Home Care Reporting System Data Submission Specifications Manual, 2017–2018

Canadian Institute for Health Information
Institut canadien d'information sur la santé

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About CIHI

The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

Privacy and confidentiality

CIHI's Privacy Program

CIHI has a comprehensive Privacy Program in place to protect the confidentiality and security of our data holdings. A cornerstone of this program is a set of strict principles and policies that govern how CIHI collects, stores, analyzes and disseminates data. These are outlined in the document *Privacy Policy on the Collection, Use, Disclosure and Retention of Personal Health Information and De-Identified Data, 2010* available at www.cihi.ca. These policies have been reviewed to ensure they are aligned with Schedule 1 of the federal *Personal Information Protection and Electronic Documents Act* (PIPEDA).

The Privacy Program also includes

- A Privacy Secretariat committed to developing a culture of privacy at CIHI;
- An active Privacy, Confidentiality and Security team that includes representation from across the organization;
- A chief privacy advisor who provides advice and counsel on privacy matters;
- A Privacy and Data Protection Committee (subcommittee of CIHI's Board of Directors);
- Mandatory staff training to keep health information protection matters front and centre; and
- Outreach activities to keep stakeholders advised.

Chapter 1 — Introduction

The Home Care Reporting System (HCRS) standards include CIHI data elements and 2 clinical instruments developed by interRAI, an international network of researchers:

- Resident Assessment Instrument–Home Care (RAI-HC) © interRAI Corporation, Washington, D.C., 1994, 1996, 1997, 1999, 2001. Modified with permission for Canadian use under licence to the Canadian Institute for Health Information. Canadianized items and their descriptions © Canadian Institute for Health Information, 2013.
- interRAI Contact Assessment (interRAI CA) © interRAI Corporation, Washington, D.C., 1994–2010. Modified with permission for Canadian use under licence to the Canadian Institute for Health Information. Canadianized items and their descriptions © Canadian Institute for Health Information, 2013.

The *Home Care Reporting System Data Submission Specifications Manual* is a reference for those involved in data submissions to HCRS.

This manual includes

- Relevant technical specifications, naming conventions and file characteristics for submission of RAI-HC and other HCRS data elements; and
- Directions for accurate and consistent coding for CIHI data elements. Coding instructions for the RAI-HC in community and hospital settings are found in the companion manuals described below.
- Requirements for data submission including the processes involved in accessing CIHI's electronic data submission system.

As additional support to clients, CIHI provides education on HCRS data submission processes. Please visit www.cihi.ca.

Note: Please refer to *Home Care Reporting System — Contact Assessment (HCRS-CA) Data Submission Specifications Manual* for further information on the interRAI CA and the HCRS-CA.

How to use this manual

This manual is a companion to the *RAI-Home Care (RAI-HC) User's Manual — Canadian Version, September 2010* (referred to here as the RAI-HC User's Manual).

Wherever possible, duplication of information already contained within the RAI-HC User's Manual has been avoided. Therefore, this manual excludes the definitions, intents and coding instructions for the data elements contained in the RAI-HC but includes details of how these data elements, once captured, must be submitted to CIHI. In particular, it documents where the format of the data element as it is be submitted to CIHI is different from how it is displayed or captured on the RAI-HC form provided in the RAI-HC User's Manual (e.g., BB2a Birth Date).

With permission from interRAI, HCRS has incorporated definitions of certain key data elements from the RAI-HC that can be collected on all home care clients, even if they do not receive a RAI-HC assessment. This ensures that the HCRS key demographic and administrative information is reported consistently on all home care clients. This manual provides details of these data elements and how they are to be submitted to CIHI.

Additional manuals related to HCRS include the following:

- Home Care Reporting System RAI-HC Output Specifications 2017–2018
- Home Care Reporting System — Contact Assessment (HCRS-CA): Data Submission Specifications Manual 2017–2018
- *Home Care Reporting System — Contact Assessment (HCRS-CA): Output Specifications 2017–2018*

Organization of this manual

Chapter 2 provides an overview of the data standards, HCRS scope, testing requirements, key concepts and record types.

Chapter 3 outlines the information provided for each data element or set of data elements.

Chapter 4 provides an overview of the technical requirements for submitting data elements that are on all records.

Chapter 5 provides an overview of the technical requirements for data elements submitted only on non-client records.

Chapter 6 provides an overview of the technical requirements for submitting CIHI-defined client-specific data elements.

Chapter 7 provides an overview of the technical requirements for RAI-HC data elements.

Note: Please refer to the RAI-HC User's Manual for definitions, intents and coding instructions for the RAI-HC data elements.

Chapter 8 provides details of the data and record submission specifications for use by organizations and vendors in the development of data collection and/or submission software for HCRS.

Appendix A provides a summary of all HCRS data elements by the records on which they appear.

Appendix B provides the error numbers and descriptions that appear on an organization's submission report.

How to obtain further information

Additional information on HCRS and documentation of any updates to the material contained in this manual can be found on CIHI's website at www.cihi.ca/homecare.

CIHI will also communicate such information and updates directly to current HCRS organizations and their vendors.

Vendors can contact CIHI's vendor support department by email at help@cihi.ca.

Other questions and comments can be sent by email to the HCRS team at homecare@cihi.ca.

To order another copy of this manual or to order the RAI-HC User's Manual, contact the CIHI Order Desk by email at help@cihi.ca.

Chapter 2 — Home Care Reporting System

Introduction

This chapter provides an overview of the data standards, HCRS scope, testing requirements, key concepts and record types.

Definition of home care

Publicly funded home care programs across Canada deliver a diverse set of services to meet a wide variety of client needs.

The definition of home care used for the HCRS encompasses the breadth of services offered by public programs and reflects the variety of settings where these services are now delivered:

> "An array of services, which enables clients incapacitated in whole or in part to live at home, often with the effect of preventing, delaying or substituting for long-term or acute care alternatives. These services may be provided by a number of different agencies or individuals."[i]

Individuals who receive home care have a broad range of needs — from short-term needs for a single service in response to a specific event (e.g., nursing care following a stay in an acute care hospital) to long-term need for support from a range of health providers to remain living in a community setting.

How jurisdictions meet these needs varies considerably. The services provided vary with respect to types of services provided; range and type of service providers available; settings where services are provided; organizational size, structure and governance; and eligibility, coverage and co-payment requirements and service maximums.

The service delivery models employed also vary and include services provided by in-house personnel, contracted service providers and/or self-managed care (where clients receive funding and are responsible for acquiring their services).

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i. Canadian Institute for Health Information. *Development of National Indicators and Reports for Home Care — Phase 2: Final Project Report*. 2004.

Development of the pan-Canadian Home Care Reporting System

The need for home care information

Home care services are an important and growing component of Canada's health service delivery system. The pressure to expand and enhance home-based services is seen as a result of demographic shifts in the population, changing consumer expectations with respect to service and care options, and technological and scientific advancements in the delivery of health services. In addition, many see home care as a cost-effective alternative to acute care and/or long-term institutional care.

The growth in home care services has been accompanied by an increased demand for information with which to assess and monitor home care. There was renewed emphasis, seen in the Romanow report[ii] and the 2003 Health Accord,[iii] on access to home care and the need for quality information to support quality services and public accountability.

In addition to the variability in the services provided within the home care sector, inconsistencies in data collection on home care services across Canada have made it difficult to characterize the client populations; to understand the services provided, particularly in relation to outcomes; and to make meaningful comparisons about home care across jurisdictions.

CIHI responded to this growing need for standardized home care information by developing the Home Care Reporting System.

Standardized clinical assessment tools

A key principle in developing HCRS was that wherever possible the data should be a by-product of the processes of care.

A growing consensus has emerged around the value of standardized clinical assessment tools to support front-line care planning and quality. Jurisdictions are also moving toward new comprehensive health information systems to integrate client information across the continuum of care.

After undertaking evaluations, many Canadian jurisdictions selected the RAI-HC instrument for the assessment and care planning of their longer-term home care clients. The data is captured electronically at the point of care for use at individual and aggregate (system) levels.

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ii. Commission on the Future of Health Care in Canada. *Building on Values: The Future of Health Care in Canada — Final Report*. 2002.
iii. For further information, see Health Canada's website.

The RAI-HC with its associated Clinical Assessment Protocols supports quality of care through

- A comprehensive understanding of clients' characteristics;
- A standardized and more objective approach to assessing the needs of a diverse home care population;
- Real-time feedback on client risks and needs for care planning; and
- Clinical benchmarking using risk-adjusted indicators and outcome scales.

Jurisdictions are also in the process of implementing the interRAI CA for home care intake in hospital and community settings and for screening high-risk individuals in the emergency room.

HCRS — A flexible, integrated reporting framework

HCRS provides comparative longitudinal and cross-sectional statistical reports and analyses that include information on client characteristics, outcomes and resource utilization, including RAI-HC risk-adjusted quality indicators.

With permission from interRAI, HCRS has incorporated definitions of certain key demographic and administrative data elements from the RAI-HC for all home care clients regardless of whether they receive a RAI-HC assessment.

In addition to the RAI-HC and demographic data collected, jurisdictions will be able to collect and submit administrative information and client-specific home care resource utilization data for all their home care clients. This will enable jurisdictions to report on additional indicators, including wait times and resource utilization.

HCRS has the flexibility to capture and report on this data, allowing for a basic level of comparative reporting across RAI and non-RAI jurisdictions.

Scope of the Home Care Reporting System

Organizations delivering home care

HCRS is designed to capture information on publicly funded home care services, including publicly funded services delivered by private-sector agencies and those funded and delivered by the federal government (e.g., First Nations and Inuit Health, Veterans Affairs).

Population scope

HCRS is designed to accept data on **all** individuals who have been accepted into the home care programs of the organizations described above.

This includes individuals who receive short-term care related to a time-limited, acute condition as well as clients requiring longer-term support to enable them to remain living in a community setting.

It also includes individuals for whom the only home care service received is a RAI-HC assessment, for example, to determine the need for placement to residential care.

A key feature of HCRS is that it will distinguish, at a high level, the different types of clients (Client Groups) who receive home care services. This will facilitate comparative reporting within and across jurisdictions.

HCRS will not capture data on clients receiving only privately funded home care, informal care and/or voluntary care.

Scope of the information collected

The information captured in HCRS includes

- Demographic information (which may be collected as part of a RAI-HC assessment or through other processes, such as referral and admission);
- Client Groups;
- Other administrative data such as referral and discharge information;
- Resource utilization data detailing the amount and types of services received; and
- RAI-HC assessment data, for those clients receiving a comprehensive assessment (generally clients assigned to the Long-Term Supportive Care and Maintenance Client Groups).

The amount and type of data collected and submitted for an individual home care client will depend on

- How long the client receives home care services;
- Whether the organization assesses the client using the RAI-HC assessment instrument;
- Whether there is a provincial/territorial mandate; and
- An organization’s ability to collect the CIHI administrative and resource utilization data elements.

Sources of information

If organizations have fully implemented the HCRS standards for all their home care clients, it is likely that the data will come from multiple sources and information systems, including RAI-HC data collection software and other clinical or administrative systems. These systems may have different levels of integration within the organizations but, wherever possible, organizations should aim to collect the data only once.

The data from these systems may need to be extracted and transformed from existing systems to meet CIHI's submissions requirements (as detailed in chapters 3 to 8) through mapping protocols. The HCRS team can offer assistance in quality assurance of such mapping documents.

HCRS software and testing

CIHI does not advise organizations as to the hardware or software they should acquire. Organizations should choose the equipment and systems that best meet their overall data requirements needs. All software vendors must successfully complete CIHI's vendor testing process.

In order to successfully complete CIHI's vendor testing process, vendors must submit complete records created using their HCRS software. The submitted records must be accepted by the HCRS database with no submission errors.

Organizations that develop their own in-house solutions for data collection and submission to CIHI are also required to successfully complete CIHI's vendor testing before they initiate submissions to HCRS.

For a list of vendors that have successfully passed CIHI's vendor testing process, send an email to help@cihi.ca.

Please refer to Chapter 8 — Data submission requirements for further information on vendor testing and detailed specifications for data submission.

Key concepts

There are several key concepts relating to the collection and submission of data to HCRS.

Source organizations

Source organizations have responsibility for delivering home care services and for collecting information on the clients they serve. These include regional organizations (e.g., health authorities, community care access centres) and certain provincial or territorial ministries of health.

These organizations may submit data directly to CIHI, or another organization may submit data on their behalf.

Submission organizations

Submission organizations submit data to CIHI.

In some jurisdictions, source organizations will submit their own data to CIHI and therefore will act as both source and submission organizations.

In other jurisdictions, source organizations will send their data to another organization (e.g., their provincial ministry of health), which will then submit the data to CIHI. In this scenario, it is the ministry of health that is the submission organization.

Reporting periods

Each fiscal year (April 1 to March 31) is divided into a number of reporting periods. Provinces and territories may choose to submit their HCRS data in 4 quarters, 12 months or 13 reporting periods. Data submitted in 12 or 13 reporting periods can be aggregated into fiscal quarters or years for comparative analysis.

Each client record that is created must be assigned to a reporting period. This assignment is most often based on an event date for that particular record, such as the Assessment Reference Date (A1) for the RAI-HC Assessment (RH) record or Discharge Date (X30) for the Discharge (DC) record. Further details on record types may be found in the following sections.

The table below identifies the data element on each client record that determines the reporting period to which that record should correspond. Dates for the data elements listed below must fall within the dates of the reporting period (Y13).

Record ID/name	Data element that determines the reporting period (Y13) that the record should be submitted for
UC (Update Client Profile)	X51 (Effective Date)
RH (RAI-HC Assessment)	A1 (Assessment Reference Date)
MD (Medication)	A1 (Assessment Reference Date)
SS (Service Start)	X10 (Service Start Date)
SD (Service Detail)	Can be submitted in any reporting period that occurs between X10 (Service Start Date) and Y11 (Date of Submission)
SE (Service End)	X17 (Service End Date)
ER (ER Visits)	Can be submitted in any reporting period that occurs between CC1 (Date Case Opened/Reopened) and Y11 (Date of Submission)
DC (Discharge)	X30 (Discharge Date)
OT (Organization Client Transfer)	X60 (Client Transfer Date)

Home care admission

In HCRS, a home care **admission** relates to the decision of a source organization to accept an individual for home care services. This critical event

- Defines the population scope of HCRS (only those accepted for home care service are *in scope*) and for whom HCRS records should be submitted to CIHI;
- Is the point at which an individual person can be considered to be a **home care client** and on the source organization's caseload; and
- Begins the individual's home care service episode.

The process of accepting a person for home care service begins with a referral — where the source organization is notified of an individual who may be in need of home care services. The individual referred may be

- A person who has received home care services from the source organization before and had previously been discharged;
- An existing client of the source organization who is not receiving home care (e.g., a person who is in a residential care facility run by the source organization) and who needs home care services; and
- A person who has never received any home care services from the source organization before.

In HCRS, receiving a RAI-HC assessment is considered a home care service. Therefore, individuals who receive a RAI-HC assessment but no other home care services (e.g., to determine the need for placement to residential care) are considered to have been accepted to home care.

There may be several individual processes that are required before a decision to accept a person for service is made. Examples include intake, triage and registration. These processes will vary across and within the source organizations, depending on their business practices. However the key criteria are

- Acknowledgement by the source organization that the individual qualifies for service (based on assessed needs and the program criteria); and
- Agreement between the source organization and the individual or caregiver to begin service planning and delivery.

There may be a period of time between when the individual is accepted for service and when those services begin.

Discharge

Conversely, a home care **discharge** is the administrative process by which a source organization records the termination of **all** home care services provided to an individual.

A client's discharge ends the home care service episode: the individual is no longer considered to be on the source organization's home care caseload and is no longer considered a home care client.

For the purposes of HCRS, discharges also include when the source organization stops providing home care but provides other (non–home care) services to the individual. For example, an individual would be considered discharged when the source organization officially documents the end of home care services due to the transfer to a residential care home that is run by the source organization.

The date of a client's official discharge from home care may occur after the date the client receives his or her last service visit. This will depend on the organization's discharge practices and the completion of all the required administrative processes.

Home care service episode

A service episode is the period of time between an individual's admission to and discharge from a source organization's home care service.

A client can have multiple home care service episodes. However, these must occur sequentially. An individual can be readmitted to the source organization only if he or she has been discharged from a previous admission.

Home care services

During a home care service episode, an individual will have 1 or more home care visits that may be delivered by multiple service providers in multiple locations. Information on the visits (and the minutes of service) provided can be grouped into “streams” of home care services and reported separately to allow for more detailed analysis of clients’ service utilization.

Either or both of the following 2 data elements can be used to define a separate stream of home care services:

- X11 Service Type; and
- X12 Home Care Discipline (of the service provider).

Both data elements are hierarchically structured to allow source organizations to report clients’ utilization of home care services at different levels of detail. For example, if a client receives nursing services from several registered nurses, 1 of whom also acts as the client’s case manager, rehabilitation services from a physiotherapist and a therapy assistant, and personal care from a home support worker, the following table shows how HCRS could capture information about these services depending on the level of detail used to create the service streams. See Chapter 6 — CIHI-defined client-specific data elements for more details.

Service by level of detail

X11 Service Type	X12 Home Care Discipline	Service streams captured
Finest	Finest	Case management by registered nurse (RN) Other direct home health services by registered nurse (RN) Other direct home health services by physiotherapist Other direct home health services by therapy assistant Personal care by home support personnel
Summary	Finest	Home health by registered nurse (RN) Home health by physiotherapist Home health by therapy assistant Home support by home support personnel
Not captured	Finest	All services by registered nurse (RN) All services by physiotherapist All services by therapy assistant All services by home support personnel

X11 Service Type	X12 Home Care Discipline	Service streams captured
Finest	Summary	Case management by licensed/regulated disciplines Other direct home health services by licensed/regulated disciplines Other direct home health services by unlicensed/unregulated personnel Personal care by unlicensed/unregulated personnel
Summary	Summary	Home health by licensed/regulated disciplines Home health by unlicensed/unregulated personnel Home support by unlicensed/unregulated personnel
Not captured	Summary	All services by licensed/regulated disciplines All services by unlicensed/unregulated personnel
Finest	Not captured	Case management Other direct home health services Personal care
Summary	Not captured	Home health Home support
Not captured	Not captured	All home care service is provided in a single stream

For each service stream, separate records can be submitted to document the start of the service stream, the amount of service received during each reporting period and when the client stopped receiving services in that stream. Records for multiple service streams can be submitted within a home care service episode. Clients may receive different services concurrently, and services may start and stop at different times throughout a home care service episode.

If, during a reporting period, a client receives services in different types of delivery settings (e.g., at home, in an ambulatory care setting), separate records can be submitted providing details of the amounts of service received in each setting. Similarly, separate records can be submitted by whether or not the services received were considered acute (see data element X14 Acute Services Flag).

Client Group

Client Group is a high-level description of home care clients, based on their health status (health and living conditions, and personal resources) and assessed needs. It is a standard, client-focused categorization, developed by CIHI to be used to facilitate pan-Canadian comparative reporting on home care clients. There are 5 Client Groups: Acute, End-of-Life, Rehabilitation, Long-Term Supportive Care and Maintenance.

It is expected that RAI-HC assessments will be carried out on clients assigned to the Long-Term Supportive Care and Maintenance Client Groups.

A client is assigned to a Client Group at the start of the home care service episode. The assignment is done by a home care professional, following an assessment of the client's needs. If a client's goals of care change significantly (e.g., if health status deteriorates significantly), the client may need to be reassigned to a different Client Group following a reassessment of his or her needs. This can occur at any time during a client's home care service episode.

See data element X2 Client Group in Chapter 3 for further details.

Following Client Group reassignment, the individual's care needs are likely to change, which should be reflected in the home care service utilization records submitted before and after the reassignment.

Record types

There are 14 different types of records that can be submitted to HCRS; they are distinguished by the data element Y2 Record Type, which is submitted on every record. All record types have unique record layouts, which are provided in Chapter 7.

There are 10 different client record types for the submission of client-specific data. The remaining 4 non-client record types are required for the appropriate processing of client-specific records.

Client records

The client records are designed to capture comprehensive, client-specific information on individuals who have been accepted by source organizations to receive home care services.

HCRS is an event-driven reporting system: the information submitted in the different records reflects the different events that occur throughout a client's home care service episode.

Record ID	Record name	Trigger event(s)	Summary of data collected
AD	Admission	Acceptance by a source organization to provide home care services to an individual	Personal identifiers and demographic and administrative information collected through referral, intake and acceptance processes May include data collected from initial RAI-HC assessment or the first service visit
UC	Update Client Profile	A change in client's demographic or administrative information recorded in the Admission record	The data element that has changed, the date of change and the new value

Record ID	Record name	Trigger event(s)	Summary of data collected
RH	RAI-HC Assessment	The conducting of a RAI-HC assessment	Data captured during the RAI-HC assessment, excluding demographic information already submitted on the Admission record and section Q5 of the Medications record
MD	Medication	The conducting of a RAI-HC assessment	Data captured in Q5 of RAI-HC assessment
SS	Service Start	The start of an individual stream of home care service	Type of Service, Discipline of Service Provider, Date Service Started
SD	Service Details	Delivery of home care services	The amount and delivery settings of service received during the reporting period
SE	Service End	The end of an individual stream of home care service	Date stream of service finished
ER	ER Visits	A visit to an emergency room	The number of visits to the emergency room during the reporting period
OT	Organization Client Transfer	A reorganization of the source organizations within a province/territory (e.g., boundary changes)	Organization and client identifiers to enable records to be submitted for the same individual before and after the reorganization
DC	Discharge	The discharge of the client from all home care services	Date and reason for discharge (including referrals to other health services)

Admission (AD)

This record captures demographic and administrative information on clients when they are accepted for home care by a source organization. It marks the beginning of a client's home care service episode.

Most information submitted in an Admission record is likely to be collected as part of the referral, intake and admission processes. However, information may only be collected or confirmed during the conducting of a RAI-HC assessment or the first service visit (e.g., the initial Client Group assignment).

Key data elements on the Admission record are harmonized with sections AA, BB and CC of the RAI-HC assessment and are collected whether or not the client has a RAI-HC assessment:

- AA3a Health Card Number
- AA3b Province/Territory Issuing Health Card Number
- AA4 Postal Code of Residence
- BB1 Sex
- BB2a Birth Date
- BB2b Estimated Birth Date
- BB4 Marital Status
- BB5a Primary Language
- CC1 Date Case Opened/Reopened

If the information is not collected during the referral and intake process, a client's Admission record can therefore be partially populated from the initial RAI-HC assessment.

All subsequent records related to the home care service episode are associated with an Admission record and are tracked using the data elements X1b Unique Source Organization Client Identifier and CC1 Date Case Opened/Reopened, which are submitted on the Admission record.

Update Client Profile (UC)

This record is used to inform CIHI of any changes in the client's demographic information (e.g., marital status, postal code) or key categorizations used to document the home care service episode (data elements X2 Client Group, X3 Subregion Identifier or X4 Program Type).

The source organization may become aware of such changes through a number of different processes, including routine service visits, conducting a RAI-HC assessment or direct notification by the client or caregiver.

RAI-HC Assessment (RH)

This record is used to submit the majority of the data collected during a RAI-HC assessment. The following information is not submitted on the RH record:

- The names of the client, any caregivers and assessors; and
- The demographic information collected for all home care clients. These data elements are initially submitted on the Admission record, although the information collected during the client's initial RAI-HC assessment can be used to populate the client's Admission record. Subsequent changes to the client's marital status, postal code, health card number or primary language, which may be identified through the completion of RAI-HC assessment, need to be submitted to CIHI using an Update Client Profile record.

- The detailed medications listed in Section Q5 of the assessment are submitted in a separate record type (see below).

The same record type is used to submit all types of RAI-HC assessments, as recorded in data element A2 Reason for Assessment. Users should refer to the RAI-HC User's Manual for further information on the use and timing of the RAI-HC assessments.

A change in Client Group, which is submitted to CIHI through an Update Client Profile record, may coincide with the conducting of a RAI-HC assessment. For example, a Maintenance client has a significant decline in health status. The home care professional may conduct a change in status RAI-HC assessment, following which the client is reassigned to the Long-Term Supportive Care Client Group, reflecting the new service needs.

A client may have 1 or more RAI-HC Assessment records associated with an Admission record. RAI-HC records must have a unique combination of A1 Assessment Reference Date and A2 Reason for Assessment.

Usually, only 1 RAI-HC assessment is expected on a given day. The exception to this is when inter-rater reliability assessments are carried out.

Medication (MD)

This record is used to submit the detailed list of medications collected in Section Q5 of the RAI-HC assessment. A separate record is required for each medication.

Medication records must be associated with a RAI-HC Assessment (RH) record using the data elements A1 Assessment Reference Date and A2 Reason for Assessment. They must also have a unique X40 Medication Sequence Number.

Service Start (SS)

This record captures information about when a client begins to receive home care services.

A client may have 1 or more Service Start records associated with an Admission record. These record different streams of home care services provided concurrently and/or record the start, end and resumption of a particular service stream during a home care service episode.

Each Service Start record must have a unique combination of X10 Service Start Date, X11 Service Type and X12 Home Care Discipline.

Service Details (SD)

This record captures the amount and settings of the home care services received during a given reporting period.

Separate Service Details records are submitted to record the amount of service received in each service stream. Each Service Details record must be associated with a Service Start record using X10 Service Start Date, X11 Service Type and X12 Home Care Discipline.

Separate Service Details records can be submitted providing details of the amounts of service received in each service delivery setting and/or of whether or not the services received were considered acute.

Within each service stream, each Service Details record must have a unique combination of Y13 Reporting Period, X13 Service Delivery Setting and X14 Acute Services Flag.

Service End (SE)

This record captures information about when a client stops receiving services in a given service stream. Each Service End record must be associated with a Service Start record using X10 Service Start Date, X11 Service Type and X12 Home Care Discipline.

ER Visits (ER)

This record type is used to record any emergency room (ER) visits a home care client may have had during the reporting period. It is expected that the information required to populate this record type would need to be extracted from other (i.e., non–home care) information systems.

Records need to be submitted only if a client has 1 or more ER visits in the reporting period.

Discharge (DC)

This record type is used to capture information when an individual is discharged, marking the end of the client's home care service episode.

A client can have multiple home care service episodes. However, these must occur sequentially. A client can be readmitted to the source organization only if there is a Discharge record associated with the original Admission record.

Organization Client Transfer (OT)

This record type is used when source organizations go through restructuring (e.g., major boundary changes) that results in changes to the organization and client unique identifiers. If an individual continues to receive home care services through an organization's restructuring, this record type can be used to link an individual's unique identifiers (and therefore records) before and after the restructuring.

If your organization is planning to restructure, please contact the Home Care team at homecare@cihi.ca for further information.

Submissions of client records to CIHI

Each client record created is assigned to a reporting period. CIHI and the respective provincial or territorial ministry of health will determine the timelines for submission of records for each reporting period. See Chapter 4 — Detailed submission requirements for further details on how to submit data to CIHI.

Non-client records

Submission Profile (SP)

This record type must be the first record in every file submitted to CIHI. Its function is to provide key information about the organization sending the data and to ensure that a full transmission has been received at CIHI.

Organization Profile (OP)

This record type provides basic information about the source and submission organizations that are participating in HCRS (e.g., name, address).

An Organization Profile must be submitted at the beginning of each fiscal year before any client-specific data can be submitted by that organization. Changes can be made throughout the year by submitting corrections to the original Organization Profile record.

If client records for a particular source organization are being submitted by another organization (e.g., ministry of health), CIHI must receive an Organization Profile record for the source organization and the submission organization (i.e., the ministry).

Contact Information (CI)

This record type provides CIHI with information about the individuals within each organization who will act as the key contacts for HCRS submissions and others who need to receive automatic notification when HCRS outputs are available.

Each organization that directly submits data to CIHI must have a data submission contact (see Z25 Contact Output Notification for further details). This person will act as the key day-to-day contact for HCRS submission issues. In many cases, the data submission contact will be directly responsible for submitting data to HCRS. He or she will receive automatic notification that the submission files have been processed and submission reports are available for downloading.

As with Organization Profile records, Contact Information records must be submitted at the beginning of each fiscal year before any client-specific data can be submitted by an organization.

It is vital for CIHI to have current and correct contact information. Changes to Contact Information records can be made throughout the year.

Provincial Profile (PP)

This record type is usually submitted by the provincial or territorial ministry of health. HCRS has been designed to allow flexible reporting of certain data elements. Through the Provincial Profile record, parameters can be set on the scope of the reporting in the province or territory for a given fiscal year (e.g., whether the RAI-HC is mandated and, if so, the frequency of reassessment; which CIHI data elements are mandatory). It is used by CIHI to ensure that the submitted data is processed appropriately.

The Provincial Profile record is fiscal-year specific and therefore must be submitted at the beginning of each fiscal year before any client-specific records from that province or territory can be processed. However, changes to a Provincial Profile can be made throughout the year by submitting corrections to the original record.

Revisions

Enhancements and modifications to data element specifications and validation rules will be implemented at the beginning of a fiscal year. Vendors are notified in advance of any enhancements or changes that must be applied to their software. Organizations will also be notified of any changes to elements or processes.

Chapter 3 — Data element specifications

Introduction

This chapter outlines the information provided for each data element or set of data elements.

Data elements developed by CIHI are identified by an element ID beginning with X, Y or Z. These include some client-specific data elements and all data elements submitted on non-client records.

Definition

An explanation of key terms in the data element

Intent

Reason(s) for including the data element(s) in HCRS

Records and submission status

Lists which records the data elements are submitted on and the submission status on those records

Representation

Provides information that is required to submit valid data in the data elements, including data type, layout, minimum and maximum lengths, justification and a summary of the valid values

Legend

If the data element has a set of response categories, a legend is provided showing the list of valid values and a descriptive label for each value

Coding instructions

Proper method of recording each response, with explanations of individual response categories. Where necessary, it will include sources of information and methods for determining the correct response for an element. Examples may be provided to help illustrate how an element should be coded in particular situations.

Submission instructions

Additional instructions and information to help facilitate the submission of valid data to CIHI, including specific validation rules applied to the data element(s)

interRAI data elements

This chapter includes details of only those data elements from the RAI-HC that are to be submitted to CIHI (and therefore excludes those data elements that capture the names of clients, caregivers and assessors).

To avoid duplication, this chapter excludes the definitions, intent and coding instructions, as these are included in the RAI-HC User's Manual.

However, it does provide details of how these data elements, once captured, must be submitted to CIHI. In particular, it documents where the format of the data element as it is to be submitted to CIHI is different from how it is displayed or captured on the RAI-HC form provided in the RAI-HC User's Manual (e.g., BB2a Birth Date).

With permission from interRAI, HCRS has incorporated definitions of certain key data elements from the RAI-HC that can be collected on all home care clients, even if they do not receive a RAI-HC assessment. This ensures that in HCRS the key demographic and administrative information is reported consistently on all home care clients. These data elements are the following:

- AA3a Health Card Number
- AA3b Province/Territory Issuing Health Card Number
- AA4 Postal Code of Residence
- BB1 Sex
- BB2a Birth Date
- BB2b Estimated Birth Date
- BB4 Marital Status
- BB5a Primary Language
- CC1 Date Case Opened/Reopened

For this reason, the submission of these data elements is significantly different than for other data elements captured on the RAI-HC.

Submission status

The submission status shows under which conditions data in the field is required when the record of a particular type is submitted (and would therefore result in the record being rejected if data is not present).

Note: Chapter 2 provides information on when a particular record is required to be submitted for an individual client.

The submission status of a data element will be one of the following:

Always mandatory: Data must always be present on the record

Mandatory for new and correction records: Data must be submitted when data element Y3 Submission Type is coded N or C

Note: The presence of the data element is not checked on deletion records (when Y3 is coded D).

Optional: The presence of the data element on the record is not checked

Mandatory status determined by respective Provincial Profile: The Provincial Profile governs the submission and processing of client-specific data from a given province or territory and contains information about when certain data elements are mandatory. If the relevant data element from the Provincial Profile is coded 1, the data element on the submitted record must contain data when Y3 is coded N or C; otherwise, the submission of the data element is optional.

Mandatory under other conditions: The mandatory status depends on an associated data element within the record. This chapter provides the specific conditions under which the data element must be submitted for new and correction records (Y3 is coded N or C). For these data elements, if the condition is not met, the data element must not be present. The record will be rejected if data is present.

