • BWL score must be between 1 and 7 or 999 • TBC score must be between 1 and 7 or 999 • TTL score must be between 1 and 7 or 999 • TBS score must be between 1 and 7 or 999 • LWW score must be between 1 and 7 or 999 • LST score must be between 1 and 7 or 999 • CMP score must be between 1 and 7 or 999 • EXP score must be between 1 and 7 or 999 • SOC score must be between 1 and 7 or 999 • PRS score must be between 1 and 7 or 999 • MEM score must be between 1 and 7 or 999 • COG score must be between 5 and 35 or 999 • MOT score must be between 13 and 91 or 999 <p>Where ADL Type is HON and ADL Subtype is;</p> <ul style="list-style-type: none"> • BEH score must be between 0 and 4 or 999 • NAS score must be between 0 and 4 or 999 • DDU score must be between 0 and 4 or 999 • CGP score must be between 0 and 4 or 999 • PID score must be between 0 and 4 or 999 • HAD score must be between 0 and 4 or 999 • DPS score must be between 0 and 4 or 999 • OMB score must be between 0 and 4 or 999 • SSR score must be between 0 and 4 or 999 • ADL score must be between 0 and 4 or 999 • LVC score must be between 0 and 4 or 999 | Right adjusted, zero filled from left |
|-----------|-------|---|--|

| | | | |
|--|--------|---|---|
| | | <ul style="list-style-type: none"> • WLQ score must be between 0 and 4 or 999 • TOT score must be between 0 and 48 or 999 <p>Where ADL Type is SMM and ADL Subtype is;</p> <ul style="list-style-type: none"> • ORT score must be between 0 and 5 or 999 • ORP score must be between 0 and 5 or 999 • MIM score must be between 0 and 3 or 999 • LAT score must be between 0 and 5 or 999 • MSH score must be between 0 and 3 or 999 • LMW score must be between 0 and 1 or 999 • LMP score must be between 0 and 1 or 999 • LAV score must be between 0 and 1 or 999 • LNG score must be between 0 and 1 or 999 • LAC score must be between 0 and 1 or 999 • ACD score must be between 0 and 1 or 999 • ACP score must be between 0 and 3 or 999 • TOT score must be between 0 and 30 or 999 <p>Where ADL Type is RUG and ADL Subtype is;</p> <ul style="list-style-type: none"> • TOT score must be between 4 and 18 or 999 | |
| ADL Date | 8 date | Date the ADL score was recorded | CTYYMMDD |
| ADL Time | 4 num | Not currently required | Blank if null |
| Phase Type | 2 num | <p>A distinct period or stage of illness relating to palliative care patients. For example, when SNAP Type = PAL, record one phase type:</p> <p>01 = Stable</p> <p>02 = Unstable</p> <p>03 = Deteriorating</p> <p>04 = Terminal Care</p> | <p>Blank if null</p> <p>Must not be null if SNAP Type = PAL</p> |
| Filler | 4 | Blank | |
| <p><i>ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL Type and ADL Subtype.</i></p> <p><i>For all SNAP episodes:</i></p> <ul style="list-style-type: none"> • <i>An ADL score of 999 is valid when an assessment has not been undertaken.</i> | | | |

Activity Details if Activity Code = T (Nursing Home Type)

| | | | |
|-------------------------|--------|--|---|
| Nursing Home Type Flag | 3 char | NHT = Nursing Home Flag | Not valid for patients with a care type of: 01 – Acute care 05 – Newborn care 07 – Organ procurement-posthumous 08 – Hospital Boarder |
| Date Commenced NHT Care | 8 date | Date when the patient commenced Nursing Home Type care | CTYYMMDD |
| Date Ceased NHT Care | 8 date | Date when the patient ceased Nursing Home Type care | CTYYMMDD |
| Filler | 11 | Blank | |

Activity Details if Activity Code = B (Mother's Patient Identifier of Baby Born in Hospital)

| | | | |
|-----------------------------|--------|--|--|
| Mother's Patient Identifier | 8 char | Mother's Patient Identifier of baby born in the hospital | Right adjusted and zero filled from left |
| Filler | 22 | Blank | |

Morbidity File

The header record is the first record on the file. There is only one header record, followed by the morbidity details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type MOR = Morbidity | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 66 | Blank | |

| MORBIDITY DETAILS RECORDS | | | |
|-------------------------------------|---------|---|--|
| Record Identifier | 1 char | N = New D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |
| Diagnosis Code Identifier | 3 char | PD = Principal diagnosis EX = External cause code M = Morphology OD = Other diagnosis PR = Intervention | Left adjusted |
| ICD-10-AM /ACHI Code (12th Edition) | 7 char | Code assigned from The International Statistical Classification of Diseases and Related Health Problems, 10 th Revision, Australian Modification, 12th Edition and The Australian Classification of Health Interventions, 12th Edition | Left adjusted |

MORBIDITY DETAILS RECORDS

| | | | |
|--|---------|--|------------------------------|
| Diagnosis Text | 50 char | Textual description of diseases and interventions are optional | Left adjusted, blank if null |
| Date of Intervention | 8 date | <p>Date that the intervention was performed.</p> <p>The date must be provided if the intervention is within the following block ranges:</p> <p>1 to 1059</p> <p>1062 to 1821</p> <p>1825 to 1866</p> <p>1869 to 1892</p> <p>1894 to 1912</p> <p>1920 to 2016</p> <p>8888 to 8889</p> | CTYYMMDD blank if null |
| Contract Flag | 1 num | <p>Recorded by Hospital A when a patient receives an admitted or non-admitted contracted service from the contracted hospital (Hospital B)</p> <p>1 = Contracted admitted procedure</p> <p>2 = Contracted non-admitted procedure</p> | Blank if null |
| Diagnosis Onset Type (Condition onset flag) | 1 char | <p>An indicator for each diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care.</p> <p>1 = Condition present on admission to the episode of care</p> <p>2 = Condition arises during the current episode of care</p> <p>9 = Condition onset unknown/uncertain</p> | Blank if null |
| Most Resource Intensive Condition Flag | 1 char | Currently not required | Blank if null |
| Other Co-Morbidity of Interest Flag | 1 char | Currently not required | Blank if null |

Mental Health File

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a unit transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

The header record is the first record on the file. There is only one header record, followed by the mental health details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type MEN = Mental health | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 2 | Blank | |

| MENTAL HEALTH DETAILS RECORDS | | | |
|-------------------------------|---------|---|--|
| Record Identifier | 1 char | N = New, A = Amendment D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. Unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |
| Type of Usual Accommodation | 1 char | 1 = House or flat 2 = Independent unit as part of a retirement village or similar | |

MENTAL HEALTH DETAILS RECORDS

| | | | |
|---|--------|--|--|
| | | 3 = Hostel or hostel type accommodation 4 = Psychiatric hospital 5 = Acute hospital 6 = Residential mental health care facility 7 = Other accommodation 8 = No usual residence | |
| Employment Status | 1 char | 1 = Child not at school 2 = Student 3 = Employed 4 = Unemployed 5 = Home duties 6 = Pensioner 8 = Other | |
| Pension Status | 1 char | 1 = Aged pension 2 = Repatriation pension 3 = Invalid pension 4 = Unemployment benefit 5 = Sickness benefit 7 = Other 8 = No pension/benefit | |
| First Admission For Psychiatric Treatment | 1 char | 1 = No previous admission for psychiatric treatment 2 = Previous admission for psychiatric treatment | |
| Referral to Further Care | 2 char | 01 = Not referred 02 = Private psychiatrist 03 = Other private medical practitioner 04 = Mental health/alcohol and drug facility – admitted patient 05 = Mental health/alcohol and drug facility – non-admitted patient 06 = Acute hospital - admitted patient 07 = Acute hospital - non-admitted patient 08 = Community health program 09 = General Practitioner 10 = Residential mental health care facility 29 = Other 98 = Not Applicable | Right adjusted and zero filled from left |

MENTAL HEALTH DETAILS RECORDS

| | | | |
|---|--------|---|--|
| Mental Health Legal Status Indicator | 1 char | 1 = Involuntary patient for any part of the episode 2 = Voluntary patient for all of the episode | |
| Previous Specialised Non-Admitted Treatment | 1 char | 1 = Patient has no previous non-admitted service contacts for psychiatric treatment 2 = Patient has previous non-admitted service contacts for psychiatric treatment | |

Elective Admission Surgery File

A record is to be provided on the elective admissions details file for each episode of care where one or more completed EAS entries have been linked to the episode of care.