Organization of chapters

The data elements are presented in the following order:

- Data elements submitted on all records (organization and record identifiers)
- CIHI data elements submitted on non-client records (Submission Profile, Organization Profile, Contact Information and Provincial Profile records)
- CIHI data elements submitted on client records
- RAI-HC data elements (submitted on client records)

Note: The order of the elements in these chapters does not provide the necessary information regarding the file layouts and element order to be used when submitting data to CIHI. Please refer to Chapter 8, which provides the detailed data requirements for ASCII submissions: the list of data elements to be submitted for each record, together with the start byte, representation and submission status of each data element.

Appendix A provides a summary of which records each of the data elements appears on and the submission status on that record.

Chapter 4 — Data elements submitted on all records

Introduction

This chapter provides an overview of the data elements that are submitted on all HCRS records

Y1 Unique Record ID

Definition	An identifier that uniquely identifies each record of a given type submitted for an organization
Intent	To identify an individual record throughout its submission and processing lifecycle. This tracking number will be used to facilitate data processing, particularly in identifying records that require resubmission, correcting or deleting records, and reporting errors back to submitting organizations. It will also assist with data quality analysis.

Records and submission status

Submitted on	Condition
Submission Profile	Always mandatory
Organization Profile	Always mandatory
Contact Information	Always mandatory
Provincial Profile	Always mandatory
Admission	Always mandatory
Update Client Profile	Always mandatory
RAI-HC Assessment	Always mandatory
Medication	Always mandatory
Service Start	Always mandatory
Service Details	Always mandatory
Service End	Always mandatory
ER Visits	Always mandatory
Discharge	Always mandatory
Organization Client Transfer	Always mandatory

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	20
Justification	Left
Valid values	1 to 20 alphanumeric characters

Coding instructions

Y1 can be generated automatically by organizations' IT systems. Once Y1 Unique Record ID is assigned for a record it must remain unchanged.

Y1 must uniquely identify an individual record of a given type (Y2 Record Type) from an organization (using Z1a Source Organization for client records and Z1 for non-client records).

Submission reports provided by CIHI will identify records by the Unique Record ID, and subsequent resubmissions of these records, including corrections and deletions, must contain the same Unique Record ID. Y1 is used within the CIHI database to identify records that need to be corrected or deleted and to monitor whether rejected records have been resubmitted successfully.

Submission instructions

Each unique record (based on Y1 Unique Record ID) can be submitted only once per submission file: correction and/or deletion records cannot be submitted within the same submission file as a new record. Any duplicate values of Y1 (for the same record type and organization) will be rejected.

For correction and deletion records, the Y1 of the record to be corrected or deleted must match an existing record in the CIHI database. For new records, the Y1 must not match an existing record that has been successfully submitted to the database.

Y2 Record Type

Definition	A code that identifies the type of data being submitted
Intent	To ensure that data can be identified and processed appropriately. It is also used as an abbreviation for the record type in documentation.

Records and submission status

Submitted on	Condition
Submission Profile	Always mandatory
Organization Profile	Always mandatory
Contact Information	Always mandatory
Provincial Profile	Always mandatory
Admission	Always mandatory
Update Client Profile	Always mandatory
RAI-HC Assessment	Always mandatory
Medication	Always mandatory
Service Start	Always mandatory
Service Details	Always mandatory
Service End	Always mandatory
ER Visits	Always mandatory
Discharge	Always mandatory
Organization Client Transfer	Always mandatory

Representation

Data type	String
Layout	AA
Min length	2
Max length	2
Justification	Left
Valid values	SP, OP, CI, PP, AD, UC, RH, MD, SS, SD, SE, ER, DC, OT

Legend

Value	Label
SP	Submission Profile Record Type
OP	Organizational Profile Record Type
CI	Contact Information Record Type
PP	Provincial Profile Record Type
AD	Admission Record Type
UC	Update Client Profile Record Type
RH	RAI-HC Assessment Record Type
MD	Medication Record Type
SS	Service Start Record Type
SD	Service Details Record Type
SE	Service End Record Type
ER	ER Visits Record Type
DC	Discharge Record Type
OT	Organization Client Transfer Record Type

Submission instructions

The combination of Y1 Unique Record ID and Y2 Record Type is used to uniquely identify a record (of any type) submitted for an organization, in particular for the purposes of correction and deletion of existing records.

Y3 Submission Type

Definition	A code that identifies how the record is to be processed
Intent	To ensure appropriate data processing of records. It will allow an audit trail of corrections and deletions to the database to be maintained.

Records and submission status

Submitted on	Condition
Organization Profile	Always mandatory
Contact Information	Always mandatory
Provincial Profile	Always mandatory
Admission	Always mandatory
Update Client Profile	Always mandatory
RAI-HC Assessment	Always mandatory
Medication	Always mandatory
Service Start	Always mandatory
Service Details	Always mandatory
Service End	Always mandatory
ER Visits	Always mandatory
Discharge	Always mandatory
Organization Client Transfer	Always mandatory

Representation

Data type	Alphanumeric
Layout	A
Min length	1
Max length	1
Justification	None
Valid values	N, C, D

Legend

Value	Label
N	New
C	Correction
D	Deletion

Coding instructions

Code N must be used to indicate that the record, if accepted, would constitute a **new record in the CIHI database**. Code N can be used multiple times for the same record: if the record is originally rejected and then resubmitted, both Y1 and Y3 remain the same when the record is resubmitted.

Code C is used when a record has already been accepted in the CIHI database and the information in the database needs to be corrected or changed.

Code D is used when a record has already been accepted in the CIHI database and the information in the database needs to be removed.

Additional submission instructions

Correction and/or deletion records cannot be submitted within the same submission file as the new record (i.e., duplicate values of Y1 Unique Record ID within a submission file will be rejected).

For correction and deletion records, the Y1 of the record to be corrected or deleted must match an existing record in the CIHI database. For new records, the Y1 must not match an existing record that has been successfully submitted to the database.

For deletion records in ASCII submission files, data elements not used to process the deletion will be ignored and not validated. For XML submissions, these data elements are not present in the schema structure for the deletion submission type.

Note: Y3 Submission Type is not submitted on the Submission Profile record. As each submission file must be unique, the SP record will correspond to that individual file and does not require a submission type.

Z1 Organization Identifiers

Definition	A code that uniquely identifies an organization
Intent	To identify the organization that is submitting data or the organization to which the data in an individual record relates

Elements

Element ID	Element name
Z1	Organization Identifier
Z1a	Source Organization Identifier
Z1b	Submission Organization Identifier
Z1p	Previous Source Organization Identifier

Records and submission status

Element ID	Submitted on	Condition
Z1	Organization Profile	Always mandatory
	Contact Information	Always mandatory
Z1a	Admission	Always mandatory
	Update Client Profile	Always mandatory
	RAI-HC Assessment	Always mandatory
	Medication	Always mandatory
	Service Start	Always mandatory
	Service Details	Always mandatory
	Service End	Always mandatory
	ER Visits	Always mandatory
	Discharge	Always mandatory
	Organization Client Transfer	Always mandatory
Z1b	Submission Profile	Always mandatory
Z1p	Organization Client Transfer	Mandatory for new or correction records

Representation

Data type	Alphanumeric
Layout	ANNNN
Min length	5
Max length	5
Justification	Left
Valid values	First character must be 0–9, Y, N, V

Coding instructions

Each organization has a unique identifier assigned by CIHI in consultation with its provincial/territorial ministry of health and the organization. The first character of the code identifies the province or territory the organization is located within:

Code	Province/territory
0	Newfoundland and Labrador
1	Prince Edward Island
2	Nova Scotia
3	New Brunswick
4	Quebec
5	Ontario
6	Manitoba
7	Saskatchewan
8	Alberta
9	British Columbia
Y	Yukon
N	Northwest Territories
V	Nunavut

It is used in several places within the specifications:

- To identify the organization that is submitting data to CIHI (for itself or on behalf of other organizations). The submitting organization must use its unique identifier in **Z1b** of the Submission Profile record and in the name of the submission file.
- To submit Organization Profile and Contact Information records. Each organization that submits data and for which data is submitted must have an Organization Profile. In order to receive automatic notifications of HCRS submission reports, each organization must also submit Contact Information records. The organization's unique identifier is submitted in **Z1** of these records.
- In all client-specific records, the unique identifier of the source organization is submitted in **Z1a**.
- When an organization restructuring takes place, in order to maintain the longitudinal integrity of the clients' home care service episodes, existing clients can be transferred from an organization to another using the Organization Client Transfer record. In addition to the current source organization, the unique identifier of the previous source organization is submitted in **Z1p**.

Note: Organizations undergoing restructuring should forward any new information regarding the organization name and number to CIHI at homecare@cihi.ca in advance so that it can be set up in HCRS.

Using the organization identifiers in this method allows designated organizations to submit records on behalf of others and to submit data for multiple source organizations within a single file. It also allows CIHI to appropriately process and report on the data submitted.

When organizations submit their own data, the same identifier will be used in Z1, Z1a and Z1b.

Submission instructions

The submitted identifier must be a valid organization number.

In order to submit client-specific records, Organization Profile records must exist for the source and submission organizations, and a data submission contact must exist for the submission organization.

In the unusual situation when more than 1 organization uses the same identifier, then the Organization Effective Date is used in conjunction with the Organization Identifier to uniquely identify an organization.

Z1c, Z1pc Organization Effective Date

Definition	The date on which an organization came into effect
Intent	To uniquely identify an individual organization when 2 or more organizations use the same Organization Identifier

Elements

Element ID	Element name
Z1c	Organization Effective Date
Z1pc	Previous Source Organization Effective Date

Records and submission status

Element ID	Submitted on	Condition
Z1c	Submission Profile	Optional
	Organization Profile	Optional
	Contact Information	Optional
	Admission	Optional
	Update Client Profile	Optional
	RAI-HC Assessment	Optional
	Medication	Optional
	Service Start	Optional
	Service Details	Optional
	Service End	Optional
	ER Visits	Optional
	Discharge	Optional
	Organization Client Transfer	Optional
Z1pc	Organization Client Transfer	Optional

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

Most organizations will not need to use this data element as their Organization Identifier will be used solely by them. This element is most likely to be used during and after an organization restructuring — where the geographic boundaries of organizations may change and organization identifiers may be reused.

In these situations, the Organization Effective Date must be submitted with the Organization Identifier to uniquely identify an organization.

Submission instructions

The combination of Organization Identifier and Organization Effective Date must constitute a valid organization number.

Chapter 5 — Data elements submitted on non-client records only

Introduction

This chapter provides detailed specifications for data elements submitted on non-client HCRS records.

Y10a–Y10e Vendor Code

Definition	The vendor codes for the systems used by an organization for the collection and submission of HCRS data
Intent	To ensure that only licensed vendors for an organization submit data to CIHI

Elements

Element ID	Element name
Y10a	Vendor Code 1
Y10b	Vendor Code 2
Y10c	Vendor Code 3
Y10d	Vendor Code 4
Y10e	Vendor Code 5

Records and submission status

Element ID	Submitted on	Condition
Y10a	Organization Profile	Mandatory for new or correction records
Y10b–Y10e	Organization Profile	Optional

Representation

Data type	Alphanumeric
Layout	ANNNN
Min length	5
Max length	5
Justification	None
Valid values	Assigned by CIHI

Coding instructions

Vendor codes are assigned by CIHI.

Both independent vendor software systems and organizations’ in-house systems must have vendor codes.

Submission instructions

An organization must have at least 1 vendor code. Each code must be a valid vendor code as assigned by CIHI.

Y10y Data Submission Vendor Code

Definition	The vendor code assigned to the system that is responsible for creating the data submission file
Intent	To identify the software system responsible for creating the submission file. To ensure that only licensed vendors submit data to CIHI.

Records and submission status

Submitted on	Condition
Submission Profile	Always mandatory

Representation

Data type	Alphanumeric
Layout	ANNNN
Min length	5
Max length	5
Justification	None
Valid values	Assigned by CIHI

Coding instructions

Vendor codes are assigned by CIHI.

Submission instructions

Must be a valid vendor code.

Y11 Date of Submission

Definition	The date the submission file was created
Intent	To record when the data was ready to be submitted to CIHI for processing

Records and submission status

Submitted on	Condition
Submission Profile	Always mandatory

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Submission instructions

If Y11 is missing or invalid (e.g., contains a date after the date on which CIHI attempts to process the file) the entire submission file will be rejected.

Y12 Reporting Fiscal Year

Definition	The fiscal year to which the data being submitted relates
Intent	To allow for appropriate processing and reporting of data

Records and submission status

Submitted on	Condition
Submission Profile	Always mandatory

Representation

Data type	Year
Layout	YYYY
Min length	4
Max length	4
Justification	None
Valid values	YYYY

Coding instructions

Fiscal years run from April 1 of a given year to March 31 of the next year. Enter the year that corresponds to the first part of the fiscal year (April 1 to December 31). For example, enter 2013 for fiscal year 2013–2014.

Submission instructions

If Y12 is missing or invalid the entire submission file will be rejected.

Y14 Number of Records in Transmission File

Definition	The number of records in a submission file, excluding the Submission Profile record
Intent	To ensure that CIHI has received all records that were submitted

Records and submission status

Submitted on	Condition
Submission Profile	Always mandatory

Representation

Data type	Numeric
Layout	NNNNNN
Min length	1
Max length	6
Justification	Left
Valid values	0–999999

Coding instructions

The record count must exclude the Submission Profile record.

Submission instructions

If Y14 is missing or invalid, or if the count does not match the actual number of records in the file, the entire submission file will be rejected.

Z2 Organization Name

Definition	The official name of an organization
Intent	To record and identify the official name of an organization, which will appear on all HCRS reports and correspondence with an organization

Records and submission status

Submitted on	Condition
Organization Profile	Mandatory for new or correction records

Representation

Data type	String
Layout	String
Min length	5
Max length	50
Justification	Left
Valid values	String characters

Z3–Z4 Organization Address Lines

Definition	The postal address of an organization
Intent	To record and identify the postal address of an organization, which will be used for correspondence with an organization

Elements

Element ID	Element name
Z3	Organization Address Line 1
Z4	Organization Address Line 2

Records and submission status

Element ID	Submitted on	Condition
Z3	Organization Profile	Mandatory for new or correction records
Z4	Organization Profile	Optional

Representation

Data type	String
Layout	String
Min length	5
Max length	50
Justification	Left
Valid values	String characters

Coding instructions

If an organization has more than 1 location, provide the address where CIHI may contact personnel who are responsible for the submission of HCRS data.

Submission instructions

Element Z4 — the second line of an address — is optional.

Z5 Organization City/Town

Definition	The name of the city or town where an organization is located
Intent	To record and identify the postal address of an organization, which will be used for correspondence with an organization

Records and submission status

Submitted on	Condition
Organization Profile	Mandatory for new or correction records

Representation

Data type	String
Layout	String
Min length	3
Max length	20
Justification	Left
Valid values	String characters

Coding instructions

If an organization has more than 1 location, provide the address where CIHI may contact personnel who are responsible for submission of HCRS data.

Z6 Province

Definition	A code representing the province or territory within which the organization is located (and therefore the province or territory to which the data relates)
Intent	To identify the province/territory where an organization is located, which will enable reporting of results by province/territory and will be used in the postal address when corresponding with an organization

Records and submission status

Submitted on	Condition
Submission Profile	Always mandatory

Representation

Data type	Alphanumeric
Layout	AA
Min length	2
Max length	2
Justification	None
Valid values	NL, PE, NS, NB, QC, ON, MB, SK, AB, BC, YT, NT, NU

Legend

Value	Label
NL	Newfoundland and Labrador
PE	Prince Edward Island
NS	Nova Scotia
NB	New Brunswick
QC	Quebec
ON	Ontario
MB	Manitoba
SK	Saskatchewan

Value	Label
AB	Alberta
BC	British Columbia
YT	Yukon
NT	Northwest Territories
NU	Nunavut

Coding instructions

Alpha characters must be uppercase.

Submission instructions

If Z6 is missing or invalid the entire submission file will be rejected.

Z7 Organization Postal Code

Definition	The postal code assigned by Canada Post Corporation for an organization's location
Intent	To record and identify the postal address of an organization, which will be used for correspondence with an organization

Records and submission status

Submitted on	Condition
Organization Profile	Mandatory for new or correction records

Representation

Data type	Alphanumeric
Layout	ANANAN
Min length	6
Max length	6
Justification	None
Valid values	First character must not = D, F, I, O, Q, U, W

Coding instructions

If an organization has more than 1 location, provide the postal code of the address where CIHI may contact personnel who are responsible for submission of HCRS data.

Submission instructions

Alpha characters must be uppercase.

Z8 Organization Roles

Definition	The roles an organization plays in the collection and submission of client records to HCRS
Intent	To record whether or not an organization is a source organization and, if so, which organization submits its client records. It also indicates whether or not the organization submits data on behalf of other source organizations. This information is used to ensure appropriate processing and reporting of HCRS data submitted to CIHI.

Records and submission status

Submitted on	Condition
Organization Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6, 7

Legend

Value	Description
1	The organization is a source organization. It submits its own client records to CIHI and also submits client records for other source organizations. In addition, at least 1 other organization submits client records on behalf of this organization.
2	The organization is a source organization. Client records are submitted by this organization only; no other organization submits client records on its behalf. It also submits client records on behalf of other source organizations.
3	The organization is a source organization. It submits its own client records to CIHI. In addition, at least 1 other organization submits client records on behalf of this organization. It does not submit any client records on behalf of other source organizations.
4	The organization is a source organization. Client records are submitted by this organization only; no other organization submits client records on its behalf. It does not submit any client records on behalf of other source organizations.

Value	Description
5	The organization is a source organization. It does not submit its own client records; they are submitted by at least 1 other organization.
6	The organization is not a source organization. This organization submits client records on behalf of source organizations.
7	This organization is not a source organization. It does not submit any client records.

Coding instructions

The following table provides a summary of the 4 roles an organization can play in the collection of HCRS client-specific records and their submission to CIHI.

Is the organization a source organization (collects client-specific data)?	If yes, does it submit its own client records to CIHI?	If yes, does another organization submit client records on its behalf?	Does it submit client records on behalf of another organization?	Z8 code
Yes	Yes	Yes	Yes	1
Yes	Yes	No	Yes	2
Yes	Yes	Yes	No	3
Yes	Yes	No	No	4
Yes	No	Yes	No	5
No	n/a	n/a	Yes	6
No	n/a	n/a	No	7

Examples

A regional health authority that is responsible for collecting HCRS data (i.e., is a source organization) and that is solely responsible for submitting its and only its data directly to CIHI would be coded 4.

A regional health authority that collects HCRS data but has no role in submitting any data directly to CIHI — as it submits its data to the provincial ministry of health, which then submits the data to CIHI — would be coded 5. Z8 for the provincial ministry of health would be coded 6.

A regional health authority that collects HCRS data and submits some of the data itself and has other data submitted by its ministry of health would be coded 3 — as long as it did not submit any data for any other organization. Again, Z8 for the provincial ministry of health would be coded 6.

A provincial or territorial ministry that does not submit any client-specific records but that does submit the relevant Provincial Profile and/or Organization Profile and Contact Information record to allow for automatic email notification of HCRS outputs would be coded 7.

Z9 Provincial/Territorial Ministry

Definition	A flag indicating whether an organization is (part of) a provincial or territorial ministry
Intent	To identify an organization as a provincial or territory ministry. These organizations are responsible for determining which of the discretional data elements are mandatory (as defined in the Provincial Profile record). They will also receive specific provincial/territorial outputs from HCRS.

Records and submission status

Submitted on	Condition
Organization Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Z10 Contact Languages

Definition	The preference an organization for correspondence and reports in either or both of Canada's official languages
Intent	To record the language preference(s) of an organization

Elements

Element ID	Element name
Z10a	Contact/Reporting in English
Z10b	Contact/Reporting in French

Records and submission status

Submitted on	Condition
Organizational Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

An organization must state at least 1 language preference.

Z20 Contact Name

Definition	The name of an individual within an organization who will act as an HCRS contact
Intent	To record and identify the name of the contacts within an organization. These contacts will receive automatic notifications of HCRS outputs and will also receive key communications related to HCRS.

Records and submission status

Submitted on	Condition
Contact Information	Mandatory for new or correction records

Representation

Data type	String
Layout	String
Min length	5
Max length	50
Justification	Left
Valid values	String characters

Submission instructions

Up to 4 HCRS contacts can be submitted per organization.

Z21 Contact Telephone Number

Definition	The phone number of the HCRS contact within an organization
Intent	To communicate with the HCRS contact

Records and submission status

Submitted on	Condition
Contact Information	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NNNNNNNNNN
Min length	10
Max length	10
Justification	None
Valid values	Numeric characters

Coding instructions

The telephone number must include the 3-digit area code. Do not include any formatting (spaces or hyphens) within the telephone number.

Z22 Contact Telephone Extension Number

Definition	The extension to the phone number of the HCRS contact
Intent	To communicate with the HCRS contact

Records and submission status

Submitted on	Condition
Contact Information	Optional

Representation

Data type	Numeric
Layout	NNNNNN
Min length	1
Max length	6
Justification	Left
Valid values	1 to 6 numeric characters

Z23 Contact Fax Number

Definition	The fax number of the HCRS contact
Intent	To communicate with the HCRS contact

Records and submission status

Submitted on	Condition
Contact Information	Optional

Representation

Data type	Numeric
Layout	NNNNNNNNNN
Min length	10
Max length	10
Justification	None
Valid values	Numeric characters

Coding instructions

The fax number must include the 3-digit area code. Do not include any formatting (spaces or hyphens) within the fax number.

Z24 Contact Email Address

Definition	The email address of the HCRS contact
Intent	To communicate with the HCRS contact. Used as the primary method of communication. Email will be used to automatically notify contacts that HCRS outputs are available.

Records and submission status

Submitted on	Condition
Contact Information	Mandatory for new or correction records

Representation

Data type	String
Layout	String
Min length	6
Max length	50
Justification	Left
Valid values	6 to 50 string characters

Coding instructions

The email address submitted must have a valid structure:

- It must contain 1 and only 1 @ symbol.
- The last 3 characters must be a period (.) followed by 2 alpha characters (e.g., ".ca") **or** the last 4 characters must be a period (.) followed by 3 alpha characters (e.g., ".com").
- It cannot contain consecutive periods (e.g., ".." or "…").

Z25 Contact Output Notification

Definition	A code representing when the HCRS contact will be notified of HCRS submission reports
Intent	To enable different contacts within an organization to receive notification of HCRS submission reports

Records and submission status

Submitted on	Condition
Contact Information	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1

Legend

Value	Label
1	Single point of contact/data submissions

Coding instructions

Single point of contact/data submissions

This contact is the primary contact for submissions to CIHI, corrections or other day-to-day administrative functions relating to the submission of data to HCRS for an organization.

An organization that is acting as a submission organization (Z8 Organization Role on Organization Profile is coded 1 to 4 or 6) **must** have a Contact Information record with Z25 coded 1 before any client records can be submitted by that organization.

This contact will receive an email notification for **all** submission reports from HCRS that relate to that organization.

If a source organization has data submitted for it by another organization and wants to receive submission reports, it must also submit a Contact Information record with Z25 coded 1. However, data will still be processed if no such contact exists.

Submission reports for data submitted by other organizations

If a source organization submits data for itself (and therefore has Z25 coded 1) but also has data submitted for it by another organization, it can list this secondary contact on its Contact Information record. This secondary contact will receive submission reports notifications for all the organizations on whose behalf they submit data.

ZP1 Number of Reporting Periods

Definition	The number of periods used to report on data from a province/territory
Intent	To ensure dates/periods are submitted correctly on client records. To determine how data is analyzed and reported within a fiscal year. To help monitor timeliness of submissions.

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NN
Min length	1
Max length	2
Justification	None
Valid values	4, 12, 13

Legend

Value	Label
4	Quarterly
12	Monthly/12 periods
13	13 periods

Coding instructions

If reporting in 4 periods, only codes 1 to 4 can be submitted in data element Y13 Reporting Period on individual client records, with each code representing the following reporting quarters:

1 — Quarter 1: April 1 to June 30

2 — Quarter 2: July 1 to September 30

3 — Quarter 3: October 1 to December 31

4 — Quarter 4: January 1 to March 31

If reporting in 12 periods, only codes 1 to 12 can be submitted in data element Y13 Reporting Period on individual client records, with each code representing the months of the year:

1 — April

2 — May

3 — June

4 — July

5 — August

6 — September

7 — October

8 — November

9 — December

10 — January

11 — February

12 — March

If reporting in 13 periods, all 13 codes can be submitted in data element Y13 Reporting Period on individual client records. The corresponding start and end dates for each period usually change on an annual basis and will be provided to users separately.

ZP2 Number of Submission Periods

Definition	The number of periods, with corresponding deadlines, used to submit data from the province/territory to CIHI
Intent	To help monitor timeliness of data submissions

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N, NN
Min length	1
Max length	2
Justification	None
Valid values	1, 4, 12, 13

Legend

Value	Label
1	Yearly
4	Quarterly
12	Monthly/12 periods
13	13 periods

Coding instructions

Each reporting period will have a corresponding deadline by which time all records relating to that reporting period must be submitted to CIHI. This includes the submission of correction and deletion records. The submission deadlines will usually be agreed to by CIHI and the provincial or territorial ministry.

Data will be accepted after the scheduled dates; however, failure to submit data by the required deadlines may result in that data not being included for reporting purposes.

In most instances, the number of reporting periods (ZP1) and the number of submission periods (ZP2) will be the same, with each reporting period having its own submission period and associated submission deadline. However, in some cases they may be different.

For example, a province may submit to CIHI on a quarterly basis but want its data analyzed on a monthly basis (ZP1 Number of *Reporting* Periods = 12, ZP2 Number of Submission Periods = 4). In this example, the 3 reporting periods within each quarter will have the same submission deadline.

ZP3 Flow of Client-Specific Data to CIHI

Definition	A description of how client data from source organizations within a province/territory will be submitted to CIHI
Intent	To record the data flow to CIHI

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3

Legend

Value	Label
1	Data submitted by source organizations only
2	Data submitted by other submission organizations only (on behalf of source organizations)
3	Data submitted by source and other submission organizations

Coding instructions

If any organization, including a provincial or territorial ministry, submits client data on behalf of a source organization, code 2 or 3 should be used as appropriate:

- Code 2: If none of the data is submitted by the source organizations themselves
- Code 3: If some but not all data is submitted by the source organization themselves

ZP4 Health Card Number Encryption

Definition	A flag indicating if data submitted in element AA3a Health Card Number is encrypted
Intent	To record whether or not Health Card Numbers are encrypted prior to submission to CIHI. Due to privacy policies/legislation, a province or territory may insist that this occur.

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

ZP5 Province-Wide Client Identifiers (X1a) — Submission Mandated

Definition	A flag indicating whether or not submission of data element X1a Unique Province-Wide Client Identifier is mandated
Intent	Some provinces and territories have or are developing client registries, which will uniquely identify the same individual across all health services provided in the province, regardless of whether or not that individual has a valid health card number for that province/territory. If a province or territory has such a registry, it can use this data element to indicate that the identifiers from the registry must be submitted to CIHI.

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if X1a Unique Provincial Client Identifier must be submitted on **all** client records.
If code 0 is used, organizations are still able to submit data in element X1a on an optional basis.

ZP6 Subregion Identifier — Submission Mandated

Definition	A flag indicating whether or not submission of data element X3 Subregion Identifier is mandated on all Admission records within the province or territory
Intent	To ensure appropriate processing of Admission records from the province or territory

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Admission records must be submitted with a valid value in X3 Subregion Identifier. If code 0 is used, organizations are able to submit data in element X3 on an optional basis.

ZP7 Program Identifier — Submission Mandated

Definition	A flag indicating whether or not submission of data element X4 Program Type is mandated on all Admission records within the province or territory
Intent	To ensure appropriate processing of Admission records from the province or territory

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Admission records must be submitted with a valid value in X4 Program Type. If code 0 is used, organizations are able to submit data in element X4 on an optional basis.

ZP10 Provincial/Territorial Mandate of Referral Source Data Element

Definition	A set of flags indicating that the submission of data element X5 Referral Source is mandated on Admission records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP10a	Referral Source for Acute Home Care Client Group Mandated
ZP10b	Referral Source for End-of-Life Client Group Mandated
ZP10c	Referral Source for Rehabilitation Client Group Mandated
ZP10d	Referral Source for Long-Term Supportive Care Client Group Mandated
ZP10e	Referral Source for Maintenance Client Group Mandated

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Admission records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in X5 Referral Source. If code 0 is used, organizations are able to submit data in element X5 on an optional basis.

ZP11 Provincial/Territorial Mandate of Date of Acceptance to Home Care Data Element

Definition	A set of flags indicating that the submission of data element X6 Date of Acceptance to Home Care is mandated on Admission records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP11a	Acceptance Date for Acute Home Care Client Group Mandated
ZP11b	Acceptance Date for End-of-Life Client Group Mandated
ZP11c	Acceptance Date for Rehabilitation Client Group Mandated
ZP11d	Acceptance Date for Long-Term Supportive Care Client Group Mandated
ZP11e	Acceptance Date for Maintenance Client Group Mandated

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Admission records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in X6 Date of Acceptance to Home Care. If code 0 is used, organizations are able to submit data in element X6 on an optional basis.

ZP12 Provincial/Territorial Mandate of Primary Language Data Element

Definition	A set of flags indicating that the submission of data element BB5a Primary Language is mandated on Admission records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP12a	Primary Language for Acute Home Care Client Group Mandated for Admission Record
ZP12b	Primary Language for End-of-Life Client Group Mandated for Admission Record
ZP12c	Primary Language for Rehabilitation Client Group Mandated for Admission Record
ZP12d	Primary Language for Long-Term Supportive Care Client Group Mandated for Admission Record
ZP12e	Primary Language for Maintenance Client Group Mandated for Admission Record

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Admission records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in BB5a Primary Language. If code 0 is used, organizations are able to submit data in element BB5a on an optional basis.

ZP20 Provincial/Territorial Mandate of RAI-HC Assessments

Definition	A set of indicators that state whether RAI-HC assessments are mandated for the given Client Group and, if so, the mandated frequency of reassessment
Intent	To provide the scope of the mandate for the collection and submission of RAI-HC assessments

Elements

Element ID	Element name
ZP20d	Mandate for RAI-HC Assessment of Long-Term Supportive Care Client Group
ZP20e	Mandate for RAI-HC Assessment of Maintenance Care Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 4, 9

Legend

Value	Label
0	None
1	Once a year
2	Every 6 months
4	Every 3 months
9	Other

ZP30 Provincial/Territorial Mandate of Home Care Service Utilization Records

Definition	A set of flags indicating that the submission of home care service utilization records (Service Start, Service Details and Service End) is mandated for clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP30a	Home Care Service Utilization Records — Submission Mandated for Acute Home Care Client Group
ZP30b	Home Care Service Utilization Records — Submission Mandated for End-of-Life Client Group
ZP30c	Home Care Service Utilization Records — Submission Mandated for Rehabilitation Client Group
ZP30d	Home Care Service Utilization Records — Submission Mandated for Long-Term Supportive Care Client Group
ZP30e	Home Care Service Utilization Records — Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** clients assigned to the given Client Group (element X2) must have home care service utilization records submitted. If code 0 is used, organizations are able to submit home care service utilization records on an optional basis.

ZP31 Provincial/Territorial Mandate of Service Type Data Element

Definition	A set of flags indicating that the submission of data element X11 Service Type is mandated on home care service utilization records (Service Start, Service Details and Service End) of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP31a	Service Type — Submission Mandated for Acute Home Care Client Group
ZP31b	Service Type — Submission Mandated for End-of-Life Client Group
ZP31c	Service Type — Submission Mandated for Rehabilitation Client Group
ZP31d	Service Type — Submission Mandated for Long-Term Supportive Care Client Group
ZP31e	Service Type — Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if all clients assigned to the given Client Group (element X2) must submit a value other than 99 *not specified* in data element X11 Service Type on the home care service utilization records. If code 0 is used, organizations are able to submit detailed information in X11 on an optional basis.