Each episode of care can have one or more EAS entry linked to it.

The header record is the first record on the file. There is only one header record, followed by the elective admission details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type EAS = Elective Admission Surgery | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 57 | Blank | |

| ELECTIVE ADMISSION SURGERY DETAILS RECORDS | | | |
|--|---------|---|--|
| Record Identifier | 1 char | N = New A = Amendment D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |

ELECTIVE ADMISSION SURGERY DETAILS RECORDS

| | | | |
|---------------------|--------|--|---|
| Entry Number | 3 num | The unique waiting list placement number | Right adjusted and zero filled from left |
| Planned Unit | 4 char | Currently not required | Blank if null |
| Surgical Specialty | 2 num | <p>Waiting List Speciality codes are derived from the mapping of units to one of the twelve speciality codes:</p> <p>01 = Cardiothoracic Surgery</p> <p>02 = Ear, Nose and Throat Surgery</p> <p>03 = General surgery</p> <p>04 = Gynaecology</p> <p>05 = Neurosurgery</p> <p>06 = Ophthalmology</p> <p>07 = Orthopaedic Surgery</p> <p>08 = Plastic and Reconstructive Surgery</p> <p>09 = Urology</p> <p>10 = Vascular Surgery</p> <p>11 = Other Surgical</p> <p>90 = Non-surgical</p> | Right adjusted and zero filled from left |
| Waiting List Status | 2 num | Currently not required | Blank if null |
| Reason for Removal | 2 num | <p>Reason for removal codes are derived from the mapping of waiting list status codes to reason for removal codes:</p> <p>01 = Admitted and treated as an elective patient for awaited procedure in this hospital</p> <p>02 = Admitted and treated as an emergency patient for awaited procedure in this hospital</p> <p>03 = Could not be contacted</p> <p>04 = Treated elsewhere for awaited procedure (not on behalf of this hospital or State/Territory)</p> <p>05 = Surgery not required or declined</p> <p>06 = Transferred to another hospital for awaited procedure (on behalf of this hospital or the state/territory)</p> <p>99 = Not stated/unknown</p> | Right adjusted and zero filled from left, blank if null |
| Listing Date | 8 date | Date the patient was placed on waiting list | CTYYMMDD |
| Pre-Admission Date | 8 date | Currently not required | Blank if null |

ELECTIVE ADMISSION SURGERY DETAILS RECORDS

| | | | |
|---|--------|---|---|
| (Planned) | | | |
| Urgency Category | 1 num | Clinical urgency classification from field 23 of the Waiting List Entry screen 1 = Elective Surgery – Category 1 2 = Elective Surgery – Category 2 3 = Elective Surgery – Category 3 4 = Other – Category 1 5 = Other – Category 2 6 = Other – Category 3 9 = Surveillance Procedure | |
| Accommodation (intended) | 1 char | Accommodation code from field 24 of the Waiting List Entry screen P = Public R = Private single S = Private shared | Left adjusted space filled from the right |
| Site Procedure Indicator | 3 | Not currently required | Blank if null |
| National Procedure Indicator | 2 | Not currently required | Blank if null |
| Planned Length of Stay | 3 char | Estimated stay from field 25 of the WL Entry screen. Value to be converted to zero during HQI extraction if values of 'D' for Day case encountered | Right adjusted zero filled from left |
| Planned Admission Date | 8 date | Not currently required | Blank if null |
| Pre-admission Clinic Attendance Date | 8 date | Not currently required | Blank if null |
| Planned Procedure Date | 8 date | The most recent planned procedure date for the patient prior to admission for each entry on the waiting list - from field 10 of the Booking Entry screen | CTYYMMDD Blank if null |
| Facility Identifier of the hospital managing the waiting list | 5 num | Not currently required | Blank if null |
| Planned Primary Procedure Code | 7 char | Planned Primary Procedure Code from field 27 of the Waiting List Entry screen | Left adjusted. |

ELECTIVE ADMISSION SURGERY DETAILS RECORDS

| | | | |
|--|--|--|--|
| | | Entries to be validated against the contents of the Planned Primary Procedure Code reference file. | |
|--|--|--|--|

Sub and Non-Acute Patient (SNAP) File

A record for each SNAP type is to be provided on the sub and non-acute patient details file for each episode of care where the care type is sub-acute or non-acute (i.e. Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care or Maintenance Care)

No record is to be provided if the care type is mental health, acute, newborn, boarder, organ procurement-posthumous or other care.

The header record is the first record on the file. There is only one header record, followed by the sub and non-acute patient details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type SNP = Sub and Non-acute Patient | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 31 | Blank | |

| SUB AND NON-ACUTE PATIENT DETAILS RECORDS | | | |
|---|---------|--|--|
| Record Identifier | 1 char | N = New A = Amendment D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. Unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted, zero filled from left |
| SNAP Episode Number | 3 num | The unique SNAP episode number | Right adjusted, zero filled from left |

SUB AND NON-ACUTE PATIENT DETAILS RECORDS

| | | | |
|------------------------------|--------|---|---------------|
| SNAP Type | 3 char | <p>Classification of a patient's care type based on characteristics of the person, the primary treatment goal and evidence.</p> <p>PAL = Palliative care</p> <p>RCD = Rehabilitation – congenital deformities</p> <p>ROI = Rehabilitation - other disabling impairments</p> <p>RST = Rehabilitation – stroke</p> <p>RBD = Rehabilitation – brain dysfunction</p> <p>RNE = Rehabilitation – neurological</p> <p>RSC = Rehabilitation - spinal cord dysfunction</p> <p>RAL = Rehabilitation – amputation of limb</p> <p>RPS = Rehabilitation - pain syndromes</p> <p>ROF = Rehabilitation – orthopaedic conditions, fractures</p> <p>ROR = Rehabilitation – orthopaedic conditions, replacement</p> <p>ROA = Rehabilitation – orthopaedic, all other</p> <p>RCA = Rehabilitation – cardiac</p> <p>RMT = Rehabilitation - major multiple trauma</p> <p>RPU = Rehabilitation – pulmonary</p> <p>RDE = Rehabilitation – debility (reconditioning)</p> <p>RDD = Rehabilitation – developmental disabilities</p> <p>RBU = Rehabilitation – burns</p> <p>RAR = Rehabilitation – arthritis</p> <p>GEM = Geriatric evaluation and management care</p> <p>MRE = Maintenance – respite</p> <p>MNH = Maintenance - nursing home type</p> <p>MCO = Maintenance - convalescent care</p> <p>MOT = Maintenance – other</p> <p>PSG = Psychogeriatric care</p> | |
| AN-SNAP Group Classification | 3 num | Currently not required | Blank if null |
| SNAP Episode Start Date | 8 date | The start date of each SNAP episode | CTYYMMDD |
| SNAP Episode End Date | 8 date | The end date of each SNAP episode | CTYYMMDD |