ZP32 Provincial/Territorial Mandate of Home Care Discipline Data Element

Definition	A set of flags indicating that the submission of data element X12 Home Care Discipline is mandated on home care service utilization records (Service Start, Service Details and Service End) of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP32a	Home Care Discipline — Submission Mandated for Acute Home Care Client Group
ZP32b	Home Care Discipline — Submission Mandated for End-of-Life Client Group
ZP32c	Home Care Discipline — Submission Mandated for Rehabilitation Client Group
ZP32d	Home Care Discipline — Submission Mandated for Long-Term Supportive Care Client Group
ZP32e	Home Care Discipline — Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Coding instructions

Use code 1 if **all** clients assigned to the given Client Group (element X2) must submit a value other than 999 *not specified* in data element X12 Home Care Discipline on the home care service utilization records. If code 0 is used, organizations are able to submit detailed information in X12 on an optional basis.

ZP33 Provincial/Territorial Mandate of Service Delivery Setting Data Element

Definition	A set of flags indicating that the submission of data element X13 Service Delivery Setting is mandated on Service Details records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP33a	Service Delivery Setting — Submission Mandated for Acute Home Care Client Group
ZP33b	Service Delivery Setting — Submission Mandated for End-of-Life Client Group
ZP33c	Service Delivery Setting — Submission Mandated for Rehabilitation Client Group
ZP33d	Service Delivery Setting — Submission Mandated for Long-Term Supportive Care Client Group
ZP33e	Service Delivery Setting — Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** clients assigned to the given Client Group (element X2) must submit a value other than 999 *not specified* in data element X13 Service Delivery Setting on the Service Details records. If code 0 is used, organizations are able to submit detailed information in X13 on an optional basis.

ZP34 Provincial/Territorial Mandate of Acute Services Flag Data Element

Definition	A set of flags indicating that the submission of data element X14 Acute Services Flag is mandated on Service Details records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP34a	Acute Services Flag — Submission Mandated for Acute Home Care Client Group
ZP34b	Acute Services Flag — Submission Mandated for End-of-Life Client Group
ZP34c	Acute Services Flag — Submission Mandated for Rehabilitation Client Group
ZP34d	Acute Services Flag — Submission Mandated for Long-Term Supportive Care Client Group
ZP34e	Acute Services Flag — Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** clients assigned to the given Client Group (element X2) must submit a value other than 9 *not specified* in data element X14 Acute Services Flag on the Service Details records. If code 0 is used, organizations are able to submit detailed information in X14 on an optional basis.

ZP35 Provincial/Territorial Mandate of Service Visits Data Element

Definition	A set of flags indicating that the submission of data element X15 Service Visits is mandated on Service Details records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP35a	Service Visits — Submission Mandated for Acute Home Care Client Group
ZP35b	Service Visits — Submission Mandated for End-of-Life Client Group
ZP35c	Service Visits — Submission Mandated for Rehabilitation Client Group
ZP35d	Service Visits — Submission Mandated for Long-Term Supportive Care Client Group
ZP35e	Service Visits — Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Service Details records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in X15 Service Visits. If code 0 is used, organizations are able to submit data in element X15 on an optional basis.

ZP36 Provincial/Territorial Mandate of Minutes of Service Data Element

Definition	A set of flags indicating that the submission of data element X16 Minutes of Service is mandated on Service Details records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP36a	Minutes of Service — Submission Mandated for Acute Home Care Client Group
ZP36b	Minutes of Service — Submission Mandated for End-of-Life Client Group
ZP36c	Minutes of Service — Submission Mandated for Rehabilitation Client Group
ZP36d	Minutes of Service — Submission Mandated for Long-Term Supportive Care Client Group
ZP36e	Minutes of Service — Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Service Details records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in X16 Minutes of Service. If code 0 is used, organizations are able to submit data in element X16 on an optional basis.

ZP40 ER Visits Record Mandated

Definition	A set of flags indicating that the submission of ER Visits records is mandated on Discharge records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP40a	ER Visits Records Submission Mandated for Acute Home Care Client Group
ZP40b	ER Visits Records Submission Mandated for End-of-Life Client Group
ZP40c	ER Visits Records Submission Mandated for Rehabilitation Client Group
ZP40d	ER Visits Records Submission Mandated for Long-Term Supportive Care Client Group
ZP40e	ER Visits Records Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** clients assigned to the given Client Group (element X2) must have ER Visits records submitted. If code 0 is used, organizations are able to submit ER Visits records on an optional basis.

ZP50 Provincial/Territorial Mandate of Service Goals Met Data Element

Definition	A set of flags indicating that the submission of data element X31 Service Goals Met is mandated on Discharge records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP50a	Service Goals Met Submission Mandated for Acute Home Care Client Group
ZP50b	Service Goals Met Submission Mandated for End-of-Life Client Group
ZP50c	Service Goals Met Submission Mandated for Rehabilitation Client Group
ZP50d	Service Goals Met Submission Mandated for Long-Term Supportive Care Client Group
ZP50e	Service Goals Met Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Discharge records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in X31 Service Goals Met. If code 0 is used, organizations are able to submit data in element X31 on an optional basis.

ZP51 Provincial/Territorial Mandate of Reason for Discharge Data Element

Definition	A set of flags indicating that the submission of data element X32 Reason for Discharge is mandated on Discharge records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP51a	Reason for Discharge Submission Mandated for Acute Home Care Client Group
ZP51b	Reason for Discharge Submission Mandated for End-of-Life Client Group
ZP51c	Reason for Discharge Submission Mandated for Rehabilitation Client Group
ZP51d	Reason for Discharge Submission Mandated for Long-Term Supportive Care Client Group
ZP51e	Reason for Discharge Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Discharge records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in X32 Reason for Discharge. If code 0 is used, organizations are able to submit data in element X32 on an optional basis.

ZP52 Provincial/Territorial Mandate of Referred to Other Health Services Data Element

Definition	A set of flags indicating that the submission of data element X33 Referred to Other Health Service is mandated on Discharge records of clients assigned to the given Client Group
Intent	To provide the scope of the data elements that are mandated for submission by the provincial/territorial government

Elements

Element ID	Element name
ZP52a	Referred to Other Health Service Submission Mandated for Acute Home Care Client Group
ZP52b	Referred to Other Health Service Submission Mandated for End-of-Life Client Group
ZP52c	Referred to Other Health Service Submission Mandated for Rehabilitation Client Group
ZP52d	Referred to Other Health Service Submission Mandated for Long-Term Supportive Care Client Group
ZP52e	Referred to Other Health Service Submission Mandated for Maintenance Client Group

Records and submission status

Submitted on	Condition
Provincial Profile	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

Use code 1 if **all** Discharge records of clients assigned to the given Client Group (element X2) must be submitted with a valid value in X33 Referred to Other Health Service (when X32 Reason for Discharge is coded 2). If code 0 is used, organizations are able to submit data in element X33 on an optional basis.

Chapter 6 — CIHI-defined client-specific data elements

Introduction

This chapter provides detailed specifications for all the CIHI-defined client-specific data elements.

X1a Unique Provincial Client Identifier

Definition	An identifier that is assigned to an individual person that can be used across all health services within a province or territory to identify that individual and that uniquely identifies individuals irrespective of whether the person has a valid health (insurance) number/card for that province or territory
Intent	Some provinces and territories are instituting provincial client registries that assign a single identifier to an individual to be used across the continuum of care (e.g., unique lifetime identifiers). If such identifiers are used, they can be submitted to HCRS to facilitate person-based analyses within a province/territory. They can be used to identify individuals who receive episodes of care across multiple organizations within a province/territory and provide more accurate estimates of access at a provincial/territorial level.

Records and submission status

Submitted on	Condition
Admission	Mandatory if ZP5 = 1 on Provincial Profile
RAI-HC Assessment	Mandatory if ZP5 = 1 on Provincial Profile
Medication	Mandatory if ZP5 = 1 on Provincial Profile
Service Start	Mandatory if ZP5 = 1 on Provincial Profile
Service Details	Mandatory if ZP5 = 1 on Provincial Profile
Service End	Mandatory if ZP5 = 1 on Provincial Profile
ER Visits	Mandatory if ZP5 = 1 on Provincial Profile
Discharge	Mandatory if ZP5 = 1 on Provincial Profile

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	12
Justification	Left
Valid values	1 to 12 alphanumeric characters

Submission instructions

If data element ZP5 Province-Wide Client Identifiers (X1a) — Submission Mandated is coded 1 on the Provincial Profile, then a valid value for X1a must be submitted. If ZP5 is coded 0, X1a may be submitted on an optional basis.

X1b Unique Source Organization Client Identifier

Definition	An identifier, other than the client's health card number, that is used by a source organization to identify an individual home care client
Intent	To serve as a primary client identifier within HCRS and to link records for a given client, within a single episode of care and across multiple episodes, within the same organization. This is an administrative number other than the client's health card number. It may be automatically generated by an organization's IT system and will identify individual clients even if they do not have a valid health card number. It will therefore facilitate person-based analysis (e.g., calculation of access rates). This identifier is checked against other personal identifiers (Health Card Number, Birth Date and Sex) on each new Admission record to ensure the longitudinal integrity of the database. The Unique Source Organization Client Identifier must not contain the client's health card number, name, partial name, date of birth or sex.

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Mandatory for new or correction records
RAI-HC Assessment	Mandatory for new or correction records
Medication	Mandatory for new or correction records
Service Start	Mandatory for new or correction records
Service Details	Mandatory for new or correction records
Service End	Mandatory for new or correction records
ER Visits	Mandatory for new or correction records
Discharge	Mandatory for new or correction records
Organization Client Transfer	Mandatory for new or correction records

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	12
Justification	Left
Valid values	1 to 12 alphanumeric characters

Coding instructions

The Unique Source Organization Client Identifier must not contain the client's health card number, name, partial name, date of birth or sex.

If a source organization is using client identifiers from a provincial or territorial registry that are not based on the health card number (that uniquely identify an individual across the province/territory) as its primary client identifier, then this identifier should be entered into X1b as well as X1a.

X1p Previous Unique Source Organization Client Identifier

Definition	The Unique Source Organization Client Identifier used to identify an individual client in the previous source organization
Intent	To provide a link between the client identifiers used before and after an organization restructures. It will allow records to be submitted through the new source organization for clients who were receiving services before the reorganization in a way that maintains the integrity of the home care service episode.

Records and submission status

Submitted on	Condition
Organization Client Transfer	Mandatory for new or correction records

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	12
Justification	Left
Valid values	1 to 12 alphanumeric characters

Submission instructions

X1p Previous Unique Source Organization Client Identifier and Z1p Previous Source Organization must match an existing client from an existing source organization (as submitted in data elements X1b Unique Source Organization Client Identifier and Z1a Source Organization on an accepted Admission record).

X2 Client Group

Definition	A high-level description of home care clients based on their health status (health and living conditions, and personal resources) and assessed needs
Intent	To facilitate pan-Canadian comparative reporting on home care clients using a standard, client-focused categorization

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Mandatory if X50 Element to Be Updated = 4

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 8, 9

Legend

Value	Label
1	Acute Home Care client
2	End-of-Life client
3	Rehabilitation client
4	Long-Term Supportive Care client
5	Maintenance client
8	Not applicable
9	Client Group not provided

Coding instructions

Acute home care client

A client who needs immediate or urgent time-limited (up to 3 months or less) intervention to improve or stabilize a medical or post-surgical condition.

End-of-life client

In one's best clinical judgment, a client with any end-stage disease who is expected to live less than 6 months. Judgment should be substantiated by well-documented disease diagnosis and deteriorating clinical course.

Rehabilitation client

A client with a stable health condition that is expected to improve with a time-limited focus on goal-oriented, functional rehabilitation. The rehabilitation plan specifies goals and expected duration of therapy.

Long-term supportive care client

A client who is at significant risk of institutionalization due to unstable, chronic health conditions and/or living condition(s) and/or personal resources.

Maintenance client

A client with stable chronic health conditions, stable living conditions and stable personal resources who needs ongoing support to remain living at home.

Not applicable

A client who is assessed by the home care program (e.g., for residential care placement) but will not be receiving any other home care services.

Client Group not provided

A client was not assigned to a Client Group and therefore does not fall under any of the previous categories. This option has been made available on a temporary basis to facilitate the submission of historical Admission records from submitting jurisdictions.

Principles for initial assignment to Client Group

The principles listed below are to be used as guidelines for initial assignment of clients to groups. Clinical judgment, using the best available client assessment information, is required to complete the initial assignment and any subsequent reassignment that may occur.

1. A client is assigned to a Client Group once a home care professional (clinician/case manager) assesses the client's health status, rather than programs or services available.
2. A client is assigned to a Client Group based on his or her assessed needs, encompassing current health status (health condition, personal resources, living conditions), rather than on services available or provided.
3. A Client Group is assigned for those who are receiving or who will receive home care services other than an assessment.
4. The assigned Client Group should reflect the health status and primary goals of care set for the client at the time of assessment.
5. The End-of-Life Client Group takes precedence over all other categories.
6. A client may belong to 1 group only at any time.
7. Changes in the initial assignment of Client Group can occur.

Example: A 46-year-old woman was recently discharged from an acute care facility following a left mastectomy. She has an infected surgical incision site and requires education for self-care and wound care. It is expected that within 6 weeks she will be able to manage independently and will not need further care.

Client Group: Acute

Rationale: Time-limited plan of care that requires immediate interventions to improve her post-surgical condition

Compared with: A 44-year-old client has rheumatoid arthritis that is currently stable; she has recently become unable to exit the bathtub independently. She has progressive fatigue and increasing difficulty with her activities of daily living (ADLs). It is expected that she will need 8 to 10 weeks of goal-oriented occupational and physical therapy to complete environmental adaptations and help restore her functional independence.

Client Group: Rehabilitation

Rationale: Primary need for time-limited functional rehabilitation

Initial assignment to a Client Group

A client is initially assigned to a Client Group by a home care professional at the start of the home care service episode:

- The home care professional (clinician/case manager) conducts the intake assessment and determines the client's health status, primary goals of care and expected duration of service.
- Using the decision tree (next page), the home care professional assigns the client to a Client Group.
- As a home care professional, you will also be monitoring your client's health status, needs and goals. Should these change, the Client Group assignment can also be changed.

Decision tree

Being assessed by home care program (e.g., for long-term care placement) but will not be receiving any other home care services
Yes → Not applicable
No ↓

Death anticipated within 6 months?
Yes → End of Life
No ↓

Primary need for immediate/urgent **time-limited** intervention with a goal to improve and/or stabilize medical or post-surgical condition?
No → go to "**Stable** health condition…"
Yes ↓

Also a need for rehabilitation or **ongoing** support to remain in the community?
No → Acute
Yes ↓

Stable health condition expected to improve with a **time-limited** focus on goal-oriented, functional rehabilitation?
Yes → Rehabilitation (flag)
No ↓

Significant **risk** of institutionalization due to **unstable** chronic health conditions, living conditions or personal resources?
Yes → Long-Term Supportive Care (flag)
No ↓

Maintenance (flag)

Apply the Acute Services Flag to service records of clients in the Rehabilitation, Long-Term Supportive Care and Maintenance Client Groups when these clients also require short-term acute services.

Application of the Acute Services Flag

X14 Acute Services Flag is designed to capture delivery of acute care services to clients with rehabilitation or longer-term needs.

When you apply the acute services flag to a client's Service Details record, you are capturing the fluctuating nature of care and services that may be required to support clients who **also** require ongoing, long-term care to remain in the community.

Applying the acute services flag allows for accurate recording of time-limited episodes of acute care delivered within a longer-term course of care. By using this flag, you can capture the increased acuity and complexity of care delivered in the home and community setting.

X14 Acute Services Flag facilitates the collection of comprehensive and comparable data on acute services in home care.

Example: A 48-year-old female with multiple sclerosis (MS) lives with her husband, a long-haul truck driver. She has used a manual wheelchair for 15 years. Recently, she sustained a fractured femur during a fall while transferring independently from her bathtub. The assessment revealed that she requires care for her post-surgical wound, pain management, and physical and occupational therapy for approximately 8 weeks to help her regain her functional status.

Using the decision tree, determine the following:

Client Group: Rehabilitation, with Acute Services Flag

Rationale: Nursing services are required to manage her acute need for wound care and pain management; they will be of short duration. Rehabilitation for environmental adaptation and strengthening will require approximately 8 weeks. Her chronic health condition (MS), living conditions and personal resources are stable.

Reassigning a Client Group

Many clients' health status is dynamic, with exacerbations and improvements in any or all of the domains used to define health status (health conditions, living conditions and personal resources). If there is a significant change in primary needs and/or if the priority goals of care have been met or changed, the initial Client Group may no longer be appropriate. Then the client should be reassigned.

The RAI-HC User's Manual defines significant change as occurring when the condition

- Will not resolve without intervention;
- Is not self-limited;
- Affects the client's health status; and

Requires review or revision of the care plan to ensure appropriate care is given.

Process for reassignment

To reassign a client to a different Client Group, a home care professional must

- Reassess health status and goals of care;
- Use the decision tree to confirm the client's health status and determine if primary care goals are reflected in the current Client Group; and
- Reassign the client to a new Client Group **OR** apply the acute services flag if the change in status is self-limited.

Note: End-of-Life Client Group takes precedence.

Note: A client may belong to 1 group only.

- Update the Client Group on the client's documentation with the effective date of the change.

Clients previously assigned to the *Client Group not provided* category should be reassigned to the Client Group that best reflects their current health status and needs as soon as the required clinical information is available.

The initial Client Group assignment remains in effect from the Date of Case Opened/Reopened to the date the new Client Group was assigned. Reassignment of Client Group can occur at any time during a client's care.

Example: A 78-year-old female who lived independently with her husband was discharged home from acute care following a cerebrovascular accident (CVA).

Initial Client Group: Rehabilitation, with an expected length of service of 12 weeks

Reassessment findings

- Rehabilitation goals met and significant function regained
- Strong personal resources and stable living conditions
- Requires ongoing support with personal care

Initial Client Group

Rehabilitation

New Client Group

Maintenance

Rationale

The primary goal has changed from a focus on rehabilitation to an ongoing need for ADL assistance to maintain independence at home.

Additional submission instructions

The client's initial Client Group is submitted on the Admission record. If a client is reassigned to a different Client Group, the new Client Group must be submitted on an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 4 (Client Group); X2 must contain the value of the newly assigned Client Group and X51 Element Effective Date must contain the date the change in Client Group took place.

Codes 8 and 9 (*not applicable* and *Client Group not provided*) can be used only on Admission records. If clients in these categories are assigned to a new Client Group, the new Client Group must be submitted on an Update Client Profile record.

Note: It is expected that the client's home care service utilization will be reported separately for each Client Group, as the resources required and received are likely to be different following a significant change in a client's health status.

X3 Subregion Identifier (User-Defined)

Definition	A user-defined code that represents a subdivision of a source organization's geographic jurisdiction that is responsible for delivering the home care services provided to a client
Intent	To allow a source organization to analyze its data based on its own geographic service structure (e.g., regional offices)

Records and submission status

Submitted on	Condition
Admission	Mandatory if ZP6 = 1 on Provincial Profile
Update Client Profile	Mandatory if X50 = 5

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	4
Justification	Left
Valid values	User-defined

Coding instructions

The codes corresponding to a given subdivision of a source organization will be assigned either by the source organization itself or the respective provincial or territorial ministry.

Submission instructions

The geographic jurisdiction that is initially responsible for delivering the home care services provided to a client is submitted on the Admission record. If there is a change, the information can be updated through the submission of an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 5 (Subregion Identifier); X3 must contain the new value and X51 Element Effective Date must contain the date this change took place.

If data element ZP6 Subregion Identifier — Submission Mandated is coded 1 on the Provincial Profile, then X3 must be submitted on the client's Admission record. If ZP6 is coded 0, X3 may be submitted on an optional basis.

X4 Program Type (User-Defined)

Definition	A user-defined code that represents the program under which the source organization provides home care services to a client
Intent	To allow a source organization to analyze its data based on its own home care program structure

Records and submission status

Submitted on	Condition
Admission	Mandatory if ZP7 = 1 on Provincial Profile
Update Client Profile	Mandatory if X50 = 6

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	3
Justification	None
Valid values	User-defined at a regional level

Coding instructions

The codes corresponding to a given program will be assigned either by the source organization itself or the respective provincial or territorial ministry.

Note: X4 should be used only if a client can receive services from only 1 program at a time.

Submission instructions

The program under which the client initially receives home care services is submitted on the Admission record. If there is a change, the information can be updated through the submission of an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 6 (Program); X4 must contain the new value and X51 Element Effective Date must contain the date this change took place.

If data element ZP7 Program Identifier — Submission Mandated is coded 1 on the Provincial Profile, then X4 must be submitted on the client's Admission record. If ZP7 is coded 0, X4 may be submitted on an optional basis.

X5 Referral Source

Definition	The person or organization that referred the client for home care services
Intent	To provide information on the sources of clients who are serviced by home care. The time between referral and service provision can be analyzed by the different referral sources.

Records and submission status

Submitted on	Condition
Admission	Mandatory if ZP10a–e = 1 on Provincial Profile (based on client's Client Group at time of admission; see below)

Representation

Data type	Numeric
Layout	NN
Min length	1
Max length	2
Justification	Left
Valid values	1, 2, 3, 4, 5, 6, 7 8, 9, 10, 99

Legend

Value	Label
1	Self
2	Family/friend/neighbour
3	Other home care program
4	Physician
5	Other health professional
6	Community service organization other than the home care program
7	Hospital
8	Residential care facility
9	Assisted living setting

Value	Label
10	Other
99	Asked, unknown

Coding instructions

Physician includes general practitioners, family medicine doctors or specialists.

Other health professional includes nurses, physiotherapists, occupational therapists and social workers.

Community service organization other than the home care program includes community-based referrals where no specific health professional (or type of professional) can be identified.

Hospital includes inpatient and ambulatory care services.

Residential care facility includes long-term care facilities, nursing homes, special care homes and homes for the aged.

Assisted living setting includes group homes, retirement homes, community care homes, lodges, supported housings and congregate living settings.

Submission instructions

Whether or not the submission of this data element is mandatory depends on the client's Client Group (as submitted in data element X2 on the client's Admission record) and information submitted on the Provincial Profile. X5 is therefore mandatory under the following conditions:

- If X2 = 1 (*Acute Home Care client*) and ZP10a Referral Source for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP10b Referral Source for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP10c Referral Source for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP10d Referral Source for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP10e Referral Source for Maintenance Client Group Mandated = 1

If these conditions are not met, X5 may be submitted on an optional basis.

X6 Date of Acceptance to Home Care

Definition	The date on which an individual is accepted into the home care program
Intent	To identify the date when an individual is considered by the source organization to be a home care client and on its caseload. Can be used in analyses of wait times.

Records and submission status

Submitted on	Condition
Admission	Mandatory if ZP11a–e = 1 on Provincial Profile (based on client's Client Group at time of admission; see below)

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

The official acceptance into a source organization's home care program may entail various administrative processes (e.g., registration). However the key criteria are

- Acknowledgement by the source organization that the individual qualifies for service (i.e., based on assessed needs and program criteria); and

Agreement between the source organization and the individual (or caregiver) to begin service planning and delivery.

Submission instructions

Whether or not the submission of this data element is mandatory depends on the client's Client Group (as submitted in data element X2 on the client's Admission record) and information submitted on the Provincial Profile. X6 is therefore mandatory under the following conditions:

- If X2 = 1 (*Acute Home Care client*) and ZP11a Acceptance Date for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP11b Acceptance Date for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP11c Acceptance Date for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP11d Acceptance Date for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP11e Acceptance Date for Maintenance Client Group Mandated = 1

If these conditions are not met, X6 may be submitted on an optional basis.

X10 Service Start Date

Definition	The date on which the home care service provider(s) began to provide a home care service to the client
Intent	To capture when a given home care service started (as defined by elements X11 Service Type and X12 Home Care Discipline) and to measure the length of time between a client's referral to home care and the start of a service. It will also be used to identify the mix of services a client receives at a given point in time during the home care service episode.

Records and submission status

Submitted on	Condition
Service Start	Mandatory for new or correction records
Service Details	Mandatory for new or correction records
Service End	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

Enter the date the first face-to-face or remote service visit for a given home care service was provided to or on behalf of the client.

Submission instructions

Service Start Date is used as 1 of 3 unique identifiers (together with X11 Service Type and X12 Home Care Discipline) to match Service Details and Service End records with the appropriate Service Start record within a client's home care service episode. All 3 data elements submitted on Service Details and Service End records must match those submitted on a Service Start record.

X11 Service Type

Definition	The type of home care service provided to the client
Intent	To allow service utilization to be captured separately for different types of home care service provided. The element is structured hierarchically to allow reporting of service utilization at different levels of detail. It can be combined with information collected in X12 Home Care Discipline to provide further detail on the type and range of services provided to the client.

Records and submission status

Submitted on	Condition
Service Start	Mandatory for new or correction records
Service Details	Mandatory for new or correction records
Service End	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NN
Min length	2
Max length	2
Justification	None
Valid values	10 to 99

Legend

Service Type	Value	Label
Home health services	**10**	Home health services, unspecified
	11	Case management
	12	Other direct home health services
Home support services	**20**	Home support services, unspecified
	21	Personal care
	22	Homemaking
	23	Other home support services
Not specified	**99**	Not specified (not collected)

Coding instructions

If an organization is not supplying data on service utilization broken down by different service types, then X11 on all records must be coded 99.

Home health services are those home care services provided or directly supervised by home health care professionals (see definition in data element X12 Home Care Discipline). Home health care professionals include but are not limited to nurses, occupational therapists, physiotherapists, social workers, dieticians/registered dieticians and physicians.

Interventions or therapies provided by qualified assistants (e.g., physical therapy or occupational therapy assistants) can be categorized as home health services only if the assistant is under the direction and supervision of a qualified health professional (e.g., physiotherapist, occupational therapist). In such instances, the accountability for determining service needs through assessment, development of and changes to care plans, and client outcomes remains the responsibility of the home health care professional.

Case management pertains to services provided to support and make effective and efficient use and management of available home care resources in order to meet the client's service goals and expected outcomes. Key elements of case management include

- Assessment to determine client needs, wants and service goals;
- Care and service planning, and coordination of services. This includes the location, establishment and maintenance of services, and the maintenance of communication and liaison across services;
- Care implementation;
- Monitoring and evaluation of client outcomes;
- Reassessment and subsequent revisions of care plans; and
- Service completion and discharge.

Other direct home health services pertain to all other home health services provided for or on behalf of the client/family except case management.

If the home health services provided to the client cannot be reported separately for case management and other direct home health services, use code 10 *home health services, unspecified*.

Home support services are other home care services that support and/or assist the client and that are not provided or directly supervised by home health care professionals. Home support services include activities such as personal care, homemaking, home maintenance/adaptation and respite services.

Homemaking pertains to the provision of assistance to clients with household tasks such as housecleaning, dishwashing, laundry and ironing, in-home meal preparation and shopping.

Personal care pertains to the provision of personal care services by caregivers to provide assistance to the client with self-care activities such as eating, grooming, bathing, dressing, toileting, transferring and household mobility/ambulation.

Other home support services includes

- Home maintenance and adaptation: the provision of maintenance and repair services to the client's home, garden or yard for the purpose of keeping the home environment safe and in habitable condition (e.g., lawn mowing, snow removal), and modifying or making minor renovations to a client's home to enable him or her to live at home with the disabling condition (e.g., install grab bars, hand rails, ramps and/or monitoring systems); and
- Respite services: the provision of substitute caregiving services so that primary caregivers can get temporary relief or support.

If the home support services provided to the client cannot be reported separately, use code 20 *home support services, unspecified*.

Additional submission instructions

Service Type is used as 1 of 3 unique identifiers (together with X10 Service Start Date and X12 Home Care Discipline) to match Service Details and Service End records with the appropriate Service Start record within a client's home care service episode. All 3 data elements submitted on Service Details and Service End records must match those submitted on a Service Start record.

A province/territory may mandate the reporting of X11 Service Type (i.e., values other than 99 *not specified* must be submitted) on Service Start, Service Details and Service End records. This will depend on the information submitted on the Provincial Profile and the Client Group the client is assigned on the Service Start Date (X10) of the Service Start record:

- If X2 = 1 (*Acute Home Care client*) and ZP31a Service Type for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP31b Service Type for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP31c Service Type for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP31d Service Type for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP31e Service Type for Maintenance Client Group Mandated = 1

If these conditions are not met, individual service types for X11 may be reported separately on an optional basis.

X12 Home Care Discipline

Definition	The discipline, profession or occupational group of the individuals providing home care services to the client
Intent	To allow service utilization to be captured separately by the different disciplines of the individuals providing home care services. The element is hierarchically structured to allow reporting at different levels of detail. It can be combined with information collected in X11 Service Type to provide further detail on the type and range of services provided to the client.

Records and submission status

Submitted on	Condition
Service Start	Mandatory for new or correction records
Service Details	Mandatory for new or correction records
Service End	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NNN
Min length	3
Max length	3
Justification	None
Valid values	100–999

Legend

Value	Label
100	Licensed/regulated health disciplines, unspecified
120	Nurses, unspecified
121	Registered nurse (RN)
122	Licensed practical nurse (LPN)
123	Registered psychiatric nurse (RPN)
130	Rehabilitation disciplines, unspecified

Value	Label
131	Occupational therapist
132	Physiotherapist
133	Speech–language pathologist
140	Social worker
150	Dietician/registered dietician
160	Pharmacist
190	Other licensed/regulated health disciplines
200	Unlicensed/unregulated personnel, unspecified
210	Nursing assistants
220	Therapy assistants
230	Home support personnel
290	Other unlicensed/unregulated personnel
999	Not specified (not collected)

Coding instructions

If an organization is not supplying service utilization data broken down by the home care disciplines of those providing home care services, X12 Service Types must be coded 999 on all records.

The highest level of distinction between disciplines is whether or not the individuals are part of a licensed/regulated profession or discipline.

Licensed and regulated health disciplines

People working within these disciplines are considered home health professionals and are individuals

- Who have completed the post-secondary university or college educational requirements required of their health profession;
- Who may be required to undertake continuing education to remain current;
- Who may be licensed or regulated with the province/territory in which they are employed;
- Whose scope of practice may be regulated by the province/territory where they are employed; and
- Who function independently within the bounds of their profession.

The services they provide would be considered home health services (see data element X11 Service Type).

Data element X12 lists separately the main disciplines of individuals who provide home care services. Individuals from other disciplines that are not listed should be coded under 190 *Other regulated, licensed disciplines*.

Unlicensed/unregulated personnel

These are personnel who work in disciplines/occupations that are usually unregulated or unlicensed. They usually support the licensed/regulated staff in the provision of home health services or carry out home support services.

Most occupations require at least a high school diploma. Certain disciplines, such as nursing or therapy assistants, also require certification through the completion of a vocational, college or approved program. Most personnel also receive on-the-job training.

Nursing assistants usually work under the direction and supervision of a qualified health professional. They provide nursing services and interventions within their defined scope of practice.

Therapy assistants include occupational therapy assistants, physiotherapy assistants and speech–language pathology assistants.

Therapy assistants usually work under the direction and supervision of a qualified health professional (e.g., physiotherapist, occupational therapist). They are delegated specific therapy tasks, but accountability for determining service needs through assessment, development and changes to care plans, as well as client outcomes, remains the responsibility of the home health care professional. They do not supervise others (e.g., aides, volunteers) giving therapy.

The services that therapy assistants provide are considered home health only if they are under the direction and supervision of a qualified health professional.

Home support personnel have various titles, including but not limited to home support worker, community worker and personal care assistant.

Other unlicensed/unregulated personnel include all other unlicensed or unregulated personnel providing home care services to or on behalf of clients (e.g., pharmacy technicians).

Additional submission instructions

X12 Home Care Discipline is used as 1 of 3 unique identifiers (together with X10 Service Start Date and X11 Service Type) to match Service Details and Service End records with the appropriate Service Start record within a client's home care service episode. All 3 data elements submitted on Service Details and Service End records must match those submitted on a Service Start record.

A province/territory may mandate the reporting of X12 Home Care Discipline (i.e., values other than 999 *Not specified* must be submitted) on Service Start, Service Details and Service End records. This will depend on the information submitted on the Provincial Profile and on the Client Group the client is assigned on the Service Start Date (X10) of the Service Start record:

- If X2 = 1 (*Acute Home Care client*) and ZP32a Home Care Discipline for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP32b Home Care Discipline for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP32c Home Care Discipline for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP32d Home Care Discipline for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP32e Home Care Discipline for Maintenance Client Group Mandated = 1

If these conditions are not met, individual disciplines may be reported separately for X12 on an optional basis.