SUB AND NON-ACUTE PATIENT DETAILS RECORDS

| | | | |
|-------------------------------------|--------|--|--|
| Multidisciplinary Care Plan Flag | 1 char | <p>There is documented evidence of an agreed multidisciplinary care plan.</p> <p>Y = Yes N = No U = Unknown</p> | <p>Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type.</p> <p>Blank if null</p> |
| Multidisciplinary Care Plan Date | 8 date | The date of the establishment of the multidisciplinary care plan | <p>CTYYMMDD</p> <p>Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type and Multidisciplinary Care Plan Flag = 'Y'</p> <p>Blank if null</p> |
| Proposed Principal Referral Service | 3 num | <p>The principal type of service proposed for a patient post discharge. Only one proposed service can be provided. If there is more than one proposed service, provide the principal service.</p> <p>001 = No service is required 101 = Community/home based rehabilitation 102 = Community/home based palliative 103 = Community/home based geriatric evaluation and management 104 = Community/home based respite 105 = Community/home based psychogeriatric 106 = Home and community care 107 = Community aged care package, extended aged care in the home 108 = Flexible care package 109 = Transition care program (includes intermittent care service) 110 = Outreach Service 111 = Community/home based – nursing/domiciliary 198 = Community/home based – other 201 = Hospital based (admitted) – rehabilitation 202 = Hospital based (admitted) – maintenance 203 = Hospital based (admitted) – palliative 204 = Hospital based (admitted) – geriatric evaluation and management</p> | <p>Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type.</p> <p>Blank if null</p> |

SUB AND NON-ACUTE PATIENT DETAILS RECORDS

| | | | |
|------------------------------------|--------|--|--|
| | | 205 = Hospital based (admitted) – respite 206 = Hospital based (admitted) – psychogeriatric 207 = Hospital based (admitted) – acute 208 = Hospital based – non-admitted services 298 = Hospital based – other 998 = Other service 999 = Not stated/unknown service | |
| Primary Impairment Type | 7 char | The impairment which is the primary reason for admission to the episode. | Left adjusted, Blank if null. Only required for patients with a rehabilitation SNAP type |
| Clinical Assessment Only Indicator | 1 num | Currently not required | Blank if null |

For Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care SNAP Episodes

At least one set of mandatory ADL scores must be provided for each SNAP episode.

There can only be one SNAP episode within a single sub-acute episode of care.

The start date of the SNAP episode must be the same as the start date of the episode of care.

The end date of the SNAP episode must be the same as the end date of the episode of care.

For Maintenance SNAP Episodes

At least one set of mandatory ADL scores must be provided for each SNAP episode.

There must be at least one SNAP episode within a single non-acute episode of care.

If there is more than one SNAP episode then these must be contiguous.

The start date of the first SNAP episode must be the same as the start date of the episode of care.

The end date of the last SNAP episode must be the same as the end date of the episode of care.

Palliative Care File

A record is to be provided on the palliative care details file for each episode of care where the care type is: 30 = Palliative care. No record is to be provided if the care type is NOT 30.

The header record is the first record on the file. There is only one header record, followed by the palliative care details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type PAL = Palliative Care | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |

| PALLIATIVE CARE DETAILS RECORDS | | | |
|---|---------|---|--|
| Record Identifier | 1 char | N = New A = Amendment D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. Unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |
| First Admission For Palliative Care Treatment | 1 char | 1 = No previous admission for palliative care treatment 2 = Previous admission for Palliative care treatment | |
| Previous Specialised Non-Admitted Palliative Care Treatment | 1 char | 1 = Patient has no previous non-admitted service contacts for Palliative care treatment 2 = Patient has previous non-admitted service contacts for Palliative care treatment | |

PALLIATIVE CARE DETAILS RECORDS

| | | | |
|--------|---|-------|--|
| Filler | 4 | Blank | |
|--------|---|-------|--|

Department of Veterans' Affairs File

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

The header record is the first record on the file. There is only one header record, followed by the Department of Veterans' Affairs details records.

| HEADER RECORD | | | |
|--------------------------------|---------|---|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type DVA = Department of Veterans' Affairs | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 5 | Blank | |

| DEPARTMENT OF VETERANS' AFFAIRS DETAILS RECORDS | | | |
|---|---------|---|---|
| Record Identifier | 1 char | N = New A = Amendment D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |
| DVA File Number | 10 char | The patient's Department of Veterans' Affairs identification number | Left adjusted and space filled from the right |

DEPARTMENT OF VETERANS' AFFAIRS DETAILS RECORDS

| | | | |
|---------------|--------|---|--|
| DVA Card Type | 1 char | Denotes whether the patient is a gold or white card holder G = Gold W = White | |
|---------------|--------|---|--|

Workers' Compensation File

A record is to be provided on the Workers' Compensation file where the charges for the episode of care are eligible to be met by a Queensland workers' compensation insurer. This is currently defined as those episodes where the payment class is 'WCQ' or 'WCQI'.

A record is not to be provided if the charges for the episode of care are not eligible to be met by a Queensland workers' compensation insurer.

The header record is the first record on the file. There is only one header record, followed by the Workers' Compensation Details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type; WCP = Workers' Compensation | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left; zero if null |
| Extraction Software Identifier | 10 char | Code to identify the version of the software used | Left adjusted, blank if null |
| Filler | 682 | Blank | |

| WORKERS' COMPENSATION DETAILS RECORDS | | | |
|---------------------------------------|---------|---|---|
| Record Identifier | 1 char | N = New A = Amendment D = Deletion U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |
| Workers' Compensation Record Number | 8 num | The patient's Workers' Compensation record number. Populated on the workers' compensation screen from the admission screen | Right adjusted and space filled from left |

WORKERS' COMPENSATION DETAILS RECORDS

| | | | |
|--------------------------|---------|---|---|
| Payment Class | 6 char | The patient's payment class. Populated on the workers' compensation screen from the admission screen | Left adjusted and space filled from right |
| WC Incident Date | 8 date | Date of accident recorded on the workers' compensation screen | CTYYMMDD |
| WC Incident Time | 4 num | Time of accident recorded on the workers' compensation screen (0000 to 2359) - will default to 0000 if not entered | HHMM (24 hour clock) |
| WC Incident Date Flag | 1 char | Flag to indicate that if incident date is estimated – generated by HQI based on the use of '*' in the WC Incident Date field Y = Yes N = No | |
| WC Incident Location | 55 char | Free text field used to record the location of the incident. Will have default value of 'UNKNOWN' | Left adjusted |
| Nature of Injury | 55 char | Free text field used to record the nature of the injury. Will have default value of 'UNKNOWN' | Left adjusted |
| Employer Informed | 1 char | Flag to indicate if the employer has been informed of the incident. The default value will be U Y = Yes N = No U = Unknown | |
| Authority Name | 30 char | Name of authority | Left adjusted, blank if null |
| Authority Address Line 1 | 30 char | First line of authority address details | Left adjusted, blank if null |
| Authority Address Line 2 | 30 char | Second line of authority address details | Left adjusted, blank if null |
| Authority Suburb | 30 char | Suburb of authority address details | Left adjusted, blank if null |
| Authority Postcode | 4 num | Postcode of authority address details | Blank if null |
| Employer Name | 30 char | Name of employer | Left adjusted, blank if null |
| Employer Address Line 1 | 30 char | First line of employer address details | Left adjusted, blank if null |
| Employer Address Line 2 | 30 char | Second line of employer address details | Left adjusted, blank if null |