X13 Service Delivery Setting

Definition	The location or setting where the home care service was provided to the client
Intent	To allow service utilization to be captured separately for the different locations and settings in which the client received services. The element is hierarchically structured to allow reporting at different levels of detail.

Records and submission status

Submitted on	Condition
Service Details	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NNN
Min length	3
Max length	3
Justification	None
Valid values	100–999

Legend

Value	Label
100	Face-to-face settings, unspecified
101	Private home, condominium, apartment
102	Boarding house
103	Assisted living setting
104	Residential care facility
105	Hospice
106	Ambulatory home care setting
107	Hospital
108	Shelter/public place

Value	Label
109	School
199	Other face-to-face setting, not elsewhere specified
200	Remote settings, unspecified
201	Telephone only
202	Telehealth
999	Not specified (not collected)

Coding instructions

If an organization is not supplying data on service utilization broken down by different service delivery settings, X13 must be coded 999 on all records.

Face-to-face settings

Settings and locations where services are provided to the client face-to-face. In many but not all instances, the setting will be the client's permanent or temporary residence.

Private home, condominium, apartment

Refers to any house, condominium or apartment in the community, whether owned by the client or another person. Also included in this category are retirement communities and independent housing for the elderly or disabled.

Boarding house

Refers to community accommodation where meals may be provided. Includes a rented room in a private dwelling or a hotel.

Assisted living setting

Refers to a non-institutional community setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, housekeeping, personal care, meal service, transportation, social and recreational opportunities, etc. May have limited medical/nursing services available. Includes group homes, retirement homes, community care homes, lodges, supportive housing and congregate living settings.

Residential care facility

Refers to a licensed or regulated health facility that provides 24-hour skilled or immediate nursing care (i.e., qualified nurses are on site and available to respond immediately, if required). Includes long-term care facilities, nursing homes, special care homes and homes for the aged.

Hospice

Refers to a home-like setting for persons of any age who are dying and require regular assessment of symptoms and ongoing changes in treatment and care plans, or who choose to die in a hospice environment.

Ambulatory home care setting

Refers to community service sites where services are provided by the home care program or their contracted service provider agencies.

Hospital

Refers to inpatient acute, continuing care and rehabilitation services. Also includes services provided in auxiliary hospitals.

Shelter/public place

Refers to emergency housing and public locations. Includes night shelters, hostels for the homeless, streets, parks and other public places.

School

Refers to sites associated with all levels of education. Includes elementary, intermediate and secondary schools, colleges and universities.

Other

All other locations. Includes but is not limited to work settings and hospital-based ambulatory care.

Remote settings

This refers to services that are provided to or on behalf of the client when the service provider is in a different location and that are provided in lieu of a face-to-face visit.

Telephone

Refers to services provided by the home care provider to or on behalf of the client using the telephone only.

Telehealth

Refers to services that use information and communication technologies to deliver health care services and enable the service provider to be in a different location than the client. Examples of telehealth services include web-enabled nursing visits and remote vital signs monitoring systems (for diabetes medicine, asthma monitoring and home dialysis systems).

Submission instructions

X13 Service Delivery Setting is 1 of 3 data elements (together with X14 Acute Services Flag and Y13 Reporting Period) that are used to ensure the uniqueness of each Service Details record associated with a Service Start record.

A province/territory may mandate the reporting of X13 Service Delivery Setting (i.e., values other than 999 *Not specified* must be submitted). This will depend on the information submitted on the Provincial Profile and on the Client Group the client is assigned on the Service Start Date (X10) of the Service Start record:

- If X2 = 1 (*Acute Home Care client*) and ZP33a Service Delivery Setting for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP33b Service Delivery Setting for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP33c Service Delivery Setting for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP33d Service Delivery Setting for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP33e Service Delivery Setting for Maintenance Client Group Mandated = 1

If these conditions are not met, individual delivery settings may be reported separately for X13 on an optional basis.

X14 Acute Services Flag

Definition	A flag to capture delivery of acute care services to clients with rehabilitation or longer-term needs. This data element acknowledges that some longer-term clients may require acute care services to augment ongoing support for chronic health conditions and/or functional limitations.
Intent	During their service episode, many long-term clients suffer exacerbations of existing conditions or acquire new (including post-surgical) conditions that require immediate or urgent time-limited intervention to improve or stabilize these conditions. They are likely to receive these acute services in addition to services that were put in place to support and maintain them on a long-term basis. This data element will allow organizations to record the number of acute visits and minutes of service provided separately from other (non-acute) services provided. It will also allow organizations to measure the utilization of acute services by clients with long-term care needs and therefore calculate the total amount of acute services provided to all home care clients.

Records and submission status

Submitted on	Condition
Service Details	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 9

Legend

Value	Label
0	Non-acute services
1	Acute services
9	Not specified (not collected)

Coding instructions

If an organization is not supplying Service Details records broken down by whether or not the services were acute, X14 must be coded 9.

Code 1 should be used to submit a Service Details record that provides the number of visits and minutes of a particular service that were provided within a reporting period. This can include services that were already in place but for which the intensity or frequency was increased or situations where the clinical interventions performed were altered in order to treat the time-limited condition.

Acute services are required for only a time-limited period, usually less than 3 months.

Code 0 should be used to submit a Service Details record that provides the number of all other (non-acute) visits and minutes of a particular service that were provided within a reporting period.

Submission instructions

X14 Acute Services Flag is 1 of 3 data elements (together with X13 Service Delivery Setting and Y13 Reporting Period) that are used to ensure the uniqueness of each Service Details record associated with a Service Start record.

A province/territory may mandate the reporting of X14 Acute Services Flag (i.e., values other than 9 *Not specified* must be submitted). This will depend on the information submitted on the Provincial Profile and on the Client Group the client is assigned on the Service Start Date (X10) of the Service Start record:

- If X2 = 1 (*Acute Home Care client*) and ZP34a Acute Services Flag for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP34b Acute Services Flag for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP34c Acute Services Flag for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP34d Acute Services Flag for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP34e Acute Services Flag Client Group Mandated = 1

If these conditions are not met, all values for X14 may be reported separately on an optional basis.

X15 Number of Service Visits

Definition	The number of occasions during which a home care service provider provides a given home care service, either face-to-face or remotely (in lieu of a face-to-face visit), to a client during the reporting period. These services are documented by the service provider and are provided for longer than 5 minutes.
Intent	To capture the amount of service provided to home care clients. Can be captured separately by X11 Type of Service, X12 Home Care Discipline, X13 Service Delivery Setting and X14 Acute Services Flag. As data is captured on a client-by-client basis, the relationships between the types and amount of service utilized, client demographic and health characteristics, and client outcomes can be analyzed.

Records and submission status

Submitted on	Condition
Service Details	Mandatory if ZP35a–e = 1 (based on client's Client Group at time of service start; see below)

Representation

Data type	Numeric
Layout	NNNN
Min length	1
Max length	4
Justification	Left
Valid values	0–9999

Coding instructions

Includes visits for the purposes of client assessment and other case management activities in addition to the provision of other home health and home support services.

A remote visit is an occasion where a home care service provider interacts (in real time) with the client, but where the client and home care service provider are in different locations. This interaction can take place using the telephone and/or other information and communication technologies (e.g., videoconferencing, web-based communication).

Some remote services provided or made available to the client may not result in a service visit if there is no direct interaction between the home care service provider and the client.

Submission instructions

Multiple Service Details records can be submitted for an individual client during a reporting period in order to capture separately the amount of service provided (X15 Number of Service Visits and X16 Minutes of Service) by 1 or more of the following data elements:

- X10 Service Start Date;
- X11 Type of Service;
- X12 Home Care Discipline;
- X13 Service Delivery Setting; and
- X14 Acute Services Flag.

Whether or not the submission of this data element is mandatory depends on the client's Client Group (as assigned on the Service Start Date [X10] of the Service Start record) and information submitted on the Provincial Profile. X15 is therefore mandatory under the following conditions:

- If X2 = 1 (*Acute Home Care client*) and ZP35a Service Visits for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP35b Service Visits for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP35c Service Visits for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP35d Service Visits for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP35e Service Visits for Maintenance Client Group Mandated = 1

If these conditions are not met, X15 may be submitted on an optional basis.

X16 Minutes of Service

Definition	The number of minutes spent in the delivery of a home care service to or on behalf of the home care client during the reporting period
Intent	To capture the amount of service provided to home care clients. Can be captured separately by X11 Type of Service, X12 Home Care Discipline, X13 Service Delivery Setting and X14 Acute Services Flag. As data is captured on a client-by-client basis, the relationships between the types and amount of service utilized, client demographic and health characteristics, and client outcomes can be analyzed.

Records and submission status

Submitted on	Condition
Service Details	Mandatory if ZP36a–e = 1 (based on client's Client Group at time of service start; see below)

Representation

Data type	Numeric
Layout	NNNNNNN
Min length	1
Max length	7
Justification	Left
Valid values	1–9999999

Coding instructions

Service includes

- Client assessments (including RAI-HC and other types of assessments);
- Provision of services aimed at promoting health, improving/maintaining health status or minimizing the impact of deterioration on function and quality of life;
- Consultation/communication with other service providers regarding the status and/or needs of the specific client;
- Client/caregiver education; and

- Clinical documentation related to services provided (those activities relating to the compilation of client records, including documentation of assessment findings, service planning, intervention/treatment plans, discharge plans, specific interventions or treatments provided, preparation or review of reports and written opinions, etc.).

Excludes travel time to and from the client's home or service delivery location.

Only the time of those personnel directly involved in the delivery of services (as described above) to or on behalf of the client must be recorded.

Some remote services provided or made available to the client may not result in a service visit if there is no direct interaction between the home care service provider and the client. However, some parts of the service may contribute to the service minutes if carried out by a direct service provider.

Example

A client takes his or her own blood sugar reading and reports the results through the internet. An administrative member of staff is notified that the data has been received, identifies the correct service provider (a registered nurse) and forwards the information onto him or her. The nurse assesses the results and determines no further action is required; the nurse prints a copy of the information, which is filed. Only the time the registered nurse takes to assess and document the information would contribute to X16 Minutes of Service for this client.

If the nurse followed up with the client by telephone (for longer than 5 minutes), this would count as a service visit (to be added to the count submitted in X15 Number of Service Visits) and the time spent on the phone would also contribute to X16 Minutes of Service.

Submission instructions

Multiple Service Details records can be submitted for an individual client during a reporting period in order to capture separately the amount of service provided (X15 Number of Service Visits and X16 Minutes of Service) by 1 or more of the following data elements:

- X10 Service Start Date;
- X11 Type of Service;
- X12 Home Care Discipline;
- X13 Service Delivery Setting; and
- X14 Acute Services Flag.

Whether or not the submission of this data element is mandatory depends on the client's Client Group (as assigned on the Service Start Date [X10] of the Service Start record) and information submitted on the Provincial Profile. X16 is therefore mandatory under the following conditions:

- If X2 = 1 (*Acute Home Care client*) and ZP36a Minutes of Service for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP36b Minutes of Service for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP36c Minutes of Service for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP36d Minutes of Service for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP36e Minutes of Service for Maintenance Client Group Mandated = 1

If these conditions are not met, X16 may be submitted on an optional basis.

X17 Service End Date

Definition	The date on which the home care service provider(s) stopped providing a home care service to a client
Intent	To capture when a particular service ended (as defined by elements X11 Service Type and X12 Home Care Discipline) and to measure the length of time a client received that home care service. It will also be used to identify the mix of services a client receives at a given point of time during the home care service episode. It can also be used to measure the time between when all the home care services to the client stopped and when the client is formally discharged from the home care program.

Records and submission status

Submitted on	Condition
Service End	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

The date the last face-to-face or remote service visit for the given home care service was provided to the client.

X20 Number of Emergency Room Visits

Definition	The number of times that a home care client visited a hospital-based emergency room during the reporting period
Intent	To provide information on the utilization of emergency room services by home care clients

Records and submission status

Submitted on	Condition
ER Visits	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NN
Min length	1
Max length	2
Justification	Left
Valid values	0–99

Coding instructions

Include emergency room visits that resulted in a hospital (inpatient) admission and those that did not.

Include only those visits that occurred while the individual was considered a home care client by the source organization (i.e., between his or her official acceptance and discharge from the home care program).

Note: This data element can be populated directly from integrated health information systems (e.g., ambulatory care systems) if they exist.

Submission instructions

An ER Visits record needs to be submitted only when a client has had at least 1 emergency room visit during the reporting period.

X30 Discharge Date

Definition	The date a source organization completes the administrative processes that record the termination of all home care services provided to an individual
Intent	To record the date on which an individual is no longer considered a home care client by a source organization. Facilitates analysis of readmissions to home care.

Records and submission status

Submitted on	Condition
Discharge	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

The process of discharging a client and the official discharge date may occur sometime after the date the last service was provided to the client.

Submission instructions

A client's discharge date must occur on or after all other events that are associated with the home care service episode (including CC1 Date Case Opened/Reopened, X6 Date of Acceptance to Home Care, A1 Assessment Reference Date, X10 Service Start Date and X17 Service End Date).

X31 Service Goals Met at Discharge

Definition	An indication of whether the home care client's documented service goals have been met at discharge
Intent	To provide a high-level indicator of the effectiveness of the home care services delivered to the client

Records and submission status

Submitted on	Condition
Discharge	Mandatory if ZP50a–e = 1 (based on client's Client Group at time of discharge; see below)

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Submission instructions

Whether or not the submission of this data element is mandatory depends on the client's Client Group at time of discharge (as submitted in data element X2 on the client's Admission record or subsequent Update Client Profile record) and information submitted on the Provincial Profile. X31 is therefore mandatory under the following conditions:

- If X2 = 1 (*Acute Home Care client*) and ZP50a Service Goals Met Submission Mandated for Acute Home Care Client Group = 1
- If X2 = 2 (*End-of-Life client*) and ZP50b Service Goals Met Submission Mandated for End-of-Life Client Group = 1
- If X2 = 3 (*Rehabilitation client*) and ZP50c Service Goals Met Submission Mandated for Rehabilitation Client Group = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP50d Service Goals Met Submission Mandated for Long-Term Supportive Care Client Group = 1
- If X2 = 5 (*Maintenance client*) and ZP50e Service Goals Met Submission Mandated for Maintenance Client Group = 1

If these conditions are not met, X31 may be submitted on an optional basis.

X32 Reason for Discharge

Definition	The reason for the client's discharge from the source organization's home care program
Intent	To provide an understanding of why clients stop receiving home care

Records and submission status

Submitted on	Condition
Discharge	Mandatory if ZP51a–e = 1 (based on client's Client Group at time of discharge; see below)

Representation

Data type	Numeric
Layout	NN
Min length	1
Max length	2
Justification	Left
Valid values	1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Legend

Value	Label
1	Client no longer requires service
2	Client referred to other health service
3	Client no longer eligible for service (funding)
4	Client withdrew/terminated services
5	Client moved out of area
6	Client died
7	Agency unable to contact/reach client
8	Physical environment unsuitable for service delivery
9	Services terminated due to occupational health and safety reasons
10	Other

Submission instructions

Whether or not the submission of this data element is mandatory depends on the client's Client Group at time of discharge (as submitted in data element X2 on the client's Admission record or subsequent Update Client Profile record) and information submitted on the Provincial Profile. X32 is therefore mandatory under the following conditions:

- If X2 = 1 (*Acute Home Care client*) and ZP51a Reason for Discharge Submission Mandated for Acute Home Care Client Group = 1
- If X2 = 2 (*End-of-Life client*) and ZP51b Reason for Discharge Submission Mandated for End-of-Life Client Group = 1
- If X2 = 3 (*Rehabilitation client*) and ZP51c Reason for Discharge Submission Mandated for Rehabilitation Client Group = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and Reason for Discharge Submission Mandated for Long-Term Supportive Care Client Group = 1
- If X2 = 5 (*Maintenance client*) and ZP51e Reason for Discharge Submission Mandated for Maintenance Client Group = 1

If these conditions are not met, X32 may be submitted on an optional basis.

X33 Referred to Other Health Service

Definition	The health service setting that a client was referred to at time of discharge from the home care program
Intent	To provide information on which services the client requires once he or she stops receiving home care services. To facilitate analysis of where home care fits within the continuum of care.

Records and submission status

Submitted on	Condition
Discharge	Mandatory if ZP52a–e = 1 (based on client's Client Group at time of discharge; see below)

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6

Legend

Value	Label
1	Hospital
2	Residential care facility
3	Hospital-based ambulatory care service
4	Assisted living setting
5	Community-based health service/program
6	Other

Coding instructions

This data element is applicable only when X32 Reason for Discharge is coded 2 *Referred to other health services*.

Submission instructions

If X32 Reason for Discharge has a value other than 2, X33 must be blank.

Whether or not the submission of this data element is mandatory depends on the value of X32 Reason for Discharge, the client's Client Group at time of discharge (as submitted in data element X2 on the client's Admission record or subsequent Update Client Profile record) and information submitted on the Provincial Profile. X33 is therefore mandatory under the following conditions:

If X32 Reason for Discharge is coded 2 and

- If X2 = 1 (*Acute Home Care client*) and ZP52a Referred to Other Health Service Submission Mandated for Acute Home Care Client Group = 1
- If X2 = 2 (*End-of-Life client*) and ZP52b Referred to Other Health Service Submission Mandated for End-of-Life Client Group = 1
- If X2 = 3 (*Rehabilitation client*) and ZP52c Referred to Other Health Service Submission Mandated for Rehabilitation Client Group = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP52d Referred to Other Health Service Submission Mandated for Long-Term Supportive Care Client Group = 1
- If X2 = 5 (*Maintenance client*) and ZP52e Referred to Other Health Service Submission Mandated for Maintenance Client Group = 1

If these conditions are not met, X33 may be submitted on an optional basis.

X40 Medication Sequence Number

Definition	A number representing the sequence of the medication within Section Q5 of the RAI-HC assessment that is being submitted in an individual Medication record
Intent	To uniquely identify the medications being submitted

Records and submission status

Submitted on	Condition
Medication	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NN
Min length	1
Max length	2
Justification	Left
Valid values	0–99

Coding instructions

Each unique Medication Sequence Number should correspond to a line in Q5 of the RAI-HC assessment form, which records information on an individual medication.

X41 DIN

Definition	The Drug Identification Number (DIN) of a medication listed in Section Q5 of the RAI-HC assessment
Intent	To uniquely identify the name, strength and form of a drug product using a standard identifier

Records and submission status

Submitted on	Condition
Medication	Optional

Representation

Data type	Numeric
Layout	NNNNNNNN
Min length	8
Max length	8
Justification	None
Valid values	Numeric characters

Coding instructions

Most medications (and other products with active ingredients such as vitamins) have their DINs printed on their packaging.

Some drug products are available in different strengths and have different DINs assigned for their different strengths. Ensure the correct DIN is entered for the strength of medication used by the client.

DIN information is also available in Health Canada's online Drug Product Database, which lists all drugs approved for use in Canada.

X50 Element to Be Updated

Definition	An identifier for which data element/attribute is being updated in the Update Client Profile record
Intent	To identify when key characteristics of the client or the client's home care service episode have changed. This data element also ensures that the correct data elements are populated within the Update Client Profile record and that the record is processed appropriately.

Records and submission status

Submitted on	Condition
Update Client Profile	Always mandatory

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6, 7

Legend

Value	Label
1	Postal Code of Residence
2	Language
3	Marital Status
4	Client Group
5	Subregion Identifier
6	Program
7	Health Card Number (including Province Territory Issuing Health Card Number)

Coding instructions

Only 1 of the client's attributes can be updated per Update Client Profile record.

Submission instructions

X50 dictates which data elements within the Update Client Profile record must be present and which must be blank:

- AA4 Postal Code must be present when X50 = 1; otherwise it must be blank.
- BB5a Primary Language must be present when X50 = 2; otherwise it must be blank.
- BB4 Marital Status must be present when X50 = 3; otherwise it must be blank.
- X2 Client Group must be present when X50 = 4; otherwise it must be blank.
- X3 Subregion Identifier must be present when X50 = 5; otherwise it must be blank.
- X4 Program Type must be present when X50 = 6; otherwise it must be blank.
- AA3a Health Card Number **and** AA3b Province/Territory Issuing Health Card Number must be present when X50 = 7; otherwise they must be blank.

X51 Element Effective Date

Definition	The date the characteristic/attribute identified in element X50 was changed or when the change came into effect
Intent	To identify when key characteristics of the client or the client's home care service episode have changed

Records and submission status

Submitted on	Condition
Update Client Profile	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

Wherever possible, the date the actual change took place should be recorded. For changes in the client's personal circumstances, the source organization may not know the exact date the change took place but is notified after the change takes place (e.g., if the client's marital status changes). In these situations, X51 should contain the date the source organization was notified.

If changes are identified during a RAI-HC assessment (e.g., a change in marital status or primary language) and the date of the actual change cannot be determined, X51 should be set to the A1 Assessment Reference Date of the RAI-HC assessment.

X60 Client Transfer Date

Definition	The date a client's records were transferred from the previous source organization to the current source organization, or the date the transfer came into effect
Intent	To provide a link between the client identifiers used before and after an organization restructuring. It will allow records to be submitted through the new source organization for clients who were receiving services before the reorganization, in a way that maintains the integrity of the home care service episode.

Records and submission status

Submitted on	Condition
Organization Client Transfer	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Submission instructions

X60 must occur on or after the date the organization restructuring took place.

X70 Location of Assessment

Definition	The location where the assessment takes place
Intent	To identify settings where the RAI-HC is being used and to allow for appropriate completion of the assessment, accommodating for differences between home and facility settings

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	2
Justification	Left
Valid values	1, 2, 3, 4

Legend

Value	Label
1	Private home, condominium, apartment, assisted living settings
2	Acute care hospital/unit
3	Residential care facility
4	Other

Coding instructions

Code the location of the client when the assessment takes place (i.e., on the Assessment Reference Date). Coding standards for the RAI-HC in facility settings apply for codes 2, 3 and 4 and require that data element X71 Facility Admission Date be completed.

- Private home, condominium, apartment, assisted living settings
  - Refers to any house, condominium or apartment in the community, whether owned by the client or another person. Also included in this category are retirement communities, independent housing for the elderly or disabled, group homes, retirement homes, community care homes, lodges, supportive housing and congregate living settings.
- Hospital
  - Refers to all inpatient nursing units in licensed hospitals.
- Residential care facility
  - Refers to a licensed or regulated health facility that provides 24-hour skilled or immediate nursing care (i.e., qualified nurses are on site and available to respond immediately, if required). Includes long-term care facilities, nursing homes, special care homes and homes for the aged (personal care homes).
- Other settings
  - Examples include hospices, homeless shelters, correctional facilities and ambulatory care settings.

X71 Facility Admission Date

Definition	The date the client was most recently admitted to the facility setting
Intent	To capture the date the client was admitted to the facility setting and to determine the applicability of selected time-sensitive data elements

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

If X70 = 2, 3 or 4, then X71 must be completed with a valid date. Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department at the facility.

If the time between Facility Admission Date and Assessment Date (A1) is equal to or greater than 90 days, some data elements are not mandatory.

Y10x Data Collection Vendor Code

Definition	The vendor code assigned to the system that is responsible for collecting the data submitted in the record
Intent	To uniquely identify the vendors responsible for creating the software used to collect/submit data to CIHI

Records and submission status

Submitted on	Condition
Admission	Always mandatory
Update Client Profile	Always mandatory
RAI-HC Assessment	Always mandatory
Medication	Always mandatory
Service Start	Always mandatory
Service Details	Always mandatory
Service End	Always mandatory
ER Visits	Always mandatory
Discharge	Always mandatory
Organization Client Transfer	Always mandatory

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	5
Max length	5
Justification	None
Valid values	Alphanumeric characters

Coding instructions

Vendor codes are assigned by CIHI.

Submission instructions

Must be a valid vendor code.

Must be a vendor code included in data elements Y10a to Y10e of the source organization's Organization Profile record.

Y13 Reporting Period

Definition	The fiscal period in which the client's event (or events) took place.
Intent	To allow for appropriate processing and reporting of data throughout a fiscal year.

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Mandatory for new or correction records
RAI-HC Assessment	Mandatory for new or correction records
Medication	Mandatory for new or correction records
Service Start	Mandatory for new or correction records
Service Details	Mandatory for new or correction records
Service End	Mandatory for new or correction records
ER Visits	Mandatory for new or correction records
Discharge	Mandatory for new or correction records
Organization Client Transfer	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	NN
Min length	1
Max length	2
Justification	Left
Valid values	1–13

Legend

Value	Label
1	Period 1/April/Quarter 1
2	Period 2/May/Quarter 2
3	Period 3/June/Quarter 3
4	Period 4/July/Quarter 4
5	Period 5/August
6	Period 6/September
7	Period 7/October
8	Period 8/November
9	Period 9/December
10	Period 10/January
11	Period 11/February
12	Period 12/March
13	Period 13

Coding instructions

Client events (e.g., admission, RAI-HC assessment, discharge) and their associated records are reported and analyzed either in 4, 12 or 13 reporting periods. The Provincial Profile will specify the number of periods being used in a given province or territory.

If reporting in 4 periods, only codes 1 to 4 can be used, with each code representing the following reporting quarters:

- 1 — Quarter 1: April 1 to June 30
- 2 — Quarter 2: July 1 to September 30
- 3 — Quarter 3: October 1 to December 31
- 4 — Quarter 4: January 1 to March 31

If reporting in 12 periods, only codes 1 to 12 can be used, with each code representing the months of the year:

- 1 — April
- 2 — May
- 3 — June
- 4 — July
- 5 — August
- 6 — September
- 7 — October
- 8 — November
- 9 — December
- 10 — January
- 11 — February
- 12 — March

If reporting in 13 periods, all 13 codes can be used. The corresponding start and end dates for each period usually change on an annual basis and will be provided to users separately.

Submission instructions

Each reporting period will have a corresponding deadline by which all records relating to the reporting period must be submitted to CIHI. This includes the submission of correction and deletion records.

Data will be accepted after the scheduled dates; however, failure to submit data by the required deadlines may result in that data not being included for reporting purposes.

Records for different reporting periods within the same fiscal year may be submitted within a single submission file.

Chapter 7 — RAI-HC data elements

Introduction

This chapter includes details of only those data elements from the RAI-HC that are to be submitted to CIHI (and therefore excludes those data elements that capture the names of clients, caregivers and assessors).

To avoid duplication, the information presented in this chapter excludes the definitions, intents and coding instructions, as these are included in the RAI-HC User's Manual.

However, it does provide details of how these data elements, once captured, must be submitted to CIHI. In particular, it documents where the format of the data element as it is to be submitted to CIHI is different from how it is displayed or captured on the RAI-HC form provided in the RAI-HC User's Manual (e.g., BB2a Birth Date).

HCRS has incorporated, with permission from interRAI, data element definitions of certain key data elements from the RAI-HC that can be collected on all home care clients, even if they do not receive a RAI-HC assessment. This ensures that in HCRS, the key demographic and administrative information is reported consistently on all home care clients. These data elements are the following:

- AA3a Health Card Number
- AA3b Province/Territory Issuing Health Card Number
- AA4 Postal Code of Residence
- BB1 Sex
- BB2a Birth Date
- BB2b Estimated Birth Date
- BB4 Marital Status
- BB5a Primary Language
- CC1 Date Case Opened/Reopened

For this reason, the submission of these data elements is significantly different than for other data elements captured on the RAI-HC.

See the RAI-HC User's Manual for definitions and intents for all data elements contained within the RAI-HC assessment instrument.

AA2 Case Record Number

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	12
Justification	Left
Valid values	1 to12 alphanumeric characters

Coding instructions

See RAI-HC User’s Manual for coding instructions.

AA3a Health Card Number

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Mandatory if X50 Element to Be Updated = 7

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	12
Justification	Left
Valid values	0, 1, valid Health Card Number

Legend

Value	Label
0	Asked/unknown
1	Not applicable

Coding instructions

See RAI-HC User's Manual for coding instructions.

AA3a Health Card Number is captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

The format of AA3a Health Card Number must be consistent with AA3b Province/Territory Issuing Health Card Number.

AA3a must be used consistently with AA3b Province/Territory Issuing Health Card Number and X1b Unique Source Organization to identify a single client.

If the client has had previous home care service episodes, AA3a, AA3b Province/Territory Issuing Health Card Number, BB1 Sex and BB2a Birth Date must match existing information for that client.

A client's Health Card Number may change over time (e.g., may start the home care service episode without a health card number and receive one during the episode). If a change occurs, the client's new health card number can be submitted on an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 7 and AA3a Health Card Number **and** AA3b Province/Territory Issuing Health Card Number must contain the new information to be submitted.

If the change is identified during a RAI-HC assessment and the date of the actual change cannot be determined, X51 should be set to the A1 Assessment Reference Date of the RAI-HC assessment.

AA3a (and AA3b) must be blank on Update Client Profile records when X50 Element to Be Updated is not coded 7.

AA3b Province/Territory Issuing Health Card Number

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Mandatory if X50 Element to Be Updated = 7

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	2
Max length	3
Justification	Left
Valid values	NL, PE, NS, NB, QC, ON, MB, SK, AB, BC, YT, NT, NU, -50, -70, -90

Legend

Value	Label
NL	Newfoundland and Labrador
PE	Prince Edward Island
NS	Nova Scotia
NB	New Brunswick
QC	Quebec
ON	Ontario
MB	Manitoba
SK	Saskatchewan
AB	Alberta
BC	British Columbia
YT	Yukon

Value	Label
NT	Northwest Territories
NU	Nunavut
-50	Not available/temporarily
-70	Asked, unknown
-90	Not applicable

Coding instructions

See RAI-HC User's Manual for coding instructions.

AA3b Province/Territory Issuing Health Card Number is captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

Alpha characters must be uppercase.

A client's Health Card Number may change over time (e.g., may start the home care service episode without a health card number and receive one during the episode). If a change occurs, the client's new health card number can be submitted on an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 7 and AA3a Health Card Number **and** AA3b Province/Territory Issuing Health Card Number must contain the new information to be submitted.

If the change is identified during a RAI-HC assessment and the date of the actual change cannot be determined, X51 should be set to the A1 Assessment Reference Date of the RAI-HC assessment.

AA3a and AA3b must be blank on Update Client Profile records when X50 Element to Be Updated is not coded 7.

AA4 Postal Code of Residence

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Mandatory if X50 Element to Be Updated = 1

Representation

Data type	Alphanumeric
Layout	N, ANA, ANANAN
Min length	1
Max length	6
Justification	Left
Valid values	1, 2, Canadian postal code or forward sortation area (FSA)

Legend

Value	Label
1	Asked/unknown
2	Not applicable
Z1Z1Z1	For homeless individuals

Coding instructions

See RAI-HC User's Manual for coding instructions.

AA4 Postal Code of Residence is captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

Alpha characters must be uppercase.

If a full Canadian postal code or forward sortation area (the first 3 characters of a postal code) are submitted, the first alpha character must not be D, F, I, O, Q, U or W.

A client's permanent residence and postal code may change over time. If a change occurs, the client's new postal code can be submitted on an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 1 and AA4 Postal Code must contain the new information.

If the change is identified during a RAI-HC assessment and the date of the actual change cannot be determined, X51 should be set to the A1 Assessment Reference Date of the RAI-HC assessment.

AA4 must be blank on Update Client Profile records when X50 Element to Be Updated is not coded 1.

BB1 Sex

Records and submission status

Submitted on	Condition
Admission	Optional

Representation

Data type	Alphanumeric
Layout	Alphanumeric
Min length	1
Max length	1
Justification	None
Valid values	M, F

Legend

Value	Label
M	Male
F	Female

Coding instructions

If a person's sex is unknown, the element must be left blank.

BB1 Sex is captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

Alpha characters must be uppercase.

It is expected that a client who has received a RAI-HC assessment will have a valid sex submitted.

BB2a Birth Date

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMM
Min length	6
Max length	6
Justification	None
Valid values	Valid year and month

Coding instructions

See RAI-HC User's Manual for coding instructions.

BB2a Birth Date is captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

While organizations will collect the client's full birth date, only the year and month are to be submitted to CIHI (for privacy reasons).

Do not leave any boxes blank. If the month contains only a single digit, fill the fifth character with a 0.

Example

September 2, 1934

1	9	3	4	0	9

Year Month

The client's age is calculated as of the Date Case Opened/Reopened and would be expected to be less than 120 years.

BB2b Estimated Birth Date

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

BB2b Estimated Birth Date is captured for all clients, not just those who receive a RAI-HC assessment.