| WORKERS' COMPENSATION DETAILS RECORDS | | | |
|---------------------------------------|---------|---|--|
| Employer Suburb | 30 char | Suburb of employer address details | Left adjusted, blank if null |
| Employer Postcode | 4 num | Postcode of employer address details | Blank if null |
| Insurer Name | 30 char | Name of insurer | Left adjusted, blank if null |
| Insurer Address Line 1 | 30 char | First line of insurer address details | Left adjusted, blank if null |
| Insurer Address Line 2 | 30 char | Second line of insurer address details | Left adjusted, blank if null |
| Insurer Suburb | 30 char | Suburb of insurer address details | Left adjusted, blank if null |
| Insurer Postcode | 4 num | Postcode of insurer address details | Blank if null |
| Solicitor Name | 30 char | Name of solicitor | Left adjusted, blank if null |
| Solicitor Address Line 1 | 30 char | First line of solicitor address details | Left adjusted, blank if null |
| Solicitor Address Line 2 | 30 char | Second line of solicitor address details | Left adjusted, blank if null |
| Solicitor Suburb | 30 char | Suburb of solicitor address details | Left adjusted, blank if null |
| Solicitor Postcode | 4 num | Postcode of solicitor address details | Blank if null |
| Status 1 | 2 char | Identifies how the WC Incident occurred. Possible values are AW, TW, FW, or U | Left adjusted and space filled from right |
| Status 2 | 2 char | Identifies the patient's role in the WC Incident if it was a road incident. Possible values are C, D, MC, PA, or PD | Left adjusted and space filled from right, blank if null |
| Claim Number | 20 char | Claim number entered on the workers' compensation screen | Left adjusted and space filled from right |
| Occupation | 30 char | Occupation when incident occurred. Will have default value of 'UNKNOWN' | Left adjusted |

Australian Rehabilitation Outcomes Centre File

The header record is the first record on the file. From 1 July 2013 AROC data will not be entered on HBCIS and only the header record will be provided in the AROC extract file.

Telehealth Inpatient Details File

A record is to be provided on the HQI Telehealth Inpatient Details file for each Telehealth event within an episode of care as recorded on the Telehealth Inpatient Details HBCIS screen.

A record should not be provided where a Telehealth service has not been provided to an admitted patient.

The header file is the first record on the file. There is only one header record, followed by the Telehealth Inpatient Details records.

| HEADER RECORD | | | |
|--------------------------------|---------|--|--|
| Facility Number | 5 num | Must be the same as the facility number in the corresponding header file | Right adjusted and zero filled from the left |
| Extract Period | 16 date | From date To date | CTYYMMDD CTYYMMDD |
| File Type | 3 char | Abbreviation to identify file type TID= Telehealth Inpatient Details | |
| Number of Records | 6 num | Total number of records in the file | Right adjusted and zero filled from left zero if null |
| Extraction software identifier | 10 char | Code to identify version of software used | Left adjusted blank if null |
| Filler | 49 | Blank | |

| TELEHEALTH INPATIENT DETAILS RECORDS | | | |
|--------------------------------------|---------|--|--|
| Record identifier | 1 char | N = New A = Amendment D = Deleted U = Up to date | |
| Unique Number | 12 char | A number unique within the facility to identify each admission. This number is not be reused, regardless of deletions etc. | Right adjusted and zero filled from left |
| Patient Identifier | 8 char | Unique number to identify the patient within the facility (e.g. unit record number) | Right adjusted and zero filled from left |
| Admission Number | 12 char | Admission number allocated by facility | Right adjusted and zero filled from left |
| Telehealth Event | 8 num | A unique number that identifies each Telehealth event within an episode of care | |

TELEHEALTH INPATIENT DETAILS RECORDS

| (session) Identifier | | | |
|-------------------------------------|--------|--|--|
| Retrieval Services Queensland (RSQ) | 1 num | Currently not required | Blank if null |
| Provider Facility | 5 num | A code that identifies the facility delivering clinical activity for an admitted patient Telehealth event | Right adjusted and zero filled from left If RSQ is 1 (Yes), then Provider Facility must be null |
| Provider Unit | 4 char | A code that identifies the clinical unit of the provider facility for an admitted patient Telehealth event. | Left adjusted If RSQ is 1 (Yes), then Provider Unit must be null |
| Telehealth Event Type | 2 num | The type of clinical activity delivered by a provider facility during an admitted patient Telehealth event 01 = Ward round 02 = Clinical consultation 03 = Discharge planning case conference 04 = Cancer care case conference 05 = Psychiatric case conference 06 = Multidisciplinary case conference 25 = Telehandover case conference 98 = Other 99 = Not stated/unknown | Right adjusted and zero filled from left |
| Start Date | 8 date | The date on which a Telehealth session commenced | CTYYMMDD |
| Start Time | 4 num | The time when a Telehealth event commenced | HHMM (24 hour clock) |
| End Date | 8 date | The date on which a Telehealth session was completed | CTYYMMDD |
| End Time | 4 num | The time when a Telehealth session was completed | HHMM (24 hour clock) |
| Event Count | 3 num | Count of Telehealth events within a Telehealth session | |
| Total Duration | 4 num | The total duration of a Telehealth session | HHMM (24 hour clock) |

TELEHEALTH INPATIENT DETAILS RECORDS

| | | | |
|--------------------------|--------|---|--|
| Average Duration | 4 num | The average duration of a Telehealth event | HHMM (24 hour clock) |
| Telehealth Provider Type | 2 num | The type of health professional that provides a Telehealth event to an admitted patient. 01 = Medical officer 03 = Other health professional Nurse 04 = Other health professional Allied Health 98 = Other 99 = Not stated / unknown | Must not be null for episodes discharged before 1 July 2019. Must be null for episodes discharged on or after 1 July 2019. |
| Telehealth Provider Type | 8 num | The type of healthcare provider that provided a service event to a non-admitted patient | Must not be null for episodes discharged on or after 1 July 2019. Must be null for episodes discharged before 1 July 2019. |
| Recipient Facility | 5 num | The recipient facility refers to the name of the facility where the patient is intended to be transferred to. | Right adjusted and zero filled from left For telehealth sessions with a start date on or after 1 July 2022 for sessions with an event type '25 – Telehandover'. |
| Recipient Type | 8 num | The type of health professional, at the recipient facility, participating in the Telehandover event. | For telehealth sessions with a start date on or after 1 July 2022 for sessions with an event type '25 – Telehandover'. |
| Recipient Unit | 4 char | The recipient unit refers to the name of the Recipient Unit where the patient is intended to be transferred to. | Left adjusted For telehealth sessions with a start date on or after 1 July 2022 for sessions with an event type '25 – Telehandover'. |

Public Validation Rules

These validation rules apply only to New (N), Amendment (A) and Delete (D) records. For Up to date (U) records, other validation rules apply.