BB3 Aboriginal Identity

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

The data element is mandatory for all provinces except Ontario. In Ontario, it is mandatory if X70 Location of Assessment = 1.

BB4 Marital Status

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6, 9

Legend

Value	Label
1	Never married
2	Married
3	Widowed
4	Separated
5	Divorced
6	Other
9	Unknown

Coding instructions

See RAI-HC User's Manual for coding instructions.

Note: The option of coding *Unknown* is provided for those jurisdictions that are restricted in their ability to submit this data element to CIHI.

BB4 Marital Status is captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

A client's marital status may change over time. If a change occurs, the client's new marital status can be submitted on an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 3 and BB4 must contain the new information.

If the change is identified during a RAI-HC assessment and the date of the actual change cannot be determined, X51 should be set to the A1 Assessment Reference Date of the RAI-HC assessment.

BB4 must be blank on Update Client Profile records when X50 Element to Be Updated is not coded 3.

BB5a Primary Language

Records and submission status

Submitted on	Condition
Admission	Mandatory if ZP12a–e = 1 on Provincial Profile (see below)
Update Client Profile	If X50 Element to Be Updated = 2

Representation

Data type	Alphanumeric
Layout	aaa
Min length	3
Max length	3
Justification	None
Valid values	See Language Code document for list of language codes

Coding instructions

See RAI-HC User's Manual for coding instructions.

BB5a Primary Language can be captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

Alpha characters must be lowercase.

Primary Language is usually submitted on the Admission record (even if it is captured as part of the RAI-HC assessment).

Whether or not the submission of this data element is mandatory on Admission records depends on the client's Client Group (as submitted in data element X2 on the client's Admission record) and information submitted on the Provincial Profile. X6 is therefore mandatory under the following conditions:

- If X2 = 1 (*Acute Home Care client*) and ZP12a Primary Language for Acute Home Care Client Group Mandated = 1
- If X2 = 2 (*End-of-Life client*) and ZP12b Primary Language for End-of-Life Client Group Mandated = 1
- If X2 = 3 (*Rehabilitation client*) and ZP12c Primary Language for Rehabilitation Client Group Mandated = 1
- If X2 = 4 (*Long-Term Supportive Care client*) and ZP12d Primary Language for Long-Term Supportive Care Client Group Mandated = 1
- If X2 = 5 (*Maintenance client*) and ZP12e Primary Language for Maintenance Client Group Mandated = 1

If Primary Language is not captured for a client at the time of admission or if it changes over the course of the home care service episode, it can be submitted on an Update Client Profile record. On this record, X50 Element to Be Updated must be set to 2 (Language) and BB5a must contain the new language code to be submitted.

If the new language code comes from a RAI-HC assessment and the date of the actual change cannot be determined, X51 should be set to the A1 Assessment Reference Date of the RAI-HC assessment.

BB5a must be blank on Update Client Profile records when X50 Element to Be Updated is not coded 2.

BB5b Interpreter Needed

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

BB6 Education

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6, 7, 8, 9

Legend

Value	Label
1	No schooling
2	8th grade/less
3	9–11 grades
4	High school
5	Technical or trade school
6	Some college/university
7	Diploma/bachelor's degree
8	Graduate degree
9	Unknown

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Mandatory for all provinces except Ontario. In Ontario, mandatory if X70 Location of Assessment = 1.

BB7a Legal Guardian/Substitute Decision-Maker

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 9

Legend

Value	Label
0	No
1	Yes
9	Not collected

Coding instructions

See RAI-HC User's Manual for coding instructions.

Note: The option of coding *Not collected* is provided for those jurisdictions that are restricted in their ability to submit this data element to CIHI.

Submission instructions

Mandatory for all provinces except Ontario.

BB7b Advanced Medical Directives

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Mandatory for all provinces except Ontario.

BB8 Responsibility for Payment

Elements

Element ID	Element name
BB8a	Payment — Provincial/Territorial Government Plan
BB8b	Payment — Other Province/Territory
BB8c	Payment — Federal Government — Veterans Affairs Canada (VAC)
BB8d	Payment — Federal Government — First Nations and Inuit Health Branch (FNIHB)
BB8e	Payment — Federal Government — Other (RCMP, Canadian Forces, Inmate, Refugee)
BB8f	Payment — Worker's Compensation Board (WCB/WSIB)
BB8g	Payment — Canadian Resident, Private Insurance
BB8h	Payment — Canadian Resident, Public Trustee
BB8i	Payment — Canadian Resident, Self Pay
BB8j	Payment — Other Country Resident, Self Pay
BB8k	Payment — Unknown/Unavailable

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Optional

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

BB8k Unknown/Unavailable must be coded 1 when all of BB8a to BB8j are coded 0 (*No*).

BB8k Unknown/Unavailable must be coded 0 if any of BB8a to BB8j are coded 1 (*Yes*).

CC1 Date Case Opened/Reopened

Records and submission status

Submitted on	Condition
Admission	Mandatory for new or correction records
Update Client Profile	Always mandatory
RAI-HC Assessment	Mandatory for new or correction records
Medication	Mandatory for new or correction records
Service Start	Mandatory for new or correction records
Service Details	Mandatory for new or correction records
Service End	Mandatory for new or correction records
ER Visits	Mandatory for new or correction records
Discharge	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

See RAI-HC User's Manual for coding instructions.

CC1 Date Case Opened/Reopened is captured for all clients, not just those who receive a RAI-HC assessment.

Submission instructions

CC1 Date Case Opened/Reopened is used to associate client records with a home care service episode. CC1 must be unique for each new Admission record submitted for a client; CC1 submitted on all other client records must match the CC1 on an Admission record.

CC2 Reason for Referral

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if • A1 Assessment Reference Date is greater than or equal to CC1 Date Case Opened/Reopened; **and** • A2 Reason for Assessment is equal to 1; **and** • X2 Client Group on Admission record is equal to 4 **or** 5; **and** • Number of years between CC1 Date Case Opened/Reopened and A1 Assessment Reference Date is less than or equal to 1; **then** • CC2 Reason for Referral must be equal to 1 to 6

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6

Legend

Value	Label
1	Post-hospital care
2	Community chronic care
3	Home placement screen
4	Eligibility for home care
5	Day care
6	Other

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Submission of CC2 is mandatory (on new and correction records) if the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5). The submission of data elements CC2 to CC8 is optional if A1 Assessment Reference Date is more than a year after CC1 Date Case Opened/Reopened and/or the client was initially assigned to the Acute, End-of-Life or Rehabilitation Client Group (X2 Client Group on Admission record = 1, 2 or 3).

CC3 Understanding of Goals of Care

Elements

Element ID	Element name
CC3a	Goals — Skilled Nursing Treatments
CC3b	Goals — Monitoring
CC3c	Goals — Rehabilitation
CC3d	Goals — Client/Family Education
CC3e	Goals — Family Respite
CC3f	Goals — Palliative Care

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and X2 Client Group on Admission = 4 or 5

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Submission of CC3 is mandatory (on new and correction records) when the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5). The submission of data elements CC2 to CC8 is optional if A1 is more than a year after CC1 and/or the client was initially assigned to the Acute, End-of-Life or Rehabilitation Client Group (X2 Client Group on Admission record = 1, 2 or 3).

CC4 Time Since Last Hospital Stay

Records and submission status

Submitted on	Condition
RAI-HC Assessment	In all provinces except Ontario, mandatory if • A1 Assessment Reference Date is greater than or equal to CC1 Date Case Opened/Reopened; **and** • A2 Reason for Assessment is equal to 1; **and** • X2 Client Group on Admission record is equal to 4 **or** 5; **and** • Number of years between CC1 Date Case Opened/Reopened and A1 Assessment Reference Date is less than or equal to 1; **and** • X70 Location of Assessment is equal to 1; **or** • X70 Location of Assessment is equal to 2 ,3 or 4 **and** number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90; **then** • CC4 Time Since Last Hospital Stay must be equal to 0 to 5 • Mandatory in Ontario

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5

Legend

Value	Label
0	Presently in hospital
1	No hospitalization within 180 days
2	Within last week
3	Within 8–14 days
4	Within 15–30 days
5	More than 30 days ago

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

In all provinces except Ontario, submission of CC4 is mandatory (on new and correction records) when the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5). The submission of data elements CC2 to CC8 is optional if A1 is more than a year after CC1 and/or the client was initially assigned to the Acute, End-of-Life or Rehabilitation Client Group (X2 Client Group on Admission record = 1, 2 or 3).

In Ontario, submission of CC4 is mandatory (for new and correction records).

CC5 Where Lived at Time of Referral

Records and submission status

Submitted on	Condition
RAI-HC Assessment	In all provinces except Ontario, mandatory if • A1 Assessment Reference Date is greater than or equal to CC1 Date Case Opened/Reopened; **and** • X2 Client Group on Admission record is equal to 4 **or** 5; **and** • Number of years between CC1 Date Case Opened/Reopened and A1 Assessment Reference Date is less than or equal to 1; **and** • X70 Location of Assessment is equal to 1; **or** • X70 Location of Assessment is equal to 2, 3 or 4 **and** number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90; **then** • CC5 must be equal to 1 to 5 • Mandatory in Ontario

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5

Legend

Value	Label
1	Private home/apartment with no home care services
2	Private home/apartment with home care services
3	Board and care/assisted living/group home
4	Residential care facility
5	Other

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

In all provinces except Ontario, submission of CC5 is mandatory (on new and correction records) when the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5). The submission of data elements CC2 to CC8 is optional if A1 Assessment Reference Date is more than a year after CC1 and/or the client was initially assigned to the Acute, End-of-Life or Rehabilitation Client Group (X2 Client Group on Admission record = 1, 2 or 3).

In Ontario, submission of CC5 is mandatory (on new and correction records).

CC6 Who Lived With at Time of Referral

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if • A1 Assessment Reference Date is greater than or equal to CC1 Date Case Opened/Reopened; **and** • X2 Client Group on Admission record is equal to 4 **or** 5; **and** • Number of years between CC1 Date Case Opened/Reopened and A1 Assessment Reference Date is less than or equal to 1; **and** • X70 Location of Assessment is equal to 1; **or** • X70 Location of Assessment is equal to 2, 3 or 4 **and** number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90; **then** • CC6 must equal 1 to 6

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6

Legend

Value	Label
1	Lived alone
2	Lived with spouse only
3	Lived with spouse and other(s)
4	Lived with child (not spouse)
5	Lived with other(s) (not spouse or children)
6	Lived in group setting with non-relative(s)

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Submission of CC6 is mandatory (on new and correction records) when the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5) and X70 Location of Assessment = 1 (private home, condominium, apartment) or if X70 Location of Assessment = 2, 3 or 4 (acute care hospital/unit, residential care facility or other) and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90.

The submission of data elements CC2 to CC8 is optional if A1 is more than a year after CC1 and/or the client was initially assigned to the Acute, End-of-Life or Rehabilitation Client Group (X2 Client Group on Admission record = 1, 2 or 3). The submission of data element CC6 is optional if X70 Location of Assessment is 2, 3 or 4 and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is equal to or greater than 90 days.

CC7 Prior Residential Care Facility

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if A1 Assessment Reference Date is less than or equal to a year of CC1 Date Case Opened/Reopened and X2 Client Group on Admission = 4 or 5

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Submission of CC7 is mandatory (on new and correction records) when A1 Assessment Reference Date is less than or equal to a year of CC1 Date Case Opened/Reopened and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5). The submission of data elements CC2 to CC8 is optional if A1 is more than a year after CC1 and/or the client was initially assigned to the Acute, End-of-Life or Rehabilitation Client Group (X2 Client Group on Admission record = 1, 2 or 3).

CC8 Residential History

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if • A1 Assessment Reference Date is less than or equal to a year of CC1 Date Case Opened/Reopened; **and** • X2 Client Group on Admission = 4 **or** 5; **and** • X70 Location of Assessment = 1; **or** • X70 Location of Assessment = 2, 3 or 4 **and** number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Submission of CC8 is mandatory (on new and correction records) when the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5) and X70 Location of Assessment = 1 or X70 Location of Assessment = 2, 3 or 4 and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90.

In Ontario, CC8 is mandatory when the difference between A1 Assessment Reference Date and CC1 Date Case Opened/Reopened is less than or equal to 1 year and the client was assigned to either the Long-Term Supportive Care or Maintenance Client Group on Admission (X2 Client Group on Admission record = 4 or 5) and X70 Location of Assessment = 1.

The submission of data elements CC2 to CC8 is optional if A1 is more than a year after CC1 and/or the client was initially assigned to the Acute, End-of-Life or Rehabilitation Client Group (X2 Client Group on Admission record = 1, 2 or 3).

A1 Assessment Reference Date

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records
Medication	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Usually, each assessment submitted for a given client will have a different Assessment Reference Date. Only inter-rater reliability assessments (A2 Reason for Assessment = code 8) can have the same Assessment Reference Dates.

A1 Assessment Reference Date is used, together with A2 Reason for Assessment, to uniquely identify a RAI-HC assessment within a client's home care service episode. These data elements are also used match Medication records with the appropriate RAI-HC Assessment record. Both data elements submitted on Medication records must match those submitted on a RAI-HC Assessment record.

A2 Reason for Assessment

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records
Medication	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	1, 2, 3, 4, 5, 6, 7, 8

Legend

Value	Label
1	Initial assessment
2	Follow-up assessment
3	Routine assessment at fixed intervals
4	Review within 30-day period prior to discharge from the program
5	Review at return from hospital
6	Change in status
7	Other

Coding instructions

See RAI-HC User's Manual for additional information on definitions of codes 1 to 7.

Submission instructions

A2 Reason for Assessment is used, together with A1 Assessment Reference Date, to uniquely identify a RAI-HC assessment within a client's home care service episode. These data elements are also used to match Medication records with the appropriate RAI-HC Assessment record. Both data elements submitted on Medication records must match those submitted on a RAI-HC Assessment record.

B1 Memory Recall Ability

Elements

Element ID	Element name
B1a	Short-Term Memory
B1b	Procedural Memory

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new and correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	Memory OK
1	Memory problem

Coding instructions

See RAI-HC User's Manual for coding instructions.

B2a Cognitive Skills — Decision Making

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	Independent
1	Modified independence
2	Minimally impaired
3	Moderately impaired
4	Severely impaired

Coding instructions

See RAI-HC User's Manual for coding instructions.

B2b Cognitive Skills — Worsening Decision Making

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

B3 Indicators of Delirium

Elements

Element ID	Element name
B3a	Sudden or New Onset/Change in Mental Function Over Last 7 Days
B3b	In the Last 90 Days, Client Has Become Agitated or Disoriented

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User’s Manual for coding instructions.

C1 Hearing

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	Hears adequately
1	Minimal difficulty
2	Hears in special situation only
3	Highly impaired

Coding instructions

See RAI-HC User's Manual for coding instructions.

C2 Making Self Understood

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	Understood
1	Usually understood
2	Often understood
3	Sometimes understood
4	Rarely/never understood

Coding instructions

See RAI-HC User's Manual for coding instructions.

C3 Ability to Understand Others

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	Understands
1	Usually understands
2	Often understands
3	Sometimes understands
4	Rarely/never understands

Coding instructions

See RAI-HC User's Manual for coding instructions.

C4 Communication Decline

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

D1 Vision

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	Adequate
1	Impaired
2	Moderately impaired
3	Highly impaired
4	Severely impaired

Coding instructions

See RAI-HC User’s Manual for coding instructions.

D2 Vision Limitations

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

D3 Vision Decline

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

E1 Indicators of Depression, Anxiety, Sad Mood

Elements

Element ID	Element name
E1a	Indicators of Depression — Sad Mood
E1b	Indicators of Depression — Anger
E1c	Indicators of Anxiety — Unrealistic Fears
E1d	Indicators of Anxiety — Repetitive Health Complaints
E1e	Indicators of Anxiety — Repetitive Anxious Complaints
E1f	Indicators of Sad Mood — Sad, Pained Facial Expressions
E1g	Indicators of Sad Mood — Recurrent Crying, Tearfulness
E1h	Withdrawal From Activities of Interest
E1i	Reduced Social Interaction

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	Indicator not exhibited in last 3 days
1	Exhibited 1–2 of last 3 days
2	Exhibited on each of last 3 days

Coding instructions

See RAI-HC User’s Manual for coding instructions.

E2 Mood Decline

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

E3 Behavioural Symptoms

Elements

Element ID	Element name
E3a	Wandering
E3b	Verbally Abusive
E3c	Physically Abusive
E3d	Socially Inappropriate/Disruptive
E3e	Resists Care

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	Did not occur in last 3 days
1	Occurred, easily altered
2	Occurred, not easily altered

Coding instructions

See RAI-HC User’s Manual for coding instructions.

E4 Changes in Behaviour Symptoms

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No, or no change in behavioural symptoms or acceptance by family
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

F1a At Ease Interacting With Others

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	At ease
1	Not at ease

Coding instructions

See RAI-HC User's Manual for coding instructions.

F1b Openly Expresses Conflict or Anger With Friends/Family

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

F2 Change in Social Activities

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	No decline
1	Decline, not distressed
2	Decline, distressed

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Mandatory if X70 Location of Assessment = 1 or if X70 Location of Assessment = 2, 3 or 4 for all provinces except Ontario.

F3a Length of Time Client Is Alone During Day

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	Never or hardly ever
1	About one hour
2	Long periods of time
3	All of the time

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Mandatory if X70 Location of Assessment = 1 or if X70 Location of Assessment = 2, 3 or 4 and number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90. In Ontario, mandatory if X70 Location of Assessment = 1.

F3b Client Feels Lonely

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Mandatory for new or correction records except in Ontario. In Ontario, mandatory if X70 Location of Assessment = 1.

G1e Informal Helper Lives With Client

Elements

Element ID	Element name
G1eA	Lives With Client — Primary
G1eB	Lives With Client — Secondary

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	Yes
1	No
2	No such helper

Coding instructions

See RAI-HC User’s Manual for coding instructions.

G1f Informal Helper Relationship to Client

Elements

Element ID	Element name
G1fA	Relationship to Client — Primary
G1fB	Relationship to Client — Secondary

Records and submission status

Element ID	Submitted on	Condition
G1fA	RAI-HC Assessment	Mandatory if G1eA = 0, 1
G1fB	RAI-HC Assessment	Mandatory if G1eB = 0, 1

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	Child or child-in-law
1	Spouse
2	Other relative
3	Friend/neighbour

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

G1fA must contain a valid value if G1eA is coded 0 or 1; otherwise, it must be blank.

G1fB must contain a valid value if G1eB is coded 0 or 1; otherwise, it must be blank.

G1g–G1i Informal Helper Areas of Help

Elements

Element ID	Element name
G1gA	Advice or Emotional Support — Primary
G1gB	Advice or Emotional Support — Secondary
G1hA	IADL Care — Primary
G1hB	IADL Care — Secondary
G1iA	ADL Care — Primary
G1iB	ADL Care — Secondary

Records and submission status

Element ID	Submitted on	Condition
G1gA, **G1hA,** **G1iA**	RAI-HC Assessment	In all provinces except Ontario, mandatory if • G1eA = 0 or 1; **and** • X70 Location of Assessment = 1; **or** • X70 = 2, 3 or 4 **and** number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90 • In Ontario, mandatory if G1eA = 0 or 1
G1gB, **G1hB,** **G1iB**	RAI-HC Assessment	In all provinces except Ontario, mandatory if • G1eB = 0 or 1; **and** • X70 Location of Assessment = 1; **or** • X70 = 2, 3 or 4 **and** number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90 • In Ontario, mandatory if G1eB = 0 or 1

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	Yes
1	No

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

In all provinces except Ontario, G1gA, G1hA and G1iA must contain valid values if G1eA is coded 0 or 1 and X70 Location of Assessment = 1 or X70 = 2, 3 or 4 and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90. Otherwise, they must be blank.

In Ontario, G1gA, G1hA and G1iA are mandatory (on new and correction records) if G1eA is coded 0 or 1. Otherwise, they must be blank.

In all provinces except Ontario, G1gB, G1hB and G1iB must contain valid values if G1eB is coded 0 or 1 and X70 Location of Assessment = 1 or X70 = 2, 3 or 4 and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90. Otherwise, they must be blank.

In Ontario, G1gB, G1hB and G1iB are mandatory (on new and correction records) if G1eB is coded 0 or 1. Otherwise, they must be blank.

G1j–G1l Informal Helper Willingness to Increase Help

Elements

Element ID	Element name
G1jA	Increase in Emotional Support — Primary
G1jB	Increase in Emotional support — Secondary
G1kA	Increase IADL Care — Primary
G1kB	Increase IADL Care — Secondary
G1lA	Increase ADL Care — Primary
G1lB	Increase ADL Care — Secondary

Records and submission status

Element ID	Submitted on	Condition
G1jA, G1kA, G1lA	RAI-HC Assessment	In all provinces, mandatory if G1eA = 0 or 1 and X70 Location of Assessment = 1 In all provinces except Ontario, mandatory if X70 (Location of Assessment) = 2, 3 or 4 and number of days between X71 (Facility Admission Date) and A1 (Assessment Reference Date) is less than 90
G1jB, G1kB, G1lB	RAI-HC Assessment	In all provinces, mandatory if G1eB = 0 or 1 and X70 Location of Assessment = 1 In all provinces except Ontario, mandatory if X70 (Location of Assessment) = 2, 3 or 4 and number of days between X71 (Facility Admission Date) and A1 (Assessment Reference Date) is less than 90

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	More than 2 hours per day
1	1–2 hours per day
2	No

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

G1jA, G1kA and G1lA must contain valid values if G1eA is coded 0 or 1 and X70 Location of Assessment = 1. Otherwise, they must be blank.

In all provinces except Ontario, G1jA, G1kA and G1lA are mandatory if G1eA = 0 or 1 and X70 Location of Assessment = 2, 3 or 4 and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90.

G1jB, G1kB and G1lB must contain valid values if G1eB is coded 0 or 1 and X70 Location of Assessment = 1. Otherwise, they must be blank.

In all provinces except Ontario, G1jB, G1kB and G1lB are mandatory if G1eA = 0 or 1 and X70 Location of Assessment = 2, 3 or 4 and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90.

G2 Caregiver Status

Elements

Element ID	Element name
G2a	Any Caregiver Unable to Continue
G2b	Primary Caregiver Not Satisfied With Support From Family/Friends
G2c	Primary Caregiver Expresses Feeling of Distress, Anger, Depression
G2d	Caregiver Status — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	G2a: Mandatory for new or correction records G2b–G2c: Mandatory if G1eA = 0 or 1 and X70 Location of Assessment = 1 G2d: Mandatory if G2a–G2c = 0 or 1

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

G2b–c must contain valid values if G1eA is coded 0 or 1 and X70 Location of Assessment is coded 1.

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

G2d None of the Above must be coded 1 when all of G2a to G2c are coded 0 (*No*).

G2d None of the Above must be coded 0 if any of G2a to G2c are coded 1 (*Yes*).

G3 Extent of Informal Help

Elements

Element ID	Element name
G3a	Hours of Informal Help — 5 Weekdays
G3b	Hours of Informal Help — 2 Weekend Days

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if X70 Location of Assessment = 1

Representation

Data type	Numeric
Layout	NNN
Min length	1
Max length	3
Justification	Left
Valid values	0–999

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

G3a–b must contain valid values if X70 Location of Assessment = 1; otherwise, they may be blank.

H1–A IADL Self Performance

Elements

Element ID	Element name
H1aA	Meal Preparation — Self Performance
H1bA	Ordinary Housework — Self Performance
H1cA	Managing Finances — Self Performance
H1dA	Managing Medications — Self Performance
H1eA	Phone Use — Self Performance
H1fA	Shopping — Self Performance
H1gA	Transportation — Self Performance

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if X70 Location of Assessment = 1

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 8

Legend

Value	Label
0	Independent
1	Some help
2	Full help
3	By others
8	Activity did not occur

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

H1aA–H1gA must contain valid values if X70 Location of Assessment = 1; otherwise, they may be left blank.

H1–B IADL Difficulty

Elements

Element ID	Element name
H1aB	Meal Preparation — Difficulty
H1bB	Ordinary Housework — Difficulty
H1cB	Managing Finances — Difficulty
H1dB	Managing Medications — Difficulty
H1eB	Phone Use — Difficulty
H1fB	Shopping — Difficulty
H1gB	Transportation — Difficulty

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	No difficulty
1	Some difficulty
2	Great difficulty

Coding instructions

See RAI-HC User's Manual for coding instructions.

H2 ADL Self Performance

Elements

Element ID	Element name
H2a	Mobility in Bed
H2b	Transfer
H2c	Locomotion in Home
H2d	Locomotion Outside of Home
H2e	Dressing Upper Body
H2f	Dressing Lower Body
H2g	Eating
H2h	Toilet Use
H2i	Personal Hygiene
H2j	Bathing

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5, 6, 8

Legend

Value	Label
0	Independent
1	Setup help only
2	Supervision
3	Limited assistance
4	Extensive assistance
5	Maximal assistance
6	Total dependence
8	Activity did not occur (regardless of ability)

Coding instructions

See RAI-HC User’s Manual for coding instructions.

H3 ADL Decline

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

H4 Mode of Locomotion

Elements

Element ID	Element name
H4a	Mode of Locomotion — Indoors
H4b	Mode of Locomotion — Outdoors

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 8

Legend

Value	Label
0	No assistive device
1	Cane
2	Walker/crutch
3	Scooter (e.g., Amigo)
4	Wheelchair
8	Activity did not occur

Coding instructions

See RAI-HC User's Manual for coding instructions.

H5 Stair Climbing

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	Up and down stairs without help
1	Up and down stairs with help
2	Not go up and down stairs

Coding instructions

See RAI-HC User's Manual for coding instructions.

H6a Stamina — Days

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	Every day
1	2–6 days a week
2	1 day a week
3	No days

Coding instructions

See RAI-HC User's Manual for coding instructions.

H6b Stamina — Hours

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	Two or more hours
1	Less than two hours

Coding instructions

See RAI-HC User's Manual for coding instructions.

H7 Functional Potential

Elements

Element ID	Element name
H7a	Client Believes He/She Can Increase Function Independence
H7b	Caregivers Believe Client Can Increase Function Independence
H7c	Good Prospects of Recovery
H7d	Functional Potential — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

H7d None of the Above must be coded 1 when all of H7a to H7c are coded 0 (*No*).

H7d None of the Above must be coded 0 if any of H7a to H7c are coded 1 (*Yes*).

I1a Bladder Continence

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5, 8

Legend

Value	Label
0	Continent
1	Continent with catheter
2	Usually continent
3	Occasionally incontinent
4	Frequently incontinent
5	Incontinent
8	Did not occur

Coding instructions

See RAI-HC User's Manual for coding instructions.

I1b Worsening of Incontinence

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

I2 Bladder Devices

Elements

Element ID	Element name
I2a	Pads or Briefs
I2b	Indwelling Urinary Catheter
I2c	Bladder Devices — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User’s Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

I2c None of the Above must be coded 1 when both I2a and I2b are coded 0 (*No*).

I2c None of the Above must be coded 0 if either I2*a* or I2b is coded 1 (*Yes*).

I3 Bowel Continence

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5, 8

Legend

Value	Label
0	Continent
1	Continent with ostomy
2	Usually continent
3	Occasionally incontinent
4	Frequently incontinent
5	Incontinent
8	Did not occur

Coding instructions

See RAI-HC User’s Manual for coding instructions.

J1a–J1ab Disease Diagnosis

Elements

Element ID	Element name
J1a	Cerebrovascular Accident (Stroke)
J1b	Congestive Heart Failure
J1c	Coronary Heart Disease
J1d	Hypertension
J1e	Irregularly Irregular Pulse
J1f	Peripheral Vascular Disease
J1g	Alzheimer’s
J1h	Dementia Other Than Alzheimer’s
J1i	Head Trauma
J1j	Hemiplegia/Hemiparesis
J1k	Multiple Sclerosis
J1l	Parkinsonism
J1m	Arthritis
J1n	Hip Fracture
J1o	Other Fractures (Wrist, Vertebral)
J1p	Osteoporosis
J1q	Cataract
J1r	Glaucoma
J1s	Any Psychiatric Diagnosis
J1t	HIV Infection
J1u	Pneumonia
J1v	Tuberculosis
J1w	Urinary Tract Infection
J1x	Cancer, Not Including Skin Cancer
J1y	Diabetes

Element ID	Element name
J1z	Emphysema/COPD/Asthma
J1aa	Renal Failure
J1ab	Thyroid Disease (Hyper or Hypo)

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	Not present
1	Disease is present, not subject to focused treatment or monitoring by a health care professional
2	Disease is present and is being monitored or treated by a health care professional

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

An unchecked box is coded 0 (*Not present*).

J1ac Disease — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

J1ac None of the Above must be coded 1 when all of J1a to J1ab are coded 0 (*No*).

J1ac None of the Above must be coded 0 if any of J1a to J1ab are coded 1 or 2.

J2 ICD-10-CA Codes

Elements

Element ID	Element name
J2a	Oth A — ICD-10-CA Code
J2b	Oth B — ICD-10-CA Code
J2c	Oth C — ICD-10-CA Code
J2d	Oth D — ICD-10-CA Code

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Optional

Representation

Data type	Alphanumeric
Layout	ANN-ANNNNNN
Min length	3
Max length	7
Justification	Left
Valid values	Valid ICD-10-CA code

Coding instructions

See RAI-HC User's Manual for coding instructions.

CIHI has developed an ICD-10-CA pick-list for use with HCRS. It provides a range of ICD-10-CA codes and 3-character category codes extracted from the full ICD-10-CA classification[iv] to help home care clinicians code diseases and other health conditions that frequently occur in home care.

iv. ICD-10-CA: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada. ICD-10-CA is based upon the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Copyright © World Health Organization 1992. All rights reserved. Modified by permission for Canadian government purposes by the Canadian Institute for Health Information.

K1 Preventive Health in Past Two Years

Elements

Element ID	Element name
K1a	Blood Pressure Measured
K1b	Received Influenza Vaccination
K1c	Test for Blood in Stool or Screening Endoscopy
K1d	If Female: Received Breast Examination or Mammography
K1e	Preventive Health — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Mandatory for all provinces except Ontario. In Ontario, mandatory if X70 Location of Assessment = 1.

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

K1e None of the Above must be coded 1 when all of K1a to K1d are coded 0 (*No*).

K1e None of the Above must be coded 0 if any of K1a to K1d are coded 1 (*Yes*).

K1d must be coded 0 if the client's sex is male.

K2 Problem Conditions Present on Two or More Days

Elements

Element ID	Element name
K2a	Diarrhea
K2b	Difficulty Urinating or Urinating Three or More Times a Night
K2c	Fever
K2d	Loss of Appetite
K2e	Vomiting
K2f	None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

K2f None of the Above must be coded 1 when all of K2a to K2e are coded 0 (*No*).

K2f None of the Above must be coded 0 if any of K2a to K2e are coded 1 (*Yes*).

K3 Problem Conditions

Elements

Element ID	Element name
K3a	Chest Pain
K3b	No Bowel Movement in Three Days
K3c	Dizziness/Lightheadedness
K3d	Edema
K3e	Shortness of Breath
K3f	Delusions
K3g	Hallucinations
K3h	Problem Conditions — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

K3h None of the Above must be coded 1 when all of K3a to K3g are coded 0 (*No*).

K3h None of the Above must be coded 0 if any of K3a to K3g are coded 1 (*Yes*).

K4a Pain Frequency

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	No pain
1	Less than daily
2	Daily — one period
3	Daily — multiple periods (e.g., morning and evening)

Coding instructions

See RAI-HC User's Manual for coding instructions.

K4b Pain Intensity

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	No pain
1	Mild
2	Moderate
3	Severe
4	Times when pain is horrible or excruciating

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Data element K4b must be coded 0 when K4a is coded 0 (*No pain*).

K4c Pain Disrupts Usual Activities

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Data element K4c must be coded 0 when K4a is coded 0 (*No pain*).

K4d Pain — Character

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	No pain
1	Localized
2	Multiple sites

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Data element K4d must be coded 0 when K4a is coded 0 (*No pain*).

K4e Pain — Adequate Medication

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	Yes or no pain
1	Medications do not adequately control pain
2	Pain present, medication not taken

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Data element K4e must be coded 0 when K4a is coded 0 (*No pain*).