Patient details records

| Data Item | Guidelines |
|---|---|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within facility |
| Family Name | Must not be null |
| Patient First Name | No validation |
| Patient Second Name | No validation |
| Address of Usual Residence | No validation |
| Location (Suburb/town) of Usual Residence | Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence |
| Postcode of Usual Residence | Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence |
| State of Usual Residence | Must not be null Validated against a list of State codes |
| Sex | Must not be null Validated against a list of valid sex codes |
| Date of Birth | Must not be null Must be a valid date Must not be in the future (i.e. past current date) Must not be after the admission date Must not be more than 124 years prior to admission date |

| Data Item | Guidelines |
|--|--|
| Estimated Date of Birth Indicator | Can be null Validated against a list of estimated date of birth indicator codes |
| Marital Status | Must not be null Validated against a list of marital status codes |
| Country of Birth | Must not be null Validated against country codes |
| Indigenous Status | Validated against a list of indigenous status codes Must not be null |
| Occupation | Currently not required, no validation |
| Labour Force Status | Currently not required, no validation |
| Medicare Eligibility | Must not be null Validated against a list of Medicare eligibility codes |
| Medicare Number | Must be a valid Medicare number, if not null 11 digit Medicare number required The eleventh digit is the number that precedes the patient's name on the card (the sub numerate). If a sub numerate cannot be supplied, the eleventh digit of the Medicare number should be provided as zero |
| Australian South Sea Islander Status | Must not be null Must be 1, 2 or 9 |
| Contact for Feedback Indicator | Must not be null Must be Y, N or U |
| Telephone Number – Home | Can be null |
| Telephone Number – Mobile | Can be null |
| Telephone Number – Business or Work | Can be null |
| Hospital Insurance health fund code | Can be null Validated against a list of Hospital Insurance health fund codes |
| Hospital Insurance health fund description | Can be null Should contain description when health fund code is 'Other' |

Admission details records

| Data Item | Guidelines |
|-----------------------------|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by facility Must not be null Must not be zero Must be unique for each patient within facility |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within facility |
| Admission Date | Must not be null Must be a valid date Must not be in the future (i.e. past current date) Must not be before the birth date of the patient Must be before or on separation date |
| Time of Admission | Must not be null Must be a valid time Must be before the separation time, if admitted the same day as separated |
| Account Class | No Validation |
| Chargeable Status | Validated against a list of chargeable status codes Must not be null |
| Care Type | Validated against a list of care type codes Must not be null |
| Compensable Status | Validated against a list of compensable status codes Must not be null |
| Band | Validated against a list of band codes, if not null Must be a same day patient |
| Source of Referral/Transfer | Validated against a list of source of referral/transfer codes Must not be null |
| Transferring from Facility | Must not be null if source of referral/transfer is 16, 23, 24 or 25 or 31 Only applicable if source of referral/transfer is 16, 23, 24 or 25 or 31 Must be a valid facility number |

| Data Item | Guidelines |
|------------------------------|--|
| Hospital Insurance | Validated against a list of Hospital Insurance codes Must not be null |
| Separation Date | Must not be null Must be a valid date Must not be in the future (i.e. past current date) Must be on or after admission date |
| Separation Time | Must not be null Must be a valid time Must be after admission time if separated on the same day |
| Mode of Separation | Validated against a list of mode of separation codes Must not be null |
| Transferring to Facility | Must not be null if mode of separation is 12, 16, 21 or 31 Only applicable if mode of separation is 12, 16, 21 or 31 Must be a valid facility number |
| DRG | Validated for episodes of care that have been separated. Validated against the DRG derived by SSB |
| MDC | Validated for episodes of care that have been separated. Validated against the MDC derived by SSB |
| Baby Admission Weight | Must not be null if patient age is under 29 days, or admission weight is less than 2500 grams |
| Admission Ward | Must not be null No validation |
| Admission Unit | No validation |
| Standard Unit Code | Must not be null Must be a valid standard unit code |
| Treating Doctor at Admission | Must not be null |
| Planned Same Day | Must be Y or N |
| Elective Patient Status | Must not be null Must be a valid elective patient status code |
| Qualification Status | Can be null Validated against a list of qualification status codes Must not be null if care type is 05 |
| Standard Ward Code | Can be null Must be a valid standard ward code |
| Contract Role | Can be null Must be a valid contract role code Must not be null if funding source is 10 |

| Data Item | Guidelines |
|--|---|
| Contract Type | Can be null Must be a valid contract type code Must not be null if funding source is 10 |
| Funding Source | Must not be null Validated against a list of funding source codes |
| Incident Date | Can be null Must be a valid date Must not be in the future (i.e. past current date) Must be on or before admission date |
| Incident Date Flag | Can be null Validated against a list of incident date flag codes |
| Workcover Queensland (Q-Comp) Consent | Must not be null Must be Y, N or U |
| Motor Accident Insurance Commission (MAIC) Consent | Must not be null Must be Y, N or U |
| Department of Veterans' Affairs (DVA) Consent | Must not be null Must be Y, N or U |
| Department of Defence Consent | Must not be null Must be Y, N or U |
| Interpreter Required | Must not be null Must be 1 or 2 or 9 |
| Religion | Not currently required, no validation |
| QAS Patient Identification Number (eARF Number) | Can be null Validated against source of referral/transfer |
| Purchaser/Provider Identifier | Must be a valid establishment number Must not be null if contract role = A or B and contract type is 2, 3, 4 or 5 Must not be null if contract role = B and contract type = 1 and chargeable status is public |
| Preferred Language | Must not be null Validated against a list of language codes |
| Length of Stay in an Intensive Care Unit | Must not be null if the treatment was provided in an ICU6 or CIC6 |
| Duration of Continuous Ventilatory Support | Must not be null if the patient received continuous ventilatory support |
| Criteria Led Discharge Type | Must not be null Validated against list of criteria led discharge type codes |

| Data Item | Guidelines |
|-------------------------------|--|
| Smoking Status | <p>Must not be null if age of patient at admission \geq 18 years</p> <p>Excludes</p> <p>Age of patient at admission \leq 17 years OR</p> <p>Care Type is either 05, 07, 08 OR</p> <p>Mode of Separation = 05 OR</p> <p>Same day admissions with a Principal Diagnosis of ICD-10-AM code Z51.1, Z49.1 or Z49.2.</p> |
| Smoking Pathway Completed | Must not be null if smoking status = 1 |
| Treating Doctor at Separation | Must not be null |

Activity details records

| Data Item | Guidelines |
|--------------------|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within facility |
| Activity Code | Must be a valid code (A, L, W, C, N, E, Q, S, T, B) |

Activity Code = A

| Data Item | Guidelines |
|--------------------|---|
| Account Class Code | No Validation |
| Chargeable Status | Validated against a list of chargeable status codes |
| Compensable Status | Validated against a list of compensable status codes |
| Date of Change | Valid date format Must not be null Must not be before the admission date Must not be after the separation date |
| Time of Change | Not currently required, no validation |

Activity Code = L

| Data Item | Guidelines |
|--------------------------|--|
| Date of Starting Leave | Must be a valid date Must not be null Must not be before the admission date Must not be after the separation date Must not fall within any other leave periods Same day and overnight leave are required |
| Time of Starting Leave | Must be a valid time Must not be null Same day and overnight leave are required |
| Date Returned from Leave | Must be a valid date Must not be null Must be after the date of starting leave Must not be after the separation date Must not fall within any other leave periods Same day and overnight leave are required |
| Time Returned from Leave | Must be a valid time Must not be null Same day and overnight leave are required |