K5 Falls Frequency

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5, 6, 7, 8, 9

Legend

Value	Label
0	None
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9 or more

Coding instructions

See RAI-HC User’s Manual for coding instructions.

K6 Danger of Falls

Elements

Element ID	Element name
K6a	Unsteady Gait
K6b	Limits Going Outdoors Because Afraid of Falling

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

K7 Lifestyle (Drinking/Smoking)

Elements

Element ID	Element name
K7a	Client Felt/Was Advised to Reduce Drinking/Smoking
K7b	Client Had to Have Drink First Thing in A.M./Was in Trouble Due to Drinking
K7c	Client Smoked/Chewed Tobacco Daily

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

K8 Health Status Indicators

Elements

Element ID	Element name
K8a	Client Feels He/She Has Poor Health
K8b	Unstable Condition, ADL, Mood or Behaviour
K8c	Flare-Up of a Recurrent or Chronic Problem
K8d	Treatment Changed in Last 30 Days
K8e	Prognosis of Less Than Six Months to Live
K8f	Health Status — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

K8f None of the Above must be coded 1 when all of K8a to K8e are coded 0 (*No*).

K8f None of the Above must be coded 0 if any of K8a to K8e are coded 1 (*Yes*).

K9 Other Status Indicators

Elements

Element ID	Element name
K9a	Fearful of Family Member/Caregiver
K9b	Unusually Poor Hygiene
K9c	Unexplained Injuries, Broken Bones, Burns
K9d	Neglected, Abused
K9e	Physically Restrained
K9f	Other Status — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

K9f None of the Above must be coded 1 when all of K9a to K9e are coded 0 (*No*).

K9f None of the Above must be coded 0 if any of K9a to K9e are coded 1 (*Yes*).

L1 Weight

Elements

Element ID	Element name
L1a	Weight Loss
L1b	Severe Malnutrition (Cachexia)
L1c	Morbid Obesity

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

L2 Consumption

Elements

Element ID	Element name
L2a	One or Fewer Meals a Day
L2b	Noticeable Decrease in Amount of Food or Fluids Consumed
L2c	Insufficient Fluid
L2d	Enteral Tube Feeding

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

L3 Swallowing

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	Normal
1	Requires diet modification to swallow solid foods
2	Requires modification to swallow solid foods and liquids
3	Combined oral and tube feeding
4	No oral intake (NPO)

Coding instructions

See RAI-HC User's Manual for coding instructions.

M1 Oral Status

Elements

Element ID	Element name
M1a	Problem Chewing
M1b	Dry Mouth
M1c	Problem Brushing Teeth/Dentures
M1d	Oral Status — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

M1d None of the Above must be coded 1 when all of M1a to M1c are coded 0 (*No*).

M1d None of the Above must be coded 0 if any of M1a to M1c are coded 1 (*Yes*).

N1 Skin Problems

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

N2 Ulcers

Elements

Element ID	Element name
N2a	Pressure Ulcer
N2b	Stasis Ulcer

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	No ulcer
1	Ulcers include any area of persistent skin redness (stage 1)
2	Partial loss of skin layers (stage 2)
3	Deep craters in the skin (stage 3)
4	Breaks in skin exposing muscle or bone (stage 4)

Coding instructions

See RAI-HC User’s Manual for coding instructions.

N3 Other Skin Problems Requiring Treatment

Elements

Element ID	Element name
N3a	Burns
N3b	Open Lesions (Other Than Ulcers)
N3c	Skin Tears/Cuts
N3d	Surgical Wound
N3e	Corns, Calluses, Structural Problems, Infections, Fungi
N3f	Skin Problems — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

N3f None of the Above must be coded 1 when all of N3a to N3e are coded 0 (*No*).

N3f None of the Above must be coded 0 if any of N3a to N3e are coded 1 (*Yes*).

N4 Prior Pressure Ulcer

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

N5 Wound/Ulcer Care

Elements

Element ID	Element name
N5a	Antibiotics
N5b	Dressings
N5c	Surgical Wound Care
N5d	Other Wound/Ulcer Care
N5e	Wound Care — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

N5e None of the Above must be coded 1 when all of N5a to N5d are coded 0 (*No*).

N5e None of the Above must be coded 0 if any of N5a to N5d are coded 1 (*Yes*).

O1 Home Environment

Elements

Element ID	Element name
O1a	Lighting
O1b	Floor/Carpeting
O1c	Bathroom/Toilet
O1d	Kitchen
O1e	Heating/Cooling
O1f	Personal Safety
O1g	Access to Home
O1h	Access to Rooms in House
O1i	Home Environment — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

O1a to O1h are mandatory if X70 Location of Assessment = 1 or if X70 Location of Assessment = 2, 3 or 4 and the number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90.

In Ontario, O1a, O1b and O1h are mandatory only if X70 Location of Assessment = 1.

O1i None of the Above must be coded 1 when all of O1a to O1h are coded 0 (*No*).

O2a Client Lives With Others

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

O2b Client or Primary Caregiver Feels Client Be Better Off in Another Living Arrangement

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	No
1	Client only
2	Caregiver only
3	Client and caregiver

Coding instructions

See RAI-HC User's Manual for coding instructions.

P1–A Formal Care: Number of Days

Elements

Element ID	Element name
P1aA	Home Health Aides — Days
P1bA	Visiting Nurses — Days
P1cA	Homemaking Services — Days
P1dA	Meals — Days
P1eA	Volunteer Services — Days
P1fA	Physical Therapy — Days
P1gA	Occupational Therapy — Days
P1hA	Speech Therapy — Days
P1iA	Day Care or Day Hospital — Days
P1jA	Social Worker in Home — Days

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5, 6, 7

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

In all provinces except Ontario, P1aA to P1jA must contain valid values if X70 Location of Assessment = 1. Otherwise, P1fA, P1gA, P1hA and P1jA are mandatory (for new or correction records).

In Ontario, P1aA to P1jA must contain valid values if X70 Location of Assessment = 1.

P1iA must be greater than 0 if P2r = 1 or 2 **and** X70 Location of Assessment = 1.

P1iA must be greater than 0 if P2q = 1 or 2 **and** X70 Location of Assessment = 1

P1iA must be coded 0 if P2q = 0 or 3 **and** P2r = 0 or 3 **and** X70 Location of Assessment = 1.

P1–A Formal Care: Number of Days must be coded 1 or more when P1–B Formal Care: Hours and/or P1–C Formal Care: Mins ("minutes") are coded.

P1–A Formal Care: Number of Days must be coded 0 when both P1–B Formal Care: Hours and P1–C Formal Care: Mins are coded 0.

P1–B Formal Care: Hours

Elements

Element ID	Element name
P1aB	Home Health Aides — Hours
P1bB	Visiting Nurses — Hours
P1cB	Homemaking Services — Hours
P1dB	Meals — Hours
P1eB	Volunteer Services — Hours
P1fB	Physical Therapy — Hours
P1gB	Occupational Therapy — Hours
P1hB	Speech Therapy — Hours
P1iB	Day Care or Day Hospital — Hours
P1jB	Social Worker in Home — Hours

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N, NN, NNN
Min length	1
Max length	3
Justification	Left
Valid values	0–999

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

In all provinces except Ontario, P1aB to P1eB and P1iB must contain valid values if X70 Location of Assessment = 1. P1fB to P1hB and P1jB are mandatory (for new or correction records).

In Ontario, P1aB to P1jB must contain valid values if X70 Location of Assessment = 1.

P1–C Formal Care: Mins

Elements

Element ID	Element name
P1aC	Home Health Aides — Mins
P1bC	Visiting Nurses — Mins
P1cC	Homemaking Services — Mins
P1dC	Meals — Mins
P1eC	Volunteer Services — Mins
P1fC	Physical Therapy — Mins
P1gC	Occupational Therapy — Mins
P1hC	Speech Therapy — Mins
P1iC	Day Care or Day Hospital — Mins
P1jC	Social Worker in Home — Mins

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N, NN
Min length	1
Max length	2
Justification	Left
Valid values	0–99

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

In all provinces except Ontario, P1aC to P1eC and P1iC must contain valid values if X70 Location of Assessment = 1. P1fC to P1hC and P1jC are mandatory (for new or correction records).

In Ontario, P1aC to P1jC must contain valid values if X70 Location of Assessment = 1.

P2a–P2z Special Treatments, Therapies, Programs

Elements

Element ID	Element name
P2a	Oxygen
P2b	Respirator for Assistive Breathing
P2c	All Other Respiratory Treatments
P2d	Alcohol/Drug Treatment Program
P2e	Blood Transfusion(s)
P2f	Chemotherapy
P2g	Dialysis
P2h	Infusion — Central IV
P2i	Infusion — Peripheral IV
P2j	Medication by Injection
P2k	Ostomy Care
P2l	Radiation
P2m	Tracheostomy Care
P2n	Exercise Therapy
P2o	Occupational Therapy
P2p	Physical Therapy
P2q	Day Centre
P2r	Day Hospital
P2s	Hospice Care
P2t	Physician or Clinic Visit
P2u	Respite Care
P2v	Daily Nurse Monitoring
P2w	Nurse Monitoring Less Than Daily
P2x	Medical Alert Bracelet or Electronic Security Alert
P2y	Skin Treatment
P2z	Special Diet

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	Not applicable
1	Scheduled, full adherence as prescribed
2	Scheduled, partial adherence
3	Scheduled, not received

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

An unchecked box is coded 0 (*Not applicable*).

P2aa Special Treatment — None of the Above

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

A checked box is submitted as code 1 (*Yes*) and an unchecked box is submitted as code 0 (*No*).

P2aa None of the Above must be coded 1 when all of P2a to P2z are coded 0 (*No*).

P2aa None of the Above must be coded 0 if any of P2a to P2z are coded 1 (*Yes*).

P3 Management of Equipment

Elements

Element ID	Element name
P3a	Oxygen
P3b	IV
P3c	Catheter
P3d	Ostomy

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4

Legend

Value	Label
0	Not used
1	Managed on own
2	Managed on own if laid out or with verbal reminders
3	Partially performed by others
4	Fully performed by others

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

P3a to P3d are mandatory if X70 Location of Assessment = 1.

P4 Visits in Last 90 Days (or Since Last Assessment)

Elements

Element ID	Element name
P4a	Number of Overnight Hospital Admissions
P4b	Number of ER Visits Without an Overnight Stay
P4c	Emergent Care

Records and submission status

Submitted on	Condition
RAI-HC Assessment	P4a–P4b: Mandatory for new or correction records P4c: Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5, 6, 7, 8, 9

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

P4c is mandatory for all provinces except Ontario. In Ontario, P4c is mandatory if X70 Location of Assessment = 1.

P5 Treatment Goals

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if X70 Location of Assessment = 1

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User’s Manual for coding instructions.

P6 Overall Change in Care Needs

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2

Legend

Value	Label
0	No change
1	Improved — receives fewer supports
2	Deteriorated — receives more support

Coding instructions

See RAI-HC User's Manual for coding instructions.

P7 Trade Offs

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory under other conditions

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Data element P7 must not be blank.

In Ontario, mandatory only if X70 Location of Assessment = 1.

Q1 Number of Medications

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3, 4, 5, 6, 7, 8, 9

Legend

Value	Label
0	None
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9 or more

Coding instructions

See RAI-HC User's Manual for coding instructions.

Q2 Receipt of Psychotropic Medication

Elements

Element ID	Element name
Q2a	Antipsychotic/Neuroleptic
Q2b	Anxiolytic
Q2c	Antidepressant
Q2d	Hypnotics or Analgesics

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	No
1	Yes

Coding instructions

See RAI-HC User's Manual for coding instructions.

Q3 Medical Oversight

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if X70 Location of Assessment = 1

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1

Legend

Value	Label
0	Discussed with at least one physician (or no medication taken)
1	No single physician reviewed all medications

Coding instructions

See RAI-HC User's Manual for coding instructions.

Q4 Compliance/Adherence With Medications

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory if • X70 Location of Assessment = 1; **or** • X70 Location of Assessment = 2, 3 or 4 **and** number of days between X71 Facility Admission Date and A1 Assessment Reference Date is less than 90

Representation

Data type	Numeric
Layout	N
Min length	1
Max length	1
Justification	None
Valid values	0, 1, 2, 3

Legend

Value	Label
0	Always compliant
1	Compliant 80% of time or more
2	Compliant less than 80% of time, including failure to purchase prescribed medications
3	No medications prescribed

Coding instructions

See RAI-HC User’s Manual for coding instructions.

Q5a Medication Name

Records and submission status

Submitted on	Condition
Medication	Mandatory if X41 (DIN) is blank

Representation

Data type	String
Layout	String
Min length	1
Max length	200
Justification	Left
Valid values	1 to 200 string characters

Coding instructions

See RAI-HC User’s Manual for coding instructions.

Submission instructions

Q5a is mandatory (for new and correction records) when the DIN (X41) of the medication is not submitted. If the DIN is collected, Q5a is optional.

Q5b Medication Dose

Records and submission status

Submitted on	Condition
Medication	Mandatory for new or correction records

Representation

Data type	String
Layout	String
Min length	1
Max length	20
Justification	Left
Valid values	1 to 20 string characters

Coding instructions

See RAI-HC User's Manual for coding instructions.

Q5c Medication Form

Records and submission status

Submitted on	Condition
Medication	Mandatory for new or correction records

Representation

Data type	Numeric
Layout	N, NN
Min length	1
Max length	2
Justification	Left
Valid values	1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Legend

Value	Label
1	By mouth (PO)
2	Sublingual (SL)
3	Intramuscular (IM)
4	Intravenous (IV)
5	Subcutaneous (SQ)
6	Rectal (R)
7	Topical
8	Inhalation
9	Enteral tube
10	Other

Coding instructions

See RAI-HC User's Manual for coding instructions.

Q5d Medication Frequency

Records and submission status

Submitted on	Condition
Medication	Mandatory for new or correction records

Representation

Data type	Alphanumeric
Layout	AAA
Min length	1
Max length	3
Justification	Left
Valid values	See Legend

Legend

Value	Label
PRN	As necessary
QH	Every hour
Q2H	Every two hours
Q3H	Every three hours
Q4H	Every four hours
Q6H	Every six hours
Q8H	Every eight hours
QD	Once daily
HS	Bedtime
BID	Two times daily (includes every 12 hrs)
TID	Three times daily
QID	Four times daily
5D	Five times daily

Value	Label
QOD	Every other day
QW	Once each week
2W	Two times every week
3W	Three times every week
4W	Four times every week
5W	Five times every week
6W	Six times every week
1M	Once every month
2M	Twice every month
C	Continuous
O	Other

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Alpha characters must be uppercase.

Q5e Medication Dose in Last 7 Days

Records and submission status

Submitted on	Condition
Medication	Mandatory if Q5d = PRN

Representation

Data type	Numeric
Layout	NN
Min length	1
Max length	2
Justification	Left
Valid values	0–99

Coding instructions

See RAI-HC User's Manual for coding instructions.

Submission instructions

Data element Q5e must contain a valid value when Q5d is coded PRN; otherwise, it must be blank.

R1c Date Assessment Coordinator Signed as Complete

Records and submission status

Submitted on	Condition
RAI-HC Assessment	Mandatory for new or correction records

Representation

Data type	Date
Layout	YYYYMMDD
Min length	8
Max length	8
Justification	None
Valid values	Valid date

Coding instructions

See RAI-HC User's Manual for coding instructions.

Chapter 8 — Data submission requirements

Introduction

This chapter provides details of the data and record submission specifications organizations and vendors must use when they develop data collection and/or submission software for HCRS. It includes

- Data submission requirements;
- Technical requirements;
- Submission process;
- Testing process; and
- Data record layouts for ASCII submissions.

Data submission information

HCRS combines data from multiple sources, including the RAI-HC assessment. As a result, the data to be submitted to CIHI (as specified in this chapter) may not always be in the same format or structure as it was when collected by the organization. Data may be extracted or mapped from an organization's existing information systems.

The RAI-HC form (as specified in the RAI-HC User's Manual) contains additional data elements that are to be collected during the assessment but are not submitted to CIHI (e.g., names of informal caregivers). Chapter 3 — Data element specifications provides details of where the format of individual data elements as they are to be submitted to CIHI are different from how they are displayed on the RAI-HC form (e.g., BB2a Birth Date).

As a general CIHI policy, enhancements and modifications to data element specifications and the validation and edit rules will be implemented at the beginning of a fiscal year. Organizations and vendors are notified in advance of any enhancements or changes that must be applied to their software.

CIHI requires that all data be edited at the source to ensure that all elements are completed and that records are submitted in the correct format.

Transmissions will only be accepted from organizations whose vendor has successfully completed CIHI's testing process by submitting a test file prepared using the software developed for HCRS and deployed within the organization. Submitting organizations will also need to complete submission tests before their transmissions are accepted by CIHI.

Detailed submission requirements

Usually, the organization that is responsible for collecting HCRS information (referred to as a source organization) will submit data to CIHI directly.

HCRS does allow for data from a source organization to be submitted by another organization (e.g., provincial ministry of health). The data flow from a source organization to CIHI is controlled by the Organization Profile record (of the source organization and, if applicable, of the third-party submission organization) and the Provincial Profile record.

If an organization is designated to submit data on behalf of other organizations, an individual submission file may contain records for multiple source organizations.

A submission file may contain data for multiple reporting periods. **However, it is expected that all organizations meet the specified deadlines for submitting records from each individual reporting period**. All records within a file must be submitted in the appropriate order, as specified in the section Record processing order.

All records will be edited as completely as possible to enable CIHI to inform the organization of **all** errors — when data elements are missing, coded in an invalid format or have inconsistencies within the record or with previously submitted records. ***Only* records that meet the specified level of completeness, accuracy and consistency will be accepted.**

Data that does not pass CIHI's edits and validations will be rejected; the submitting organization and, if applicable, the source organization will be notified of the errors encountered.

Correction and resubmission of records that were previously rejected is the responsibility of the organizations collecting and submitting the data.

An email notification confirming receipt and processing of the file will be sent to the relevant organizations' database contact (as specified in the Contact Information records).

Both submission and source organizations will be able to view their submission reports online. When submission files contain data for multiple source organizations, individual submission reports will be produced for each source organization. The submission organization will be able to view reports for all data it submitted; the individual source organizations will have access to only their own submission reports.

Submission process

Annual submissions

CIHI must receive certain records at the beginning of each fiscal year **before** any client-specific data from an organization can be submitted and processed:

Organization Profile

- An Organization Profile record must be received before any client-specific data can be submitted by or for an organization. For example, if a provincial ministry of health is submitting data on behalf of a source organization, CIHI must have an Organization Profile record for both the ministry (submission organization) and the source organization.

Contact Information

- Any organization submitting data directly to CIHI must submit a Contact Information record for a data submission contact.
- Submission organizations may also submit additional contacts who will receive notification of specific HCRS outputs.
- If client-specific records for a source organization are being submitted by another organization, a Contact Information record must be submitted if the source organization wishes to receive automatic notifications of any HCRS outputs, including submission reports.

Provincial Profile

- A Provincial Profile record is submitted by the provincial or territorial ministry. This record sets some of the parameters determining how all client-specific data from the province or territory is to be processed for a given fiscal year.

These records must be submitted and accepted before any client-specific data is submitted. Any submission file name containing these types of records should have a submission period = 00.

Organization Profile and Contact Information records will be maintained at CIHI for the purposes of processing data and communicating with organizations.

Note: Changes to these records can be made throughout the year by submitting corrections to the original record.

Submission of client-specific records

There are 10 client-specific record types that reflect the different events that occur during the time a person receives home care services. Details of these records are provided in the section Detailed data requirements.

Each fiscal year is divided into a number of reporting periods (4, 12 or 13) with specified beginning and end dates that are used for the purpose of reporting data. Each event (or series of events) that occurs — and therefore each client record that is created — is related to a reporting period.

Submission of historical Admission records

Historical Admission records from multiple reporting periods and fiscal years can be submitted in quarterly submission files. The submission file date should be within the current reporting period and fiscal year.

It is recommended that client-specific records be submitted on a regular basis to meet the submission deadlines for each reporting period.

On every submission file

A Submission Profile record must be present at the start of each submission file. (In the case of an XML file, the Submission Profile record is referred to as the Submission Profile element.) This is to ensure that a full transmission has been received at CIHI. Partial transmissions, where the record count does not match the total count on the Submission Profile record, will be rejected in their entirety without any further validation.

Other checks on the file are carried out that may also result in the file being rejected in its entirety without further validation (e.g., a missing or invalid value in data element Y2).

Timeliness of submissions

Submission deadlines for records relating to a given reporting period will be set on a provincial/territorial basis through agreement between CIHI and the respective provincial or territorial ministry of health.

Data submissions, including the correction of any errors, must be completed within these fixed time periods so CIHI can generate and publish reports in a timely fashion.

Data for a particular reporting period may be submitted in 1 or more files on a daily, weekly or other basis during the reporting period itself and up to the submission deadline for that reporting period.

Failure to submit data by the specified deadlines may result in that data not being included in reports produced for that reporting period.

Technical requirements

File format

HCRS will accept data in ASCII and XML formats.

Submission files must be submitted in a zipped format, as this will significantly reduce transmission times. Zipped files must have a .zip extension.

File-naming conventions

File names must be standardized to facilitate the receipt and processing of HCRS data. This file-naming convention must be adhered to or the file will not be accepted or processed. If the file name does not meet the specifications outlined below, the submitting organization will be notified either through electronic Data Submission Services (eDSS) notification or by CIHI staff. This naming convention will be strongly enforced.

The associated database identifier, organization identifier, fiscal year and submission period are embedded within the naming convention.

The file name will be in the following format:

HCRyyyypphhhhhsss.zip

HCR = Home Care Reporting System

yyyy = Fiscal year

pp = Submission period (00 to 13; see below)

hhhhh = Submission Organization Identifier (CIHI-assigned value for data element Z1b)

sss = Submission sequence number (001, 002, 003, etc.)

Fiscal year

Data for different fiscal years must be submitted in separate files. The file must be named appropriately (e.g., 2012 for fiscal year 2012–2013).

Submission period

Depending on the submission schedule agreed with your province or territory, the following values for the submission period should be used. Please note that non-client records (Organization Profile, Contact Information, Provincial Profile) should have a value of 00:

Number of submission periods

13 (periods)	12 (monthly)	4 (quarterly)	1 (annual)	Value
Period 1	April	Quarter 1	Annual	01
Period 2	May	Quarter 1	—	02
Period 3	June	Quarter 1	—	03
Period 4	July	Quarter 2	—	04
Period 5	August	Quarter 2	—	05
Period 6	September	Quarter 2	—	06
Period 7	October	Quarter 3	—	07
Period 8	November	Quarter 3	—	08
Period 9	December	Quarter 3	—	09
Period 10	January	Quarter 4	—	10
Period 11	February	Quarter 4	—	11
Period 12	March	Quarter 4	—	12
Period 13	—	—	—	13

Submission sequence number

This sequence number is important as it used by CIHI to process the files in order.

It is recommended that the submission sequence number used in the file names be set to 001 at the beginning of each submission period.

It is important that a submission sequence number be used only once within each submission period. If 2 files are submitted with the same file name, 1 of 2 things will happen, depending on the earlier file's processing status:

- If the earlier file has not yet been processed, the most recent file will overwrite the earlier file, leading to the loss of the data; or
- If the earlier file has already been processed, the most recent file will be rejected because of the duplicate file name.

File extension

Files must be submitted in a zipped format and must have a .zip extension. Once unzipped, the files must have the appropriate file extension that reflects the format of the data: .txt for ASCII submissions or .xml for XML submissions.

Due to CIHI's standard file-naming conventions, vendors must develop HCRS software to support long file names.

File characteristics

Data will be submitted in either a single ASCII file containing variable record length formats as specified in the section Detailed data requirements or in an XML file that conforms to the HCRS Submission XML Schema.

For submitted ASCII files, a Submission Profile record is the first record in the file. The layout for this record is provided in the section Detailed data requirements. Its function is to ensure that a full transmission has been received at CIHI.

For submitted XML files, the data is divided into the Submission Profile and Submission Contents elements. The Submission Profile holds the control information for the file and the Submission Contents contain both the client-specific and non-client (e.g., Organization Profile) records. Additional details regarding the XML structure can be found in the HCRS Submission XML Schema and related documentation.

Record processing order

Records are processed in the order they are received. It is therefore essential that the records be submitted in accordance with the following specifications.

All client-specific records should be submitted chronologically and in order of occurrence for each client per home care service episode to avoid possible errors and rejections.

A home care service episode is identified by a unique combination of X1b Source Organization Unique Client Identifier and CC1 Date Case Opened/Reopened, which are submitted on an Admission record. All other client records must be associated with a home care service episode through a common X1b and CC1. Therefore, an Admission record must be submitted before any other records for that home care service episode can be accepted.

In addition, the state of the home care service episode is tracked and enforced by HCRS in the following ways:

- An Admission record opens a service episode and a Discharge record closes it.
- Only 1 Admission record and 1 Discharge record will be accepted per episode.
- A Discharge record closes an episode before a subsequent Admission record opens a new episode.
- An episode can have multiple RAI-HC Assessment records associated with it, as long as A1 Assessment Reference Date and A2 Reason for Assessment for each record are unique.
- 2 RAI-HC Assessment records for the same A1 Assessment Reference Date will be accepted only if the second record has A2 Reason for Assessment = 8 (*Inter-rater reliability*).
- Medication records must be associated with a RAI-HC Assessment record through a common A1 Assessment Reference Date and A2 Reason for Assessment.
- Multiple Medication records can be associated with a RAI-HC Assessment record as long as X40 Medication Sequence Number for each record is unique.
- Within an episode, information about the client's resource utilization can be submitted by the individual services provided. An individual service is identified through a unique combination of X11 Service Type and X12 Home Care Discipline.
- An individual service can start and stop. A service is started by a Service Start record and stopped by a Service End record.
- Multiple services can be started within an episode, as long as X11 Service Type, X12 Home Care Discipline and X10 Service Start Date for each Service Start record is unique.
- Service Details and Service End records must be associated with a Service Start record through a common X11 Service Type, X12 Home Care Discipline and X10 Service Start Date.
- Service Details records can be submitted only for reporting periods in which an individual service is active (i.e., between the service start and service end dates).
- Multiple Service Details records for an active service can be submitted for a reporting period as long as X13 Service Delivery Setting and X14 Acute Services Flag for each record are unique.
- An individual service can stop and restart throughout the episode by submitting a Service End record and then submitting a Service Start record with the same X11 Service Type and X12 Home Care Discipline but with a different X10 Service Start Date.
- Individual services should stop and restart if a client is reassigned to a new Client Group (identified through the submission of an Update Client Profile record with X50 Element to Be Updated = 4).

- Event dates (Date Case Opened/Reopened, Assessment Reference Date, Service Start, Service End and Discharge Date) will be scrutinized closely to ensure that the integrity of the episode is maintained.

If a data file contains multiple records for a client's home care service episode, the records should be submitted in the following order:

- Admission (Y2 Record Type = AD)
- Home care service utilization records (Y2 Record Type = SS, SD and SE), sorted by X10 Service Start Date, X11 Service Type and X12 Home Care Discipline, then by Y2 Record Type = SS then SD then SE
- Update Client Profile (Y2 Record Type = UC), sorted by X51 Element Effective Date
- Assessment records (Y2 Record Type = RH and MD), sorted by A1 Assessment Reference Date, A2 Reason for Assessment and then Y2 Record Type = RH then Y2 = MD
- ER Visits (Y2 Record Type = ER)
- Organization Client Transfer (Y2 Record Type = OT)
- Discharge (Y2 Record Type = DC)

Records relating to the same home care service episode must be deleted in the reverse order that they were submitted. For example, all Medication records must be deleted prior to the associated RAI-HC Assessment record. Similarly, the Service End and all Service Details records must be deleted prior to the associated Service Start record. All records associated with a given home care service episode must be deleted prior to the deletion of an Admission record.

If an organization is submitting a file containing data for multiple source organizations, the file should be sorted so that all records for a source organization are submitted together.

Types of record submissions

There are 3 types of submissions — new, correction and deletion. On each record, the data element Y3 identifies the submission type as follows:

N = new

C = correction

D = deletion

The values submitted for Y3 must be uppercase.

Note: Correction and/or deletion records cannot be submitted within the same submission file as a new record.

For deletion records in ASCII submission files, data elements not used for the deletion processing will be ignored and not validated. For XML submissions, these data elements are not present in the schema structure for the deletion submission type.

It is imperative that the data element Y1 Unique Record ID assigned for a record remains unchanged throughout the entire process: Y1 is used within the CIHI database to identify which record needs to be corrected or deleted.

Unique Record ID

Data element Y1 Unique Record ID is a mandatory part of each record and must uniquely identify a record of a given type (Y2 Record Type) from a given source organization (identified by data element Z1a).

Submission reports provided by CIHI will identify records by the Unique Record ID, and subsequent corrections and deletions to these records must be resubmitted with the same Unique Record ID.

Once assigned, the Unique Record ID must never change. This includes all client and non-client record types.

Examples of records submitted for Client X:

File sequence number	Y1 Unique Record ID	Y2 Record Type	Y3 Submission Type
001	45	AD — Admission	N — New
001	65	RH — RAI-HC Assessment	N — New
001	66	MD — Medication	N — New
001	102	SS — Service Start	N — New
002	66	MD — Medication	C — Correction
002	425	SD — Service Details	N — New
002	498	SE — Service End	N — New
002	597	DC — Discharge	N — New
003	597	DC — Discharge	D — Deletion

Note: Each unique record can be submitted only once per submission file. Correction and/or deletion records cannot be submitted within the same submission file as a new record.

Submission protocols — electronic Data Submission Services

In order to satisfy national, provincial and territorial privacy legislation, CIHI is offering a single method for transmission of electronic HCRS files to CIHI via the internet. An organization must have the ability to connect to the internet using a browser such as Microsoft Internet Explorer or Firefox. To help both organizations and vendors understand the scope of choice, and to drill down to CIHI's detailed requirements, the following overview is provided.

The eDSS method of transmission provides security that meets corporate and industry standards through the use of

- Secure encrypted protocols during file upload and transfer from the client's machine to CIHI's servers in a secure area zone (SAZ);
- Encryption of any temporary data residing on CIHI's web server files within the demilitarized zone (DMZ);
- Fail-over and fault-tolerance capabilities that automatically remove any temporary encrypted files in the DMZ; and
- Restricted system access to only those users who have been authorized and authenticated.

This method includes file identification information used to check that there is a match to the file name. **Note:** The use of the standard naming convention is mandatory and must be adhered to strictly — including sequence numbers.

The eDSS user receives a message indicating that the file was submitted successfully. It should be noted that this indicates the file was successfully transferred to CIHI; it does not indicate that the file has been processed by the HCRS system (i.e., passed through all the HCRS edits and validations).

Transmission of data can occur 24 hours a day, 7 days a week. Once the initial set-up has been put into place, organizations can submit data to CIHI at their convenience; there is no requirement to contact CIHI to arrange transmission times.

Vendors will also be provided with application access codes so that they may submit test files using this protocol.

XML submissions

File validity

XML submissions must be well-formed and valid according to the HCRS Submission XML Schema (HCRSSubmission.xsd). XML submissions that are not well-formed or that are invalid will not be processed and must be corrected prior to resubmission with a new submission sequence number.

Root element

The Schema Location attribute of the root element start tag of the HCRS Submission XML Schema instance document must not contain any specific file directory information; otherwise, the file will not be processed. The expected format of the root element start tag is

<HCRSSubmission xmlns="http://www.cihi.ca/HCRS/*x.y*"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"

xsi:schemaLocation="http://www.cihi.ca/HCRS/*x.y*HCRSSubmission.xsd">

where *x.y* is the current version number of the XML schema.

Submission type

Deletion submission type records are structured differently from new or correction records. For deletion records, only the Record Key elements are present (not the Record Attribute elements).

For example, a new or correction Admission record element contains the sequence of

- Key elements (AdmissionKeyElements);
- New or correction elements (AdmissionNewOrCorrectionElements), which contains the sequence of
  - Submission Type element (SubmissionType with the value of N or C); and
  - Attribute elements (AdmissionAttributeElements).

An Admission deletion record element contains the sequence of

- Key elements (AdmissionKeyElements); and

Submission Type element (SubmissionType with the value of D).

Optional elements

An optional element with blank data should be represented by an empty string. For example, an empty element Z1c Organization Effective Date should **not** be submitted as <OrganizationEffectiveDate></OrganizationEffectiveDate>.