Activity Code = W

| Data Item | Guidelines |
|---------------------------|---|
| Ward | Must not be null No validation |
| Unit | No validation |
| Standard Unit Code | Must be valid standard unit code Must not be null |
| Date of Transfer | Must be a valid date Must not be in the future Must not be before the admission date Must not be within any leave periods Must not be after the separation date Must not be null |
| Time of Transfer | Must be a valid time Must not be null |
| Standard Ward Code | Must be a valid standard ward code Can be null |

Activity Code = C

| Data Item | Guidelines |
|-------------------------------|---|
| Date Transferred for Contract | Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after the separation date Must not be in future Must not be null Must not be after date returned from contract |
| Date Returned from Contract | Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after the separation date Must not be in future Must not be null Must not be before the date transferred for contract |
| Facility Contracted to | Must not be null if there is a date transferred for contract Must be a valid facility number |

Activity Code = N

| Data Item | Guidelines |
|---------------------------------|--|
| Entry Number | Must not be null Must not be zero |
| Date Not Ready for Surgery | Must be a valid date Must not be after the admission date Must not be in the future Must not be null Must not be after the last not ready for surgery date |
| Time Not Ready for Surgery | Not currently collected, no validation |
| Last Date Not Ready for Surgery | Must be a valid date Must not be after the admission date Must not be in the future Must not be null Must not be before the date not ready for surgery |
| Last Time Not Ready for Surgery | Not currently collected, no validation |

Activity Code = E

| Data Item | Guidelines |
|------------------------------|---|
| Entry Number | Must not be null Must not be zero |
| Urgency Category | Must not be null Validate against Waiting List Category codes reference file |
| Accommodation | Not currently required, no validation |
| Site Procedure Indicator | Not currently required, no validation |
| National Procedure Indicator | Not currently required, no validation |
| Planned Length of Stay | Not currently required, no validation |
| Planned Admission Date | Not currently required, no validation |
| Date of Change | Must be a valid date Can be after the admission date Must not be null |

Activity Code = Q

| Data Item | Guidelines |
|----------------------|---|
| Qualification Status | Must not be null Validated against list of qualification status codes |
| Date of Change | Must be a valid date Must not be before the admission date Must not be after the separation date Must not be in the future Must not be null |
| Time of Change | Not currently required, no validation |

Activity Code = S

| Data Item | Guidelines |
|---------------------|---|
| SNAP Episode Number | Must not be null Must not be zero |
| ADL Type | Must not be null Validated against a list of ADL type codes |
| ADL Subtype | Must not be null Validated against a list of ADL subtype codes |
| ADL Score | Must not be null Validated against a list of ADL scores ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL Type and ADL Subtype. |

| Data Item | Guidelines |
|------------|--|
| | <p>For all SNAP episodes:</p> <p>An ADL score of 999 is valid when an assessment has not been undertaken.</p> |
| ADL Date | <p>Must be a valid date</p> <p>Must not be before the admission date</p> <p>Must not be after the separation date</p> <p>Must not be in the future</p> <p>Must not be null</p> |
| ADL Time | Not currently collected, no validation |
| Phase Type | <p>Can be null</p> <p>Must not be null if SNAP type = PAL</p> <p>Validated against a list of phase type codes</p> |

Activity Code = T

| Data Item | Guidelines |
|-------------------------|--|
| Nursing Home Type Flag | <p>Must not be null</p> <p>Must be a valid Nursing Home Flag code</p> <p>Not valid for patients with a care type of:</p> <p>01 – Acute</p> <p>05 – Newborn</p> <p>07 – Organ Procurement-posthumous</p> <p>08 – Boarder</p> |
| Date Commenced NHT Care | <p>Must be a valid date</p> <p>Must not be before the admission date</p> <p>Must not be after the separation date</p> <p>Must not be in the future</p> <p>Must not be null</p> <p>Must be before the date ceased NHT care</p> <p>Must not fall within any other NHT periods</p> <p>Same day and overnight NHT periods are required</p> |
| Date Ceased NHT Care | <p>Must be a valid date</p> <p>Must not be before the admission date</p> <p>Must not be after separation date</p> <p>Must not be in the future</p> <p>Must not be null</p> <p>Must be after the date commenced NHT care</p> <p>Must not fall within any other NHT periods</p> <p>Same day and overnight NHT periods are required</p> |

Activity Code = B

| Data Item | Guidelines |
|-----------------------------|--|
| Mother's Patient Identifier | Must not be zero Must be unique for each patient within the facility Must not be null for Source of Referral/Transfer = 09 |

Morbidity details records

| Data Item | Guidelines |
|--|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| Diagnosis Code Identifier | Must not be null Validated against list of diagnosis code types Every separation must have one and only one PD Cannot have an OD, EX, PR or M without a PD Cannot have a PD, OD, EX, M following a PR |
| ICD-10-AM/ACHI Code (12th Edition) | Must not be null Please refer to Queensland Hospital Admitted Patient Data Collection Manual for the sequencing of ICD-10-AM/ACHI codes. |
| Diagnosis Text | Text is optional, as ICD-10-AM/ACHI codes must be supplied. |
| Date of Intervention | Must be a valid date Must not be in the future Must not be null for interventions with block codes between: 1 to 1059 1062 to 1821 1825 to 1866 1869 to 1892 1894 to 1912 1920 to 2016 8888 to 8889 |
| Contract Flag | Validated against a list of contract flag codes |
| Diagnosis Onset Type (Condition onset flag) | Validated against a list of Diagnosis Onset Type codes Must not be null if Diagnosis Code Identifier = PD, OD, EX or M |

| | |
|--|---------------------------------------|
| Most Resource Intensive Condition Flag | Not currently required, no validation |
| Other Co-Morbidity of Interest Flag | Not currently required, no validation |

Mental Health details records

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a unit transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

| Data Item | Guidelines |
|---|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by a facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| Type of Usual Accommodation | Must not be null Validated against the type of usual accommodation codes |
| Employment Status | Must not be null Validated against the employment status codes If 1 then age must be < 18 If 3, 4, or 6 then age must be > 14 |
| Pension Status | Must not be null Validated against pension status codes If 1 then age must be > 59 if female and > 64 if male If 2 to 5 then age must be between 14 and 65 |
| First Admission For Psychiatric Treatment | Must not be null Validated against the previous admission for psychiatric treatment codes |
| Referral To Further Care | Must not be null Validated against referral to further care codes |
| Mental Health Legal Status Indicator | Must not be null Validated against legal status indicator codes |

| Data Item | Guidelines |
|---|---|
| Previous Specialised Non-admitted Treatment | Must not be null Validated against previous specialised non-admitted treatment codes |

Elective Admission Surgery details records

A record is to be provided on the elective admissions details file for each episode of care where one or more completed EAS entries have been linked to the episode of care.

Each episode of care can have one or more EAS entry linked to it.

| Data Item | Guidelines |
|---------------------------------|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| Entry Number | Must not be null Must not be zero |
| Planned Unit | Not currently required, no validation |
| Surgical Speciality | Must not be null Validated against the waiting list speciality codes |
| Waiting List Status | Not currently required, no validation |
| Reason for Removal | Can be null Validated against the waiting list status reference file |
| Listing Date | Must be a valid date Must not be after the admission date Must not be in the future Must not be null |
| Pre-admission Date (planned) | Not currently required, no validation |
| Urgency Category | Must not be null Validated against the waiting list category codes reference file |
| Accommodation | Must not be null Validated against the waiting list accommodation codes reference file |

| Data Item | Guidelines |
|---|---|
| Site Procedure Indicator | Not currently required, no validation |
| National Procedure Indicator | Not currently required, no validation |
| Planned Length of Stay | Must not be null Must be numeric Zero values accepted |
| Planned Admission Date | Not currently required, no validation |
| Pre-admission Clinic Attendance Date | Not currently required, no validation |
| Planned Procedure Date | Must be a valid date Can be after the admission date Can be null Must not be null if reason for removal = 01 Cannot be greater than 15 years after the listing date |
| Facility Identifier of the hospital managing the waiting list | Not currently required, no validation |
| Planned Primary Procedure Code | Validated against a list of planned primary procedure codes Must not be null |

Sub and Non-Acute Patient details records

A record for each SNAP type is to be provided on the sub and non-acute patient details file for each episode of care where the care type is sub-acute or non-acute (i.e. Rehabilitation care, Geriatric Evaluation and Management care, Palliative care, Psychogeriatric care or Maintenance care)

No record is to be provided if the care type is mental health, acute, newborn, boarder, organ procurement-posthumous or other care.

| Data Item | Guidelines |
|------------------------------|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| SNAP Episode Number | Must not be null Must not be zero |
| SNAP Type | Must not be null Validated against a list of SNAP type codes For Palliative care only PAL is valid For Rehabilitation care only RCD, ROI, RST, RBD, RNE, RSC, RAL, RPS, ROF, ROR, ROA, RCA, RMT, RPU, RDE, RDD, RBU, RAR are valid For Geriatric Evaluation and Management only GEM is valid For Maintenance care only MRE, MNH, MCO, MOT are valid For Psychogeriatric care only PSG is valid |
| AN-SNAP Group Classification | Not currently required, no validation |

| Data Item | Guidelines |
|-------------------------------------|--|
| SNAP Episode Start Date | Must not be null Must be a valid date Must not be in the future (i.e. past current date) Must not be before the birth date of the patient Must be on or after the admission date Must be before or on the separation date |
| SNAP Episode End Date | Must not be null Must be a valid date Must not be in the future (i.e. past current date) Must be on or after the admission date Must be before or on the separation date |
| Multidisciplinary Care Plan Flag | Must be a valid value Must not be null if SNAP Type is Rehabilitation care, Geriatric Evaluation and Management, Palliative care or Psychogeriatric care |
| Multidisciplinary Care Plan Date | Must be a valid date Must not be in the future (i.e. past current date) Must be before or on the separation date Can be null |
| Proposed Principal Referral Service | Must not be null if SNAP Type is Rehabilitation, Geriatric Evaluation and Management, Palliative or Psychogeriatric Validated against the list of proposed service codes |
| Primary Impairment Type | Must not be null if SNAP Type is Rehabilitation Validated against the list of Primary Impairment Type codes |
| Clinical Assessment Only Indicator | Not currently required, no validation |

For Maintenance care SNAP Episodes:

At least one set of mandatory ADL scores must be provided for each SNAP episode.

There must be at least one SNAP episode within a single non-acute episode of care.

If there is more than one SNAP episode then these must be contiguous.

The start date of the first SNAP episode must be the same as the start date of the episode of care.

The end date of the last SNAP episode must be the same as the end date of the episode of care.

For Rehabilitation care, Geriatric Evaluation and Management, Palliative care and Psychogeriatric care SNAP Episodes:

At least one set of mandatory ADL scores must be provided for each SNAP episode.

There can only be one SNAP episode within a single sub-acute episode of care.

The start date of the SNAP episode must be the same as the start date of the episode of care.

The end date of the SNAP episode must be the same as the end date of the episode of care.

Palliative care details records

A record is to be provided on the palliative care details file for each episode of care where the care type is: 30 = Palliative care

No record is to be provided if the care type is NOT 30.

| Data Item | Guidelines |
|---|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| First Admission For Palliative Care Treatment | Must not be null Validated against the first admission for palliative care treatment codes |
| Previous Specialised Non-Admitted Palliative Care Treatment | Must not be null Validated against the previous specialised non-admitted palliative care treatment codes |

Department of Veterans' Affairs details records

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

| Data Item | Guidelines |
|--------------------|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| DVA File Number | Must not be null |
| DVA Card Type | Must not be null Must be a valid Card Type code |

Workers Compensation records

A record is to be provided on the Workers' Compensation details file where the charges for the episode of care are met by WorkCover Queensland. This is currently defined as those episodes where the payment class is 'WCQ' or 'WCQI'.

A record is not to be provided if the charges for the episode of care are not met by WorkCover Queensland.

| Data Item | Guidelines |
|-------------------------------------|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| Workers' Compensation Record Number | Must not be null |
| Payment Class | Must be WCQ or WCQI Must not be null |
| WC Incident Date | Valid date format Must not be null Must not be after the separation date |
| WC Incident Time | Valid time format Must not be null Must be between 0000 and 2359 |
| WC Incident Date Flag | Must be Y or N Must not be null |
| WC Incident Location | Default value will be UNKNOWN Must not be null |
| Nature of Injury | Default value will be UNKNOWN Must not be null |

| Data Item | Guidelines |
|--------------------------|---|
| Employer Informed | Must be Y, or N, or U Must not be null |
| Authority Name | No validation |
| Authority Address Line 1 | No validation |
| Authority Address Line 2 | No validation |
| Authority Suburb | Validated against locality data set parts with the Authority Postcode |
| Authority Postcode | Validated against locality data set parts with the Authority Suburb |
| Employer Name | No validation |
| Employer Address Line 1 | No validation |
| Employer Address Line 2 | No validation |
| Employer Suburb | Validated against locality data set parts with the Employer Postcode |
| Employer Postcode | Validated against locality data set parts with the Employer Suburb |
| Insurer Name | No validation |
| Insurer Address Line 1 | No validation |
| Insurer Address Line 2 | No validation |
| Insurer Suburb | Validated against locality data set parts with the Insurer Postcode |
| Insurer Postcode | Validated against locality data set parts with the Insurer Suburb |
| Solicitor Name | No validation |
| Solicitor Address Line 1 | No validation |
| Solicitor Address Line 2 | No validation |
| Solicitor Suburb | Validated against locality data set parts with the Solicitor Postcode |
| Solicitor Postcode | Validated against locality data set parts with the Solicitor Suburb |
| Status 1 | Must be AW, TW, FW or U Must not be null |
| Status 2 | Must be C, D, MC, PA, PD or null |
| Claim Number | Must not be null |
| Occupation | Default value will be UNKNOWN Must not be null |

Australian Rehabilitation Outcomes Centre records

From 1 July 2013 AROC data will not be entered on HBCIS and only the header record will be provided in the AROC extract file.