Testing process

CIHI's policy is to accept only pre-edited data that passes all HCRS validations and edits. Therefore, before any live data will be accepted at CIHI, an organization's vendor must have successfully completed the standard testing process.

A maximum of 3 test submissions will be accepted at no charge. Any further test submissions will incur a charge.

Additionally, as part of the Vendor Subscription Service, CIHI expects vendors to submit at least 1 test file annually.

Note: Until a vendor has submitted a successful test, CIHI will not accept any organization test files. (The definition of a successful test is demonstrated ability to submit new, correction and deletion records and to resubmit rejected records with an ultimate result that demonstrates that all of CIHI's validation rules have been applied at the source.)

If a vendor wishes to use an organization as a beta site, the vendor needs to notify CIHI in writing. In this instance, the test will fulfil both the vendor and organization tests. As part of the Vendor Subscription Service, CIHI will accept 3 test submissions annually at no charge.

If an organization has multiple vendors, each vendor must successfully complete the CIHI testing process. Some organizations may have a vendor that is responsible for submitting only certain record types (such as RAI-HC Assessment and Medication records). In these cases, the vendors need to test only those types of records. If an organization has developed its own HCRS software (for some or all of its HCRS submissions), submissions from this software will be tested when organization test files are submitted.

Each test file should contain sufficient test records to enable CIHI to provide good feedback to the vendor. (It is recommended that a sufficient number of records be submitted for each type of record the vendor software is responsible for submitting.)

This process tests the Submission Profile record, file format and file size; it also performs a full edit test on the file. Feedback (i.e., rejection file and submission report) is provided to the vendors outlining the problem areas where changes are required. CIHI staff does a minimal amount of analysis of the report and supports the vendor throughout the development process.

Vendors are expected to test the resubmission process (i.e., submitting only those records that were rejected on the previous test) and to submit some correction and deletion records for records previously accepted in the first test file.

CIHI recognizes that a vendor may simply correct the test data to bypass the CIHI edits (i.e., no rejected records during the vendor testing phase) rather than ensure that the edits programmed within the software are accurate. Vendor names will be posted on CIHI's website following a successful test. However, if data submitted during the organization testing phase does not successfully pass the HCRS edits and validations, CIHI reserves the right to remove the vendor's name from the website.

During the test phase, vendors are encouraged to direct all technical and content queries to their vendor support representative, who will refer content-related queries to the HCRS support representative.

Detailed data requirements

There are 14 different types of record that can be submitted to HCRS; they are distinguished by the data element Y2 Record Type, which is submitted on every record. There are 10 record types for the submission of client-specific data. The remaining 4 non-client record types are required for the appropriate processing of client-specific records from the different organizations submitting to HCRS.

For submission in ASCII format, each record type has a unique, fixed-width column layout and must be of the length specified below. If data elements do not contain data or contain values with a length less than the maximum length, the data element must be padded with spaces to ensure that subsequent data elements are in the correct columns and the record is the appropriate length.

Non-client records

Record type		Length
SP	Submission Profile	60 bytes
OP	Organization Profile	242 bytes
CI	Contact Information	163 bytes
PP	Provincial Profile	104 bytes

Client records

Record type		Length
AD	Admission	126 bytes
UC	Update Client Profile	105 bytes
RH	RAI-HC Assessment	473 bytes
MD	Medication	321 bytes
SS	Service Start	88 bytes
SD	Service Details	103 bytes
SE	Service End	96 bytes
ER	ER Visits	77 bytes
DC	Discharge	87 bytes
OT	Organization Client Transfer	88 bytes

ASCII format record layouts

SP Submission Profile record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	SP	String	Left	21	2	2
Z1b	Submission Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	23	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	28	8	8
Y10y	Data Submission Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	36	5	5
Z6	Province	Always mandatory	NL, PE, NS, NB, QC, ON, MB, SK, AB, BC, YT, NT, NU	Alphanumeric	None	41	2	2

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y11	Date of Submission	Always mandatory	YYYYMMDD, valid date	Date	None	43	8	8
Y12	Reporting Fiscal Year	Always mandatory	YYYY	Year	None	51	4	4
Y14	Number of Records in Transmission File	Always mandatory	0–999999	Numeric	Left	55	1	6

OP Organization Profile record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	OP	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1	Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Z2	Organization Name	Mandatory for new or correction records		String	Left	37	5	50
Z3	Organization Address Line 1	Mandatory for new or correction records		String	Left	87	5	50
Z4	Organization Address Line 2	Optional		String	Left	137	5	50
Z5	Organization City/Town	Mandatory for new or correction records		String	Left	187	3	20

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Z7	Organization Postal Code	Mandatory for new or correction records	ANANAN, first character must not = D, F, I, O, Q, U, W	Alphanumeric	None	207	6	6
Z8	Organization Roles	Mandatory for new or correction records	1, 2, 3, 4, 5, 6, 7	Numeric	None	213	1	1
Z9	Provincial/ Territorial Ministry	Mandatory for new or correction records	0, 1	Numeric	None	214	1	1
Z10a	Contact/ Reporting in English	Mandatory for new or correction records	0, 1	Numeric	None	215	1	1
Z10b	Contact/ Reporting in French	Mandatory for new or correction records	0, 1	Numeric	None	216	1	1
Y10a	Vendor Code 1	Mandatory for new or correction records	Assigned by CIHI to each vendor	Alphanumeric	None	217	5	5
Y10b	Vendor Code 2	Optional	Assigned by CIHI to each vendor	Alphanumeric	None	222	5	5
Y10c	Vendor Code 3	Optional	Assigned by CIHI to each vendor	Alphanumeric	None	227	5	5
Y10d	Vendor Code 4	Optional	Assigned by CIHI to each vendor	Alphanumeric	None	232	5	5
Y10e	Vendor Code 5	Optional	Assigned by CIHI to each vendor	Alphanumeric	None	237	5	5

CI Contact Information record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	CI	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1	Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Z20	Contact Name	Mandatory for new or correction records		String	Left	37	5	50
Z21	Contact Telephone Number	Mandatory for new or correction records		Numeric	None	87	10	10
Z22	Contact Telephone Extension Number	Optional		Numeric	Left	97	1	6
Z23	Contact Fax Number	Optional		Numeric	None	103	10	10
Z24	Contact Email Address	Mandatory for new or correction records		String	Left	113	6	50
Z25	Contact Output Notification	Mandatory for new or correction records	1	Numeric	None	163	1	1

PP Provincial Profile record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	PP	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
ZP1	Number of Reporting Periods	Mandatory for new or correction records	4, 12, 13	Numeric	None	24	1	2
ZP2	Number of Submission Periods	Mandatory for new or correction records	1, 4, 12, 13	Numeric	None	26	1	2
ZP3	Flow of client-Specific Data to CIHI	Mandatory for new or correction records	1, 2, 3	Numeric	None	28	1	1
ZP4	Health Card Number Encryption	Mandatory for new or correction records	0, 1	Numeric	None	29	1	1
ZP5	Province-Wide Client Identifiers (X1a) — Submission Mandated	Mandatory for new or correction records	0, 1	Numeric	None	30	1	1
ZP6	Subregion Identifier — Submission Mandated	Mandatory for new or correction records	0, 1	Numeric	None	31	1	1
ZP7	Program Identifier — Submission Mandated	Mandatory for new or correction records	0, 1	Numeric	None	32	1	1
ZP10a	Referral Source for Acute Home Care Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	33	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP10b	Referral Source for End-of-Life Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	34	1	1
ZP10c	Referral Source for Rehabilitation Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	35	1	1
ZP10d	Referral Source for Long-Term Supportive Care Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	36	1	1
ZP10e	Referral Source for Maintenance Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	37	1	1
ZP11a	Acceptance Date for Acute Home Care Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	38	1	1
ZP11b	Acceptance Date for End-of-Life Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	39	1	1
ZP11c	Acceptance Date for Rehabilitation Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	40	1	1
ZP11d	Acceptance Date for Long-Term Supportive Care Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	41	1	1
ZP11e	Acceptance Date for Maintenance Client Group Mandated	Mandatory for new or correction records	0, 1	Numeric	None	42	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP12a	Primary Language for Acute Home Care Client Group Mandated for Admission Record	Mandatory for new or correction records	0, 1	Numeric	None	43	1	1
ZP12b	Primary Language for End-of-Life Client Group Mandated for Admission Record	Mandatory for new or correction records	0, 1	Numeric	None	44	1	1
ZP12c	Primary Language for Rehabilitation Client Group Mandated for Admission Record	Mandatory for new or correction records	0, 1	Numeric	None	45	1	1
ZP12d	Primary Language for Long-Term Supportive Care Client Group Mandated for Admission Record	Mandatory for new or correction records	0, 1	Numeric	None	46	1	1
ZP12e	Primary Language for Maintenance Client Group Mandated for Admission Record	Mandatory for new or correction records	0, 1	Numeric	None	47	1	1
ZP20d	Mandate for RAI Assessment of Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1, 2, 4, 9	Numeric	None	48	1	1
ZP20e	Mandate for RAI Assessment of Maintenance Client Group	Mandatory for new or correction records	0, 1, 2, 4, 9	Numeric	None	49	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP30a	Home Care Service Utilization Records — Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	50	1	1
ZP30b	Home Care Service Utilization Records — Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	51	1	1
ZP30c	Home Care Service Utilization Records — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	52	1	1
ZP30d	Home Care Service Utilization Records — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	53	1	1
ZP30e	Home CareService Utilization Records — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	54	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP31a	Service Type — Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	55	1	1
ZP31b	Service Type — Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	56	1	1
ZP31c	Service Type — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	57	1	1
ZP31d	Service Type — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	58	1	1
ZP31e	Service Type — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	59	1	1
ZP32a	Home Care Discipline — Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	60	1	1
ZP32c	Home Care Discipline — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	62	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP32d	Home Care Discipline — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	63	1	1
ZP32e	Home Care Discipline — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	64	1	1
ZP33a	Service Delivery Setting — Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	65	1	1
ZP33b	Service Delivery Setting — Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	66	1	1
ZP33c	Service Delivery Setting — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	67	1	1
ZP33d	Service Delivery Setting — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	68	1	1
ZP33e	Service Delivery Setting — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	69	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP34a	Acute Services Flag — Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	70	1	1
ZP34b	Acute Services Flag — Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	71	1	1
ZP34c	Acute Services Flag — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	72	1	1
ZP34d	Acute Services Flag — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	73	1	1
ZP34e	Acute Services Flag — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	74	1	1
ZP35a	Service Visits — Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	75	1	1
ZP35b	Service Visits — Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	76	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP35c	Service Visits — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	77	1	1
ZP35d	Service Visits — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	78	1	1
ZP35e	Service Visits — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	79	1	1
ZP36a	Minutes of Service — Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	80	1	1
ZP36b	Minutes of Service — Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	81	1	1
ZP36c	Minutes of Service — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	82	1	1
ZP36d	Minutes of Service — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	83	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP36e	Minutes of Service — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	84	1	1
ZP40a	ER Visits Records Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	85	1	1
ZP40b	ER Visits Records — Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	86	1	1
ZP40c	ER Visits Records — Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	87	1	1
ZP40d	ER Visits Records — Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	88	1	1
ZP40e	ER Visits Records — Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	89	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP52a	Referred to Other Health Services Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	100	1	1
ZP52b	Referred to Other Health Services Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	101	1	1
ZP52c	Referred to Other Health Services Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	102	1	1
ZP52d	Referred to Other Health Services Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	103	1	1
ZP52e	Referred to Other Health Services Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	104	1	1
ZP50a	Service Goals Met Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	90	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP50b	Service Goals Met Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	91	1	1
ZP50c	Service Goals Met Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	92	1	1
ZP50d	Service Goals Met Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	93	1	1
ZP50e	Service Goals Met Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	94	1	1
ZP51a	Reason for Discharge Submission Mandated for Acute Home Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	95	1	1
ZP51b	Reason for Discharge Submission Mandated for End-of-Life Client Group	Mandatory for new or correction records	0, 1	Numeric	None	96	1	1
ZP51c	Reason for Discharge Submission Mandated for Rehabilitation Client Group	Mandatory for new or correction records	0, 1	Numeric	None	97	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
ZP51d	Reason for Discharge Submission Mandated for Long-Term Supportive Care Client Group	Mandatory for new or correction records	0, 1	Numeric	None	98	1	1
ZP51e	Reason for Discharge Submission Mandated for Maintenance Client Group	Mandatory for new or correction records	0, 1	Numeric	None	99	1	1
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	AD	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2

AD Admission record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
AA3a	Health Card Number	Mandatory for new or correction records	0, 1, valid Health Card Number	Alphanumeric	Left	68	1	12
AA3b	Province/ Territory Issuing Health Card Number	Mandatory for new or correction records	NL, PE, NS, NB, QC, ON, MB, SK, AB, BC, YT, NT, NU, -50, -70, -90	Alphanumeric	Left	80	2	3
AA4	Postal Code of Residence	Mandatory for new or correction records	ANANAN, ANA, 1, 2; first character must not = D, F, I, O, Q, U, W	Alphanumeric	Left	83	1	6
BB1	Sex	Optional	M, F	Alphanumeric	None	89	1	1
BB2a	Birth Date	Mandatory for new or correction records	YYYYMM	Year–month	None	90	6	6
BB2b	Estimated Birth Date	Mandatory for new or correction records	0, 1	Numeric	None	96	1	1
BB4	Marital Status	Mandatory for new or correction records	1, 2, 3, 4, 5, 6, 9	Numeric	None	97	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
BB5a	Primary Language	Mandatory status determined by respective Provincial Profile	See Language Code document	Alphanumeric	None	98	3	3
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	101	8	8
X2	Client Group	Mandatory for new or correction records	1, 2, 3, 4, 5, 8, 9	Numeric	None	109	1	1
X3	Subregion Identifier (User-Defined)	Mandatory status determined by respective Provincial Profile	User-defined	Alphanumeric	Left	110	1	4
X4	Program Type (User-Defined)	Mandatory status determined by respective Provincial Profile	User-defined at a region level	Alphanumeric	None	114	1	3
X5	Referral Source	Mandatory status determined by respective Provincial Profile	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 99	Numeric	Left	117	1	2
X6	Date of Acceptance to Home Care	Mandatory status determined by respective Provincial Profile	YYYYMMDD, valid date	Date	None	119	8	8

UC Update Client Profile record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	UC	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	44	1	12
CC1	Date Case Opened/ Reopened	Always mandatory	YYYYMMDD, valid date	Date	None	56	8	8
X50	Element to Be Updated	Always mandatory	1, 2, 3, 4, 5, 6, 7	Numeric	None	64	1	1
X51	Element Effective Date	Mandatory for new or correction records	YYYYMMDD, valid date	date	None	65	8	8
AA4	Postal Code of Residence	Mandatory under other conditions	ANANAN, ANA, 1, 2; first character must not = D, F, I, O, Q, U, W	Alphanumeric	Left	73	1	6

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
BB4	Marital Status	Mandatory under other conditions	1, 2, 3, 4, 5, 6, 9	Numeric	None	79	1	1
BB5a	Primary Language	Mandatory under other conditions	See Language Code document	Alphanumeric	None	80	3	3
AA3a	Health Card Number	Mandatory under other conditions	0, 1, valid Health Card Number	Alphanumeric	Left	83	1	12
AA3b	Province/ Territory Issuing Health Card Number	Mandatory under other conditions	NL, PE, NS, NB, QC, ON, MB, SK, AB, BC, YT, NT, NU, -50, -70, -90	Alphanumeric	Left	95	2	3
X2	Client Group	Mandatory under other conditions	1, 2, 3, 4, 5, 8, 9	Numeric	None	98	1	1
X3	Subregion Identifier (User-Defined)	Mandatory under other conditions	User-defined	Alphanumeric	Left	99	1	4
X4	Program Type (User-Defined)	Mandatory under other conditions	User-defined at a region level	Alphanumeric	None	103	1	3

RH RAI-HC Assessment record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	RH	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
AA2	Case Record Number	Mandatory for new or correction records		Alphanumeric	Left	68	1	12
BB3	Aboriginal Identity	Mandatory under other conditions	0, 1	Numeric	None	80	1	1
BB5b	Interpreter Needed	Mandatory for new or correction records	0, 1	Numeric	None	81	1	1
BB6	Education	Mandatory under other conditions	1, 2, 3, 4, 5, 6, 7, 8, 9	Numeric	None	82	1	1
BB7a	Legal Guardian/ Substitute Decision-Maker	Mandatory for new or correction records	0, 1, 9	Numeric	None	83	1	1
BB7b	Advanced Medical Directives	Mandatory for new or correction records	0, 1, 9	Numeric	None	84	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
BB8b	Payment — Other Province/ Territory	Optional	0, 1	Numeric	None	86	1	1
BB8c	Payment — Federal Government — Veterans Affairs Canada	Optional	0, 1	Numeric	None	87	1	1
BB8d	Payment — Federal Government — First Nations and Inuit Health Branch	Optional	0, 1	Numeric	None	88	1	1
BB8e	Payment — Federal Government — Other (RCMP, Canadian Forces, Inmate, Refugee)	Optional	0, 1	Numeric	None	89	1	1
BB8f	Payment — Worker's Compensation Board	Optional	0, 1	Numeric	None	90	1	1
BB8g	Payment — Canadian Resident — Private Insurance	Optional	0, 1	Numeric	None	91	1	1
BB8h	Payment — Canadian Resident — Public Trustee	Optional	0, 1	Numeric	None	92	1	1
BB8i	Payment — Canadian Resident — Self Pay	Optional	0, 1	Numeric	None	93	1	1
BB8j	Payment — Other Country Resident — Self Pay	Optional	0, 1	Numeric	None	94	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
BB8k	Payment — Unknown/ Unavailable	Optional	0, 1	Numeric	None	95	1	1
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	96	8	8
CC2	Reason for Referral	Mandatory under other conditions	1, 2, 3, 4, 5, 6	Numeric	None	104	1	1
CC3a	Goals — Nursing Treatments	Mandatory under other conditions	0, 1	Numeric	None	105	1	1
CC3b	Goals — Monitoring	Mandatory under other conditions	0, 1	Numeric	None	106	1	1
CC3c	Goals — Rehabilitation	Mandatory under other conditions	0, 1	Numeric	None	107	1	1
CC3d	Goals — Client/Family Education	Mandatory under other conditions	0, 1	Numeric	None	108	1	1
CC3e	Goals — Family Respite	Mandatory under other conditions	0, 1	Numeric	None	109	1	1
CC3f	Goals — Palliative Care	Mandatory under other conditions	0, 1	Numeric	None	110	1	1
CC4	Time Since Last Hospital Stay	Mandatory under other conditions	0, 1, 2, 3, 4, 5	Numeric	None	111	1	1
CC5	Where Lived at Time of Referral	Mandatory under other conditions	1, 2, 3, 4, 5	Numeric	None	112	1	1
CC6	Who Lived With at Time of Referral	Mandatory under other conditions	1, 2, 3, 4, 5, 6	Numeric	None	113	1	1
CC7	Prior Residential Care Facility	Mandatory under other conditions	0, 1	Numeric	None	114	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
CC8	Residential History	Mandatory under other conditions	0, 1	Numeric	None	115	1	1
A1	Assessment Reference Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	116	8	8
A2	Reason for Assessment	Mandatory for new or correction records	1, 2, 3, 4, 5, 6, 7, 8	Numeric	None	124	1	1
X70	Location of Assessment	Mandatory for new or correction records	1, 2, 3, 4	Numeric	Left	125	1	2
X71	Facility Admission Date	Mandatory under other conditions	YYYYMMDD, valid date	Date	None	127	8	8
B1a	Short-Term Memory	Mandatory for new or correction records	0, 1	Numeric	None	135	1	1
B1b	Procedural Memory	Mandatory for new or correction records	0, 1	Numeric	None	136	1	1
B2a	Cognitive Skills — Decision Making	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	137	1	1
B2b	Cognitive Skills — Worsening Decision Making	Mandatory for new or correction records	0, 1	Numeric	None	138	1	1
B3a	Sudden or New Onset/Change in Mental Function Over Last 7 Days	Mandatory for new or correction records	0, 1	Numeric	None	139	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
B3b	In the Last 90 Days, Client Has Become Agitated or Disoriented	Mandatory for new or correction records	0, 1	Numeric	None	140	1	1
C1	Hearing	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	141	1	1
C2	Making Self Understood	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	142	1	1
C3	Ability to Understand Others	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	143	1	1
C4	Communication Decline	Mandatory for new or correction records	0, 1	Numeric	None	144	1	1
D1	Vision	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	145	1	1
D2	Visual Limitations	Mandatory for new or correction records	0, 1	Numeric	None	146	1	1
D3	Visual Decline	Mandatory for new or correction records	0, 1	Numeric	None	147	1	1
E1a	Indicators of Depression — Sad Mood	Mandatory for new or correction records	0, 1, 2	Numeric	None	148	1	1
E1b	Indicators of Depression — Anger	Mandatory for new or correction records	0, 1, 2	Numeric	None	149	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
E1c	Indicators of Anxiety — Unrealistic Fears	Mandatory for new or correction records	0, 1, 2	Numeric	None	150	1	1
E1d	Indicators of Anxiety — Repetitive Health Complaints	Mandatory for new or correction records	0, 1, 2	Numeric	None	151	1	1
E1e	Indicators of Anxiety — Repetitive Anxious Complaints	Mandatory for new or correction records	0, 1, 2	Numeric	None	152	1	1
E1f	Indicators of Sad Mood — Sad, Pained Facial Expressions	Mandatory for new or correction records	0, 1, 2	Numeric	None	153	1	1
E1g	Indicators of Sad Mood — Recurrent Crying, Tearfulness	Mandatory for new or correction records	0, 1, 2	Numeric	None	154	1	1
E1h	Withdrawal From Activities of Interest	Mandatory for new or correction records	0, 1, 2	Numeric	None	155	1	1
E1i	Reduced Social Interaction	Mandatory for new or correction records	0, 1, 2	Numeric	None	156	1	1
E2	Mood Decline	Mandatory for new or correction records	0, 1	Numeric	None	157	1	1
E3a	Wandering	Mandatory for new or correction records	0, 1, 2	Numeric	None	158	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
E3b	Verbally Abusive	Mandatory for new or correction records	0, 1, 2	Numeric	None	159	1	1
E3c	Physically Abusive	Mandatory for new or correction records	0, 1, 2	Numeric	None	160	1	1
E3d	Socially Inappropriate/ Disruptive	Mandatory for new or correction records	0, 1, 2	Numeric	None	161	1	1
E3e	Resists Care	Mandatory for new or correction records	0, 1, 2	Numeric	None	162	1	1
E4	Changes in Behaviour Symptoms	Mandatory for new or correction records	0, 1	Numeric	None	163	1	1
F1a	At Ease Interacting With Others	Mandatory for new or correction records	0, 1	Numeric	None	164	1	1
F1b	Openly Expresses Conflict or Anger With Family/Friends	Mandatory for new or correction records	0, 1	Numeric	None	165	1	1
F2	Change in Social Activities	Mandatory under other conditions	0, 1, 2	Numeric	None	166	1	1
F3a	Length of Time Client Is Alone During Day	Mandatory under other conditions	0, 1, 2, 3	Numeric	None	167	1	1
F3b	Client Feels Lonely	Mandatory under other conditions	0, 1	Numeric	None	168	1	1
G1eA	Lives With Client — Primary	Mandatory for new or correction records	0, 1, 2	Numeric	None	169	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
G1fA	Relationship to Client — Primary	Mandatory under other conditions	0, 1, 2, 3	Numeric	None	170	1	1
G1gA	Advice or Emotional Support — Primary	Mandatory under other conditions	0, 1	Numeric	None	171	1	1
G1hA	IADL Care — Primary	Mandatory under other conditions	0, 1	Numeric	None	172	1	1
G1iA	ADL Care — Primary	Mandatory under other conditions	0, 1	Numeric	None	173	1	1
G1jA	Increase in Emotional Support — Primary	Mandatory under other conditions	0, 1, 2	Numeric	None	174	1	1
G1kA	Increase in IADL Care — Primary	Mandatory under other conditions	0, 1, 2	Numeric	None	175	1	1
G1lA	Increase in ADL Care — Primary	Mandatory under other conditions	0, 1, 2	Numeric	None	176	1	1
G1eB	Lives With Client — Secondary	Mandatory for new or correction records	0, 1, 2	Numeric	None	177	1	1
G1fB	Relationship to Client — Secondary	Mandatory under other conditions	0, 1, 2, 3	Numeric	None	178	1	1
G1gB	Advice or Emotional Support — Secondary	Mandatory under other conditions	0, 1	Numeric	None	179	1	1
G1hB	IADL Care — Secondary	Mandatory under other conditions	0, 1	Numeric	None	180	1	1
G1iB	ADL Care — Secondary	Mandatory under other conditions	0, 1	Numeric	None	181	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
G1jB	Increase in Emotional Support — Secondary	Mandatory under other conditions	0, 1, 2	Numeric	None	182	1	1
G1kB	Increase in IADL Care — Secondary	Mandatory under other conditions	0, 1, 2	Numeric	None	183	1	1
G1lB	Increase in ADL Care — Secondary	Mandatory under other conditions	0, 1, 2	Numeric	None	184	1	1
G2a	Any Caregiver Unable to Continue	Mandatory for new or correction records	0, 1	Numeric	None	185	1	1
G2b	Primary Caregiver Not Satisfied With Support From Family/Friends	Mandatory under other conditions	0, 1	Numeric	None	186	1	1
G2c	Primary Caregiver Expresses Distress, Anger, Depression	Mandatory under other conditions	0, 1	Numeric	None	187	1	1
G2d	Caregiver Status — None of the Above	Mandatory under other conditions	0, 1	Numeric	None	188	1	1
G3a	Hours of Informal Help — 5 Weekdays	Mandatory under other conditions	0–999	Numeric	Left	189	1	3
G3b	Hours of Informal Help — 2 Weekend Days	Mandatory under other conditions	0–999	Numeric	Left	192	1	3
H1aA	Meal Preparation — Self Performance	Mandatory under other conditions	0, 1, 2, 3, 8	Numeric	None	195	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
H1bA	Ordinary Housework — Self Performance	Mandatory under other conditions	0, 1, 2, 3, 8	Numeric	None	196	1	1
H1cA	Managing Finances — Self Performance	Mandatory under other conditions	0, 1, 2, 3, 8	Numeric	None	197	1	1
H1dA	Managing Medications — Self Performance	Mandatory under other conditions	0, 1, 2, 3, 8	Numeric	None	198	1	1
H1eA	Phone Use — Self Performance	Mandatory under other conditions	0, 1, 2, 3, 8	Numeric	None	199	1	1
H1fA	Shopping — Self Performance	Mandatory under other conditions	0, 1, 2, 3, 8	Numeric	None	200	1	1
H1gA	Transportation — Self Performance	Mandatory under other conditions	0, 1, 2, 3, 8	Numeric	None	201	1	1
H1dB	Managing Medications — Difficulty	Mandatory for new or correction records	0, 1, 2	Numeric	None	205	1	1
H1eB	Phone Use — Difficulty	Mandatory for new or correction records	0, 1, 2	Numeric	None	206	1	1
H1fB	Shopping — Difficulty	Mandatory for new or correction records	0, 1, 2	Numeric	None	207	1	1
H1gB	Transportation — Difficulty	Mandatory for new or correction records	0, 1, 2	Numeric	None	208	1	1
H2a	Mobility in Bed	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	209	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
H2b	Transfer	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	210	1	1
H2c	Locomotion in Home	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	211	1	1
H2d	Locomotion Outside of Home	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	212	1	1
H2e	Dressing Upper Body	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	213	1	1
H2f	Dressing Lower Body	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	214	1	1
H2g	Eating	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	215	1	1
H2h	Toilet Use	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	216	1	1
H2i	Personal Hygiene	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	217	1	1
H2j	Bathing	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 8	Numeric	None	218	1	1
H3	ADL Decline	Mandatory for new or correction records	0, 1	Numeric	None	219	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
H4a	Mode of Locomotion — Indoors	Mandatory for new or correction records	0, 1, 2, 3, 4, 8	Numeric	None	220	1	1
H4b	Mode of Locomotion — Outdoors	Mandatory for new or correction records	0, 1, 2, 3, 4, 8	Numeric	None	221	1	1
H5	Stair Climbing	Mandatory for new or correction records	0, 1, 2	Numeric	None	222	1	1
H6a	Stamina — Days	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	223	1	1
H6b	Stamina — Hours	Mandatory for new or correction records	0, 1	Numeric	None	224	1	1
H7a	Client Believes She/He Can Increase Function Independence	Mandatory for new or correction records	0, 1	Numeric	None	225	1	1
H7b	Caregivers Believe Client Can Increase Function Independence	Mandatory for new or correction records	0, 1	Numeric	None	226	1	1
H7c	Good Prospects of Recovery	Mandatory for new or correction records	0, 1	Numeric	None	227	1	1
H7d	Functional Potential — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	228	1	1
I1a	Bladder Continence	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 8	Numeric	None	229	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
I1b	Worsening of Incontinence	Mandatory for new or correction records	0, 1	Numeric	None	230	1	1
I2a	Pads or Briefs	Mandatory for new or correction records	0, 1	Numeric	None	231	1	1
I2b	Indwelling Urinary Catheter	Mandatory for new or correction records	0, 1	Numeric	None	232	1	1
I2c	Bladder Devices — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	233	1	1
I3	Bowel Continence	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 8	Numeric	None	234	1	1
J1a	Cerebrovascular Accident (Stroke)	Mandatory for new or correction records	0, 1, 2	Numeric	None	235	1	1
J1b	Congestive Heart Failure	Mandatory for new or correction records	0, 1, 2	Numeric	None	236	1	1
J1c	Coronary Heart Disease	Mandatory for new or correction records	0, 1, 2	Numeric	None	237	1	1
J1d	Hypertension	Mandatory for new or correction records	0, 1, 2	Numeric	None	238	1	1
J1e	Irregularly Irregular Pulse	Mandatory for new or correction records	0, 1, 2	Numeric	None	239	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
J1f	Peripheral Vascular Disease	Mandatory for new or correction records	0, 1, 2	Numeric	None	240	1	1
J1g	Alzheimer's	Mandatory for new or correction records	0, 1, 2	Numeric	None	241	1	1
J1h	Dementia Other Than Alzheimer's	Mandatory for new or correction records	0, 1, 2	Numeric	None	242	1	1
J1i	Head Trauma	Mandatory for new or correction records	0, 1, 2	Numeric	None	243	1	1
J1j	Hemiplegia/ Hemiparesis	Mandatory for new or correction records	0, 1, 2	Numeric	None	244	1	1
J1k	Multiple Sclerosis	Mandatory for new or correction records	0, 1, 2	Numeric	None	245	1	1
J1l	Parkinsonism	Mandatory for new or correction records	0, 1, 2	Numeric	None	246	1	1
J1m	Arthritis	Mandatory for new or correction records	0, 1, 2	Numeric	None	247	1	1
J1n	Hip Fracture	Mandatory for new or correction records	0, 1, 2	Numeric	None	248	1	1
J1o	Other Fractures (Wrist, Vertebral)	Mandatory for new or correction records	0, 1, 2	Numeric	None	249	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
J1p	Osteoporosis	Mandatory for new or correction records	0, 1, 2	Numeric	None	250	1	1
J1q	Cataract	Mandatory for new or correction records	0, 1, 2	Numeric	None	251	1	1
J1r	Glaucoma	Mandatory for new or correction records	0, 1, 2	Numeric	None	252	1	1
J1s	Any Psychiatric Diagnosis	Mandatory for new or correction records	0, 1, 2	Numeric	None	253	1	1
J1t	HIV Infection	Mandatory for new or correction records	0, 1, 2	Numeric	None	254	1	1
J1u	Pneumonia	Mandatory for new or correction records	0, 1, 2	Numeric	None	255	1	1
J1v	Tuberculosis	Mandatory for new or correction records	0, 1, 2	Numeric	None	256	1	1
J1w	Urinary Tract Infection	Mandatory for new or correction records	0, 1, 2	Numeric	None	257	1	1
J1x	Cancer, Not Including Skin Cancer	Mandatory for new or correction records	0, 1, 2	Numeric	None	258	1	1
J1y	Diabetes	Mandatory for new or correction records	0, 1, 2	Numeric	None	259	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
J1z	Emphysema/ COPD/Asthma	Mandatory for new or correction records	0, 1, 2	Numeric	None	260	1	1
J1aa	Renal Failure	Mandatory for new or correction records	0, 1, 2	Numeric	None	261	1	1
J1ab	Thyroid Disease (Hyper or Hypo)	Mandatory for new or correction records	0, 1, 2	Numeric	None	262	1	1
J1ac	Disease — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	263	1	1
J2a	Oth A — ICD-10-CA Code	Optional	Valid ICD-10-CA code	Alphanumeric	Left	264	3	7
J2b	Oth B — ICD-10-CA Code	Optional	Valid ICD-10-CA code	Alphanumeric	Left	271	3	7
J2c	Oth C — ICD-10-CA Code	Optional	Valid ICD-10-CA code	Alphanumeric	Left	278	3	7
J2d	Oth D — ICD-10-CA Code	Optional	Valid ICD-10-CA code	Alphanumeric	Left	285	3	7
K1a	Blood Pressure Measured	Mandatory under other conditions	0, 1	Numeric	None	292	1	1
K1b	Received Influenza Vaccine	Mandatory under other conditions	0, 1	Numeric	None	293	1	1
K1c	Test for Blood in Stool or Screening Endoscopy	Mandatory under other conditions	0, 1	Numeric	None	294	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
K1d	If Female: Received Breast Exam or Mammography	Mandatory under other conditions	0, 1	Numeric	None	295	1	1
K1e	Preventive Health — None of the Above	Mandatory under other conditions	0, 1	Numeric	None	296	1	1
K2a	Diarrhea	Mandatory for new or correction records	0, 1	Numeric	None	297	1	1
K2b	Difficulty Urinating or Urinating Three or More Times a Night	Mandatory for new or correction records	0, 1	Numeric	None	298	1	1
K2c	Fever	Mandatory for new or correction records	0, 1	Numeric	None	299	1	1
K2d	Loss of Appetite	Mandatory for new or correction records	0, 1	Numeric	None	300	1	1
K2e	Vomiting	Mandatory for new or correction records	0, 1	Numeric	None	301	1	1
K2f	Problem Conditions Present on 2 or More Days Days — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	302	1	1
K3a	Chest Pain	Mandatory for new or correction records	0, 1	Numeric	None	303	1	1
K3b	No Bowel Movement in 3 Days	Mandatory for new or correction records	0, 1	Numeric	None	304	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
K3c	Dizziness/ Lightheadedness	Mandatory for new or correction records	0, 1	Numeric	None	305	1	1
K3d	Edema	Mandatory for new or correction records	0, 1	Numeric	None	306	1	1
K3e	Shortness of Breath	Mandatory for new or correction records	0, 1	Numeric	None	307	1	1
K3f	Delusions	Mandatory for new or correction records	0, 1	Numeric	None	308	1	1
K3g	Hallucinations	Mandatory for new or correction records	0, 1	Numeric	None	309	1	1
K3h	Problem Conditions — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	310	1	1
K4a	Pain — Frequency	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	311	1	1
K4b	Pain — Intensity	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	312	1	1
K4c	Pain — Disrupts Usual Activities	Mandatory for new or correction records	0, 1	Numeric	None	313	1	1
K4d	Pain — Character	Mandatory for new or correction records	0, 1, 2	Numeric	None	314	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
K4e	Pain — Adequate Medication	Mandatory for new or correction records	0, 1, 2	Numeric	None	315	1	1
K5	Falls Frequency	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	Numeric	None	316	1	1
K6a	Unsteady Gait	Mandatory for new or correction records	0, 1	Numeric	None	317	1	1
K6b	Client Limits Going Outdoors Because Afraid of Falling	Mandatory for new or correction records	0, 1	Numeric	None	318	1	1
K7a	Client Felt/Was Advised to Reduce Drinking/ Smoking	Mandatory for new or correction records	0, 1	Numeric	None	319	1	1
K7b	Client Had to Have Drink First Thing in A.M., Was in Trouble Due to Drinking	Mandatory for new or correction records	0, 1	Numeric	None	320	1	1
K7c	Smoked or Chewed Tobacco Daily	Mandatory for new or correction records	0, 1	Numeric	None	321	1	1
K8a	Client Feels He/She Has Poor Health	Mandatory for new or correction records	0, 1	Numeric	None	322	1	1
K8b	Unstable Condition, ADL, Mood, or Behaviour	Mandatory for new or correction records	0, 1	Numeric	None	323	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
K8c	Flare-Up of a Recurrent or Chronic Problem	Mandatory for new or correction records	0, 1	Numeric	None	324	1	1
K8d	Treatment Changed in Last 30 Days	Mandatory for new or correction records	0, 1	Numeric	None	325	1	1
K8e	Prognosis of Less Than 6 Months to Live	Mandatory for new or correction records	0, 1	Numeric	None	326	1	1
K8f	Health Status — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	327	1	1
K9a	Fearful of Family Member/ Caregiver	Mandatory for new or correction records	0, 1	Numeric	None	328	1	1
K9b	Unusually Poor Hygiene	Mandatory for new or correction records	0, 1	Numeric	None	329	1	1
K9c	Unexplained Injuries, Broken Bones, Burns	Mandatory for new or correction records	0, 1	Numeric	None	330	1	1
K9d	Neglected, Abused	Mandatory for new or correction records	0, 1	Numeric	None	331	1	1
K9e	Physically Restrained	Mandatory for new or correction records	0, 1	Numeric	None	332	1	1
K9f	Other Status — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	333	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
L1a	Weight Loss	Mandatory for new or correction records	0, 1	Numeric	None	334	1	1
L1b	Severe Malnutrition (Cachexia)	Mandatory for new or correction records	0, 1	Numeric	None	335	1	1
L1c	Morbid Obesity	Mandatory for new or correction records	0, 1	Numeric	None	336	1	1
L2a	One or Fewer Meals a Day	Mandatory for new or correction records	0, 1	Numeric	None	337	1	1
L2b	Noticeable Decrease in Amount of Food or Fluids Consumed	Mandatory for new or correction records	0, 1	Numeric	None	338	1	1
L2c	Insufficient Fluid	Mandatory for new or correction records	0, 1	Numeric	None	339	1	1
L2d	Enteral Tube Feeding	Mandatory for new or correction records	0, 1	Numeric	None	340	1	1
L3	Swallowing	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	341	1	1
M1a	Problem Chewing	Mandatory for new or correction records	0, 1	Numeric	None	342	1	1
M1b	Dry Mouth	Mandatory for new or correction records	0, 1	Numeric	None	343	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
M1c	Problem Brushing Teeth/Dentures	Mandatory for new or correction records	0, 1	Numeric	None	344	1	1
M1d	Oral Status — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	345	1	1
N1	Skin Problems	Mandatory for new or correction records	0, 1	Numeric	None	346	1	1
N2a	Pressure Ulcer	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	347	1	1
N2b	Stasis Ulcer	Mandatory for new or correction records	0, 1, 2, 3, 4	Numeric	None	348	1	1
N3a	Burns	Mandatory for new or correction records	0, 1	Numeric	None	349	1	1
N3b	Open Lesions (Other Than Ulcers)	Mandatory for new or correction records	0, 1	Numeric	None	350	1	1
N3c	Skin Tears/Cuts	Mandatory for new or correction records	0, 1	Numeric	None	351	1	1
N3d	Surgical Wound	Mandatory for new or correction records	0, 1	Numeric	None	352	1	1
N3e	Corns, Calluses, Structural Problems, Infections, Fungi	Mandatory for new or correction records	0, 1	Numeric	None	353	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
N3f	Skin Problems — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	354	1	1
N4	Prior Pressure Ulcer	Mandatory for new or correction records	0, 1	Numeric	None	355	1	1
N5a	Antibiotics	Mandatory for new or correction records	0, 1	Numeric	None	356	1	1
N5b	Dressings	Mandatory for new or correction records	0, 1	Numeric	None	357	1	1
N5c	Surgical Wound Care	Mandatory for new or correction records	0, 1	Numeric	None	358	1	1
N5d	Other Wound/ Ulcer Care	Mandatory for new or correction records	0, 1	Numeric	None	359	1	1
N5e	Wound Care — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	360	1	1
O1a	Lighting	Mandatory under other conditions	0, 1	Numeric	None	361	1	1
O1b	Floors/Carpets	Mandatory under other conditions	0, 1	Numeric	None	362	1	1
O1c	Bathroom/Toilet	Mandatory under other conditions	0, 1	Numeric	None	363	1	1
O1d	Kitchen	Mandatory under other conditions	0, 1	Numeric	None	364	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
O1e	Heating/ Cooling	Mandatory under other conditions	0, 1	Numeric	None	365	1	1
O1f	Personal Safety	Mandatory under other conditions	0, 1	Numeric	None	366	1	1
O1g	Access to Home	Mandatory under other conditions	0, 1	Numeric	None	367	1	1
O1h	Access to Rooms in House	Mandatory under other conditions	0, 1	Numeric	None	368	1	1
O1i	Home Environment — None of the Above	Mandatory under other conditions	0, 1	Numeric	None	369	1	1
O2a	Client Lives With Others	Mandatory for new or correction records	0, 1	Numeric	None	370	1	1
O2b	Client or Primary Caregiver Feels Client Be Better Off in Another Living Arrangement	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	371	1	1
P1aA	Home Health Aides — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	372	1	1
P1bA	Visiting Nurses — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	373	1	1
P1cA	Homemaking Services — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	374	1	1
P1dA	Meals — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	375	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
P1eA	Volunteer Services — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	376	1	1
P1fA	Physical Therapy — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	377	1	1
P1gA	Occupational Therapy — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	378	1	1
P1hA	Speech Therapy — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	379	1	1
P1iA	Day Care or Day Hospital — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	380	1	1
P1jA	Social Worker in Home — Days	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7	Numeric	None	381	1	1
P1aB	Home Health Aides — Hours	Mandatory under other conditions	0–999	Numeric	Left	382	1	3
P1bB	Visiting Nurses — Hours	Mandatory under other conditions	0–999	Numeric	Left	385	1	3
P1cB	Homemaking Services — Hours	Mandatory under other conditions	0–999	Numeric	Left	388	1	3
P1dB	Meals — Hours	Mandatory under other conditions	0–999	Numeric	Left	391	1	3
P1eB	Volunteer Services — Hours	Mandatory under other conditions	0–999	Numeric	Left	394	1	3
P1fB	Physical Therapy — Hours	Mandatory under other conditions	0–999	Numeric	Left	397	1	3
P1gB	Occupational Therapy — Hours	Mandatory under other conditions	0–999	Numeric	Left	400	1	3