Telehealth Admission details records

A record is to be provided on the Telehealth admissions details file where a Telehealth service has been provided to an admitted patient.

| Data Item | Guidelines |
|---------------------------------------|--|
| Record Identifier | Must be a valid value Must not be null |
| Unique Number | Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission |
| Patient Identifier | Must not be null Must not be zero Must be unique for each patient within the facility |
| Admission Number | Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility |
| Telehealth Event (session) Identifier | Must not be null Must not be zero Must be a valid facility number |
| Retrieval Services Queensland (RSQ) | Not currently required, no validation |
| Provider Facility | Must not be null Must be a valid facility code |
| Provider Unit | If RSQ is 1 (yes), then provider unit must be null |
| Telehealth Event Type | Must not be null Must be a valid Telehealth event type code |
| Start Date | Must be a valid date Must not be after the end date Must not be in the future Must not be null |
| Start Time | Must be a valid time Must not be null |
| End Date | Must be a valid date Must be after the start date Must not be in the future |

| Data Item | Guidelines |
|--------------------------|--|
| | Must not be null |
| End Time | Must be a valid time Must not be null |
| Event Count | Must not be null |
| Total Duration | Must not be null Must be numeric |
| Average Duration | Must not be null Must be numeric Zero values accepted |
| Telehealth Provider Type | Must not be null Must be a valid Telehealth provider type code |
| Recipient Facility | Must be a valid facility code Reported for telehealth sessions with a start date on or after 1 July 2022 with an event type '25 – Telehandover' |
| Recipient Type | Must be a valid Telehealth provider type code Reported for telehealth sessions with a start date on or after 1 July 2022 with an event type '25 – Telehandover' |
| Recipient Unit | Must be a valid unit code Reported for telehealth sessions with a start date on or after 1 July 2022 with an event type '25 – Telehandover' |

Public Processing Rules

The processing rules apply to New (N), Amendment (A), Delete (D) and Up to date (U) records.

RECORD IDENTIFIER = N

Description:

Patient separated in the extract period or patient separated prior to the extract period but not previously submitted (late insertion).

Patient File

- A corresponding record must exist in the admission file.

Admission File

- Admission record must not already exist.
- A corresponding record must exist in the patient file.
- Patient must be separated in the extract period or patient separated prior to extract period but not previously submitted (late insertion).
- Late insertions for the current financial year can be received up to and including the extraction for August data of the next financial year (due in early October).

Activity File

- A corresponding record must exist in the admission file and in the patient file.
- All activities must occur within the admission and separation dates.

Account Class Variations

- Must not already exist.

Leave

- Must not already exist.
- Leave period must not overlap with any other leave periods for admission.

Ward Transfer

- Must not already exist for admission.

Contract Status

- Must not already exist for admission.

Not Ready For Surgery

- Must not already exist for admission.
- Not ready for surgery period must not overlap with any other not ready for surgery periods for admission.

Qualification Status

- Must not already exist for admission.

Elective Surgery Items

- Must not already exist for admission.

Sub and Non-acute Patient Items

- Must not already exist for admission.

Nursing Home Type Patient Items

- Must not already exist for admission.

Delayed Assessed Separation Event

- Must not already exist for admission.
- Event period must not overlap with any other event periods for admission.

Patient Identifier of mother of baby born in hospital

- Must not already exist for admission.

Morbidity File

- A corresponding record must exist in the admission file and in the patient file.
- The ICD-10-AM code must not already exist for this admission except for procedure, morphology and external cause codes.

Mental Health File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.
- Must exist if any standard unit code in the activity or admission file is in the range PYAA to PYZZ.

Elective Admission Surgery File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Sub and Non-Acute Patient File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Palliative Care File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Department of Veterans' Affairs File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Workers' Compensation File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Telehealth Inpatient Details File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

RECORD IDENTIFIER = A

Description:

Amendment to records submitted prior to the extract period. Amendment records for the current financial year can be received up to and including the extraction of July data of the next financial year (due in early September).

These processing rules also apply to Up to Date records previously sent.

Patient File

- Patient record must exist.

Admission File

- Admission record must exist

Activity File

- Cannot be amended, must instead be deleted and re-created.

Morbidity File

- Cannot be amended, must instead be deleted and re-created.

Mental Health File

- Mental Health record must exist.

Elective Admission Surgery File

- Elective Admission Surgery record must exist.

Sub and Non-acute Patient File

- Sub and Non-acute Patient record must exist.

Palliative Care File

- Palliative Care patient record must exist.

Department of Veterans' Affairs File

- Department of Veterans' Affairs record must exist.

Workers' Compensation File

- Workers' Compensation record must exist.

Telehealth Inpatient Details File

- Telehealth Inpatient record must exist.

RECORD IDENTIFIER = D

Description:

Deletion of any record previously sent. Deletion records for the current financial year can be received up to and including the extraction of July data of the next financial year (due in early September).

These processing rules also apply to Up to Date records previously sent.

Patient File

- Deletion is not applicable to patient records.

Admission File

- The admission record must exist.

Activity File

- Only the one record matching the previously submitted record exactly will be deleted.

Account Class Variations

- The record must exist

Leave

- The record must exist

Ward Transfer

- The record must exist

Contract Status

- The record must exist

Not Ready For Surgery

- The record must exist

Qualification Status

- The record must exist

Elective Surgery Items

- The record must exist

Sub and Non-acute Items

- The record must exist

Nursing Home Type Patient Items

- The record must exist

Delayed Assessed Separation Event

- The record must exist

Patient Identifier of mother of baby born in hospital

- The record must exist

Morbidity File

- All morbidity records in relation to that admission will be deleted.
- The morbidity record must exist.

Mental Health File

- Mental Health record must exist.

Elective Admission Surgery File

- Elective Admission Surgery record must exist.

Sub and Non-Acute Patient File

- Sub and Non-acute Patient record must exist.

Palliative Care File

- Palliative Care record must exist.

Department of Veterans' Affairs File

- Department of Veterans' Affairs record must exist.

Workers' Compensation File

- Workers' Compensation record must exist.

Telehealth Inpatient Details File

- Telehealth Inpatient record must exist.

RECORD IDENTIFIER = U

Description:

Patient admitted during, or prior to, the extract period but who is not separated in the extract period.

A 'U' Up to Date record identifier replaces a 'N' New record identifier when the Up to Date record is first supplied in the extract. All amendments to an up to date record should be provided using the processing rules applied to end dated records. Following the separation of a patient the end date of the record will be provided in the extract as an amendment record within the admission file.

Patient File

- A corresponding record must exist in the admission file.

Admission File

- Admission record must not already exist.
- A corresponding record must exist in the patient file.
- Patient admitted during or prior to extract period but who is not separated in extract period or separated prior to extract period but not previously submitted (late insertion).
- During each collection period there will be a 'refresh point' for U records. This will entail SSB deleting all existing U records. Therefore, all records that meet the 'U' criteria, including those records that have been previously supplied, are required to be submitted in the first extract following the extract period for August data.

Activity File

- A corresponding record must exist in the admission file and in the patient file.
- All activities must occur within the admission and extract period to dates.

Account Class Variations

- Must not already exist.

Leave

- Must not already exist.
- Leave period must not overlap with any other leave periods for admission.

Ward Transfer

- Must not already exist for admission.

Contract Status

- Must not already exist for admission.

Not Ready For Surgery

- Must not already exist for admission.
- Not ready for surgery period must not overlap with any other not ready for surgery periods for admission.

Qualification Status

- Must not already exist for admission.

Elective Surgery Items

- Must not already exist for admission.

Sub and Non-acute Patient Items

- Must not already exist for admission.

Nursing Home Type Patient Items

- Must not already exist for admission.

Delayed Assessed Separation Event

- Must not already exist for admission.
- Event period must not overlap with any other event periods for admission.

Patient Identifier of mother of baby born in hospital

- Must not already exist for admission.

Morbidity File

- A corresponding record must exist in the admission file and in the patient file.
- The ICD-10-AM code must not already exist for this admission except for procedure, morphology and external cause codes.

Mental Health File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.
- Must exist if any standard ward/unit code in the activity or admission file is in the range PYAA to PYZZ.

Elective Admission Surgery File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Sub and Non-Acute Patient File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Palliative Care File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Department of Veterans' Affairs File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Workers' Compensation File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Telehealth Inpatient Details File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.