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
P1hB	Speech Therapy — Hours	Mandatory under other conditions	0–999	Numeric	Left	403	1	3
P1iB	Day Care or Day Hospital — Hours	Mandatory under other conditions	0–999	Numeric	Left	406	1	3
P1jB	Social Worker in Home — Hours	Mandatory under other conditions	0–999	Numeric	Left	409	1	3
P1aC	Home Health Aides — Mins	Mandatory under other conditions	0–99	Numeric	Left	412	1	2
P1bC	Visiting Nurses — Mins	Mandatory under other conditions	0–99	Numeric	Left	414	1	2
P1cC	Homemaking Services — Mins	Mandatory under other conditions	0–99	Numeric	Left	416	1	2
P1dC	Meals — Mins	Mandatory under other conditions	0–99	Numeric	Left	418	1	2
P1eC	Volunteer Services — Mins	Mandatory under other conditions	0–99	Numeric	Left	420	1	2
P1fC	Physical Therapy — Mins	Mandatory under other conditions	0–99	Numeric	Left	422	1	2
P1gC	Occupational Therapy — Mins	Mandatory under other conditions	0–99	Numeric	Left	424	1	2
P1hC	Speech Therapy — Mins	Mandatory under other conditions	0–99	Numeric	Left	426	1	2
P1iC	Day Care or Day Hospital — Mins	Mandatory under other conditions	0–99	Numeric	Left	428	1	2
P1jC	Social Worker in Home — Mins	Mandatory under other conditions	0–99	Numeric	Left	430	1	2

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
P2a	Oxygen	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	432	1	1
P2b	Respirator for Assistive Breathing	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	433	1	1
P2c	All Other Respiratory Treatments	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	434	1	1
P2d	Alcohol/Drug Treatment Program	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	435	1	1
P2e	Blood Transfusion(s)	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	436	1	1
P2f	Chemotherapy	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	437	1	1
P2g	Dialysis	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	438	1	1
P2h	IV Infusion — Central	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	439	1	1
P2i	IV Infusion — Peripheral	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	440	1	1
P2j	Medication by Injection	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	441	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
P2k	Ostomy Care	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	442	1	1
P2l	Radiation	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	443	1	1
P2m	Tracheostomy Care	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	444	1	1
P2n	Exercise Therapy	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	445	1	1
P2o	Occupational Therapy	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	446	1	1
P2p	Physical Therapy	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	447	1	1
P2q	Day Centre	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	448	1	1
P2r	Day Hospital	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	449	1	1
P2s	Hospice Care	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	450	1	1
P2t	Physician or Clinic Visit	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	451	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
P2u	Respite Care	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	452	1	1
P2v	Daily Nurse Monitoring	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	453	1	1
P2w	Nurse Monitoring Less Than Daily	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	454	1	1
P2x	Medical Alert Bracelet or Electronic Security Alert	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	455	1	1
P2y	Skin Treatment	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	456	1	1
P2z	Special Diet	Mandatory for new or correction records	0, 1, 2, 3	Numeric	None	457	1	1
P2aa	Special Treatment — None of the Above	Mandatory for new or correction records	0, 1	Numeric	None	458	1	1
P3a	Oxygen	Mandatory under other conditions	0, 1, 2, 3, 4	Numeric	None	459	1	1
P3b	IV	Mandatory under other conditions	0, 1, 2, 3, 4	Numeric	None	460	1	1
P3c	Catheter	Mandatory under other conditions	0, 1, 2, 3, 4	Numeric	None	461	1	1
P3d	Ostomy	Mandatory under other conditions	0, 1, 2, 3, 4	Numeric	None	462	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
P4a	Number of Overnight Hospital Admissions	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	Numeric	None	463	1	1
P4b	Number of ER Visits Without an Overnight Stay	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	Numeric	None	464	1	1
P4c	Emergent Care	Mandatory under other conditions	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	Numeric	None	465	1	1
P5	Treatment Goals	Mandatory under other conditions	0, 1	Numeric	None	466	1	1
P6	Overall Change in Care Needs	Mandatory for new or correction records	0, 1, 2	Numeric	None	467	1	1
P7	Trade Offs	Mandatory under other conditions	0, 1	Numeric	None	468	1	1
Q1	Number of Medications	Mandatory for new or correction records	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	Numeric	None	469	1	1
Q2a	Antipsychotic/ Neuroleptic	Mandatory for new or correction records	0, 1	Numeric	None	470	1	1
Q2b	Anxiolytic	Mandatory for new or correction records	0, 1	Numeric	None	471	1	1
Q2c	Antidepressant	Mandatory for new or correction records	0, 1	Numeric	None	472	1	1
Q2d	Hypnotics or Analgesics	Mandatory for new or correction records	0, 1	Numeric	None	473	1	1

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Q3	Medical Oversight	Mandatory under other conditions	0, 1	Numeric	None	474	1	1
Q4	Compliance/ Adherence With Medications	Mandatory under other conditions	0, 1, 2, 3	Numeric	None	475	1	1
R1c	Date Assessment Coordinator Signed as Complete	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	476	8	8

MD Medication record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	MD	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	68	8	8
A1	Assessment Reference Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	76	8	8
A2	Reason for Assessment	Mandatory for new or correction records	1, 2, 3, 4, 5, 6, 7, 8	Numeric	None	84	1	1
X40	Medication Sequence Number	Mandatory for new or correction records	0–99	Numeric	Left	85	1	2
X41	DIN	Optional		Numeric	None	87	8	8
Q5a	Medication Name	Mandatory under other conditions		String	Left	95	1	200
Q5b	Medication Dose	Mandatory for new or correction records		String	Left	295	1	20
Q5c	Medication Form	Mandatory for new or correction records	1, 2, 3, 4, 5, 6, 7, 8, 9, 10	Numeric	Left	315	1	2
Q5d	Medication Frequency	Mandatory for new or correction records	See RAI-HC list	Alphanumeric	Left	317	1	3
Q5e	Number of Doses in Last 7 Days	Mandatory under other conditions	0–99	Numeric	Left	320	1	2

SS Service Start record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	SS	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	68	8	8
X10	Service Start Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	76	8	8
X11	Service Type	Mandatory for new or correction records	10–99	Numeric	None	84	2	2

SD Service Details record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	SD	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	68	8	8
X10	Service Start Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	76	8	8

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
X11	Service Type	Mandatory for new or correction records	10–99	Numeric	None	84	2	2
X12	Home Care Discipline	Mandatory for new or correction records	100–999	Numeric	None	86	3	3
X13	Service Delivery Setting	Mandatory for new or correction records	100–999	Numeric	None	89	3	3
X14	Acute Services Flag	Mandatory for new or correction records	0, 1, 9	Numeric	None	92	1	1
X15	Number of Service Visits	Mandatory status determined by respective Provincial Profile	0–9999	Numeric	Left	93	1	4
X16	Minutes of Service	Mandatory status determined by respective Provincial Profile	0–9999999	Numeric	Left	97	1	7

SE Service End record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	SE	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	68	8	8
X10	Service Start Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	76	8	8

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
X11	Service Type	Mandatory for new or correction records	10–99	Numeric	None	84	2	2
X12	Home Care Discipline	Mandatory for new or correction records	100–999	Numeric	None	86	3	3
X17	Service End Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	89	8	8

ER Visits record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	ER	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	68	8	8
X20	Number of Emergency Room Visits	Mandatory for new or correction records	0–99	Numeric	Left	76	1	2

DC Discharge record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	DC	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1a	Unique Provincial Client Identifier	Mandatory status determined by respective Provincial Profile		Alphanumeric	Left	44	1	12
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	56	1	12
CC1	Date Case Opened/ Reopened	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	68	8	8
X30	Discharge Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	76	8	8
X31	Service Goals Met at Discharge	Mandatory status determined by respective Provincial Profile	0, 1	Numeric	None	84	1	1
X32	Reason for Discharge	Mandatory status determined by respective Provincial Profile	1, 2, 3, 4, 5, 6, 7, 8, 9, 10	Numeric	Left	85	1	2
X33	Referred to Other Health Service	Mandatory status determined by respective Provincial Profile	1, 2, 3, 4, 5, 6	Numeric	None	87	1	1

OT Organization Client Transfer record

Element ID	Element name	Mandatory status	Valid values	Data type	Justification	Start byte	Minimum length	Maximum length
Y1	Unique Record ID	Always mandatory		Alphanumeric	Left	1	1	20
Y2	Record Type	Always mandatory	OT	String	Left	21	2	2
Y3	Submission Type	Always mandatory	N, C, D	Alphanumeric	None	23	1	1
Z1a	Source Organization Identifier	Always mandatory	First character must be 0–9, Y, N, V	Alphanumeric	Left	24	5	5
Z1c	Organization Effective Date	Optional	YYYYMMDD, valid date	Date	None	29	8	8
Y10x	Data Collection Vendor Code	Always mandatory	Assigned by CIHI to each vendor	Alphanumeric	None	37	5	5
Y13	Reporting Period	Mandatory for new or correction records	1–13	Numeric	Left	42	1	2
X1b	Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	44	1	12
Z1p	Previous Source Organization Identifier	Mandatory for new or correction records	First character must be 0–9, Y, N, V	Alphanumeric	Left	56	5	5
Z1pc	Effective Date of Previous Organization	Optional	YYYYMMDD, valid date	Date	None	61	8	8
X1p	Previous Unique Source Organization Client Identifier	Mandatory for new or correction records		Alphanumeric	Left	69	1	12
X60	Client Transfer Date	Mandatory for new or correction records	YYYYMMDD, valid date	Date	None	81	8	8

Appendix A — Data elements by Record Type

The following tables list on which HCRS record types each of the data elements appears. It also shows, for each record type, when the presence of data is required in that data element. (This is checked on submission of the record and will result in the record being rejected if the data element is blank.)

Note: The order of the elements in these tables does not provide the necessary information regarding the file layouts to be used when submitting data to CIHI. Please refer to Chapter 8.

The legend for the tables is as follows:

A Must always be present (on new, correction and deletion records)

M Mandatory for new and correction records

O Optional (the presence of the data element on a record is not checked)

E Mandatory status depends on an associated data element within the record (see chapters 3 to 7 for full details of what these conditions are)

P Mandatory status depends on the Provincial Profile that governs the submission and processing of data from a given province/territory

Blank This element is not present on the record

Data elements identified with an asterisk (*) are personal identifiers and demographic data elements that are harmonized with the RAI-HC that are submitted for all clients and appear on administrative records.

The record types are identified using the Record Type ID; the legend is as follows:

Record Type	Client records
Administrative	**AD —** Admission
	UC — Update Client Profile
	OT — Organization Client Transfer
	DC — Discharge
Assessment	**RH —** RAI-HC Assessment
	MD — Medication
Home care service utilization	**SS —** Service Start
	SD — Service Details
	SE — Service End
Utilization of other health services	**ER —** ER Visits

Non-client records	
SP	Submission Profile
OP	Organization Profile
CI	Contact Information
PP	Provincial Profile

Client records

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization	Z1a	Source Organization Identifier	A	A	A	A	A	A	A	A	A	A
	Z1c	Organization Effective Date	O	O	O	O	O	O	O	O	O	O
	Z1p	Previous Source Organization Identifier									M	
	Z1pc	Effective Date of Previous Organization									O	

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Record	Y1	Unique Record ID	A	A	A	A	A	A	A	A	A	A
	Y2	Record Type	A	A	A	A	A	A	A	A	A	A
	Y3	Submission Type	A	A	A	A	A	A	A	A	A	A
	Y10x	Data Collection Vendor Code	A	A	A	A	A	A	A	A	A	A
	Y13	Reporting Period	M	M	M	M	M	M	M	M	M	M
Client identifiers and demographic information	X1a	Unique Provincial Client Identifier	P		P	P	P	P	P	P		P
	X1b	Unique Source Organization Client Identifier	M	M	M	M	M	M	M	M	M	M
	X1p	Previous Unique Source Organization Client Identifier									M	
	AA3a*	Health Card Number	M	E								
	AA3b*	Province/Territory Issuing Health Card Number	M	E								
	AA4*	Postal Code of Residence	M	E								
	BB1*	Sex	O									
	BB2a*	Birth Date	M									
	BB2b*	Estimated Birth Date	M									
	BB4*	Marital Status	M	E								
	BB5a*	Primary Language	P	E								
Administrative information	CC1*	Date Case Opened/Reopened	M	A	M	M	M	M	M	M		M
	X2	Client Group	M	E								
	X3	Subregion Identifier (User-Defined)	P	E								
	X4	Program Type (User-Defined)	P	E								
	X5	Referral Source	P									

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Administrative information (cont'd)	X6	Date of Acceptance to Home Care	P									
	X50	Element to be Updated		A								
	X51	Element Effective Date		M								
	X30	Discharge Date										M
	X31	Service Goals Met at Discharge										P
	X32	Reason for Discharge										P
	X33	Referred to Other Health Service										P
	X60	Client Transfer Date									M	
Home care service utilization information	X10	Service Start Date					M	M	M			
	X11	Service Type					M	M	M			
	X12	Home Care Discipline					M	M	M			
	X13	Service Delivery Setting						M				
	X14	Acute Services Flag						M				
	X15	Number of Service Visits						P				
	X16	Minutes of Service						P				
	X17	Service End Date							M			
Utilization of other health services information	X20	Number of Emergency Room Visits								M		
RAI-HC assessment data	AA2	Case Record Number			M							
	BB3	Aboriginal Identity			E							
	BB5b	Interpreter Needed			M							
	BB6	Education			E							
	BB7a	Legal Guardian/Substitute Decision-Maker			M							
	BB7b	Advanced Medical Directives			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
RAI-HC assessment data (cont'd)	BB8a	Payment — Provincial/Territorial Government Plan			O							
	BB8b	Payment — Other Province/Territory			O							
	BB8c	Payment — Federal Government — Veterans Affairs Canada			O							
	BB8d	Payment — Federal Government — First Nations and Inuit Health Branch			O							
	BB8e	Payment — Federal Government — Other (RCMP, Canadian Forces, Inmate, Refugee)			O							
	BB8f	Payment — Worker's Compensation Board			O							
	BB8g	Payment — Canadian Resident — Private Insurance			O							
	BB8h	Payment — Canadian Resident — Public Trustee			O							
	BB8i	Payment — Canadian Resident — Self Pay			O							
	BB8j	Payment — Other Country Resident — Self Pay			O							
	BB8k	Payment — Unknown/Unavailable			O							
	CC2	Reason for Referral			E							
	CC3a	Goals — Nursing Treatments			E							
	CC3b	Goals — Monitoring			E							
	CC3c	Goals — Rehabilitation			E							
	CC3d	Goals — Client/Family Education			E							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
RAI-HC assessment data (cont'd)	CC3e	Goals — Family Respite			E							
	CC3f	Goals — Palliative Care			E							
	CC4	Time Since Last Hospital Stay			E							
	CC5	Where Lived at Time of Referral			E							
	CC6	Who Lived With at Time of Referral			E							
	CC7	Prior Residential Care Facility			E							
	CC8	Residential History			E							
	A1	Assessment Reference Date			M	M						
	A2	Reason for Assessment			M	M						
	X70	Location of Assessment			M							
	X71	Facility Admission Date			E							
	B1a	Short-Term Memory			M							
	B1b	Procedural Memory			M							
	B2a	Cognitive Skills — Decision Making			M							
	B2b	Cognitive Skills — Worsening Decision Making			M							
	B3a	Sudden or New Onset/ Change in Mental Function Over Last 7 Days			M							
	B3b	In the Last 90 Days, Client Has Become Agitated or Disoriented			M							
	C1	Hearing			M							
	C2	Making Self Understood			M							
	C3	Ability to Understand Others			M							
	C4	Communication Decline			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
RAI-HC assessment data (cont’d)	D1	Vision			M							
	D2	Visual Limitations			M							
	D3	Visual Decline			M							
	E1a	Indicators of Depression — Sad Mood			M							
	E1b	Indicators of Depression — Anger			M							
	E1c	Indicators of Anxiety — Unrealistic Fears			M							
	E1d	Indicators of Anxiety — Repetitive Health Complaints			M							
	E1e	Indicators of Anxiety — Repetitive Anxious Complaints			M							
	E1f	Indicators of Sad Mood — Sad, Pained Facial Expressions			M							
	E1g	Indicators of Sad Mood — Recurrent Crying, Tearfulness			M							
	E1h	Withdrawal From Activities of Interest			M							
	E1i	Reduced Social Interaction			M							
	E2	Mood Decline			M							
	E3a	Wandering			M							
	E3b	Verbally Abusive			M							
	E3c	Physically Abusive			M							
	E3d	Socially Inappropriate/Disruptive			M							
	E3e	Resists Care			M							
	E4	Changes in Behaviour Symptoms			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
RAI-HC assessment data (cont'd)	F1a	At Ease Interacting With Others			M							
	F1b	Openly Expresses Conflict or Anger With Family/Friends			M							
	F2	Change in Social Activities			E							
	F3a	Length of Time Client Is Alone During Day			E							
	F3b	Client Feels Lonely			E							
	G1eA	Lives With Client — Primary			M							
	G1eB	Lives With Client — Secondary			M							
	G1fA	Relationship to Client — Primary			E							
	G1fB	Relationship to Client — Secondary			E							
Organization	G1gA	Advice or Emotional Support — Primary			P							
	G1gB	Advice or Emotional Support — Secondary			P							
	G1hA	IADL Care — Primary			P							
	G1hB	IADL Care — Secondary			P							
	G1iA	ADL Care — Primary			P							
	G1iB	ADL Care — Secondary			P							
	G1jA	Increase in Emotional Support — Primary			E							
	G1jB	Increase in Emotional Support — Secondary			E							
	G1kA	Increase in IADL Care — Primary			E							
	G1kB	Increase in IADL Care — Secondary			E							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	G1IA	Increase in ADL Care — Primary			E							
	G1IB	Increase in ADL Care — Secondary			E							
	G2a	Any Caregiver Unable to Continue			M							
	G2b	Primary Caregiver Not Satisfied With Support From Family/Friends			E							
	G2c	Primary Caregiver Expresses Distress, Anger, Depression			E							
	G2d	Caregiver Status — None of the Above			E							
	G3a	Hours of Informal Help — 5 Weekdays			E							
	G3b	Hours of Informal Help — 2 Weekend Days			E							
	H1aA	Meal Preparation — Self Performance			E							
	H1aB	Meal Preparation — Difficulty			M							
	H1bA	Ordinary Housework — Self Performance			E							
	H1bB	Ordinary Housework — Difficulty			M							
	H1cA	Managing Finances — Self Performance			E							
	H1cB	Managing Finances — Difficulty			M							
	H1dA	Managing Medications — Self Performance			E							
	H1dB	Managing Medications — Difficulty			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	H1eA	Phone Use — Self Performance			E							
	H1eB	Phone Use — Difficulty			M							
	H1fA	Shopping — Self Performance			E							
	H1fB	Shopping — Difficulty			M							
	H1gA	Transportation — Self Performance			E							
	H1gB	Transportation — Difficulty			M							
	H2a	Mobility in Bed			M							
	H2b	Transfer			M							
	H2c	Locomotion in Home			M							
	H2d	Locomotion Outside of Home			M							
	H2e	Dressing Upper Body			M							
	H2f	Dressing Lower Body			M							
	H2g	Eating			M							
	H2h	Toilet Use			M							
	H2i	Personal Hygiene			M							
	H2j	Bathing			M							
	H3	ADL Decline			M							
	H4a	Mode of Locomotion — Indoors			M							
	H4b	Mode of Locomotion — Outdoors			M							
	H5	Stair Climbing			M							
	H6a	Stamina — Days			M							
	H6b	Stamina — Hours			M							
	H7a	Client Believes She/He Can Increase Function Independence			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	H7b	Caregivers Believe Client Can Increase Function Independence			M							
	H7c	Good Prospects of Recovery			M							
	H7d	Functional Potential — None of the Above			M							
	I1a	Bladder Continence			M							
	I1b	Worsening of Incontinence			M							
	I2a	Pads or Briefs			M							
	I2b	Indwelling Urinary Catheter			M							
	I2c	Bladder Devices — None of the Above			M							
	I3	Bowel Continence			M							
	J1a	Cerebrovascular Accident (Stroke)			M							
	J1b	Congestive Heart Failure			M							
	J1c	Coronary Heart Disease			M							
	J1d	Hypertension			M							
	J1e	Irregularly Irregular Pulse			M							
	J1f	Peripheral Vascular Disease			M							
	J1g	Alzheimer's			M							
	J1h	Dementia Other Than Alzheimer's			M							
	J1i	Head Trauma			M							
	J1j	Hemiplegia/Hemiparesis			M							
	J1k	Multiple Sclerosis			M							
	J1l	Parkinsonism			M							
	J1m	Arthritis			M							
	J1n	Hip Fracture			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	J1o	Other Fractures (Wrist, Vertebral)			M							
	J1p	Osteoporosis			M							
	J1q	Cataract			M							
	J1r	Glaucoma			M							
	J1s	Any Psychiatric Diagnosis			M							
	J1t	HIV Infection			M							
	J1u	Pneumonia			M							
	J1v	Tuberculosis			M							
	J1w	Urinary Tract Infection			M							
	J1x	Cancer, Not Including Skin Cancer			M							
	J1y	Diabetes			M							
	J1z	Emphysema/COPD/Asthma			M							
	J1aa	Renal Failure			M							
	J1ab	Thyroid Disease (Hyper or Hypo)			M							
	J1ac	Disease — None of the Above			M							
	J2a	Oth A — ICD-10-CA Code			O							
	J2b	Oth B — ICD-10-CA Code			O							
	J2c	Oth C — ICD-10-CA Code			O							
	J2d	Oth D — ICD-10-CA code			O							
	K1a	Blood Pressure Measured			E							
	K1b	Received Influenza Vaccine			E							
	K1c	Test for Blood in Stool or Screening Endoscopy			E							
	K1d	If Female: Received Breast Exam or Mammography			E							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	K1e	Preventive Health — None of the Above			E							
	K2a	Diarrhea			M							
	K2b	Difficulty Urinating or Urinating 3 or more Times a Night			M							
	K2c	Fever			M							
	K2d	Loss of Appetite			M							
	K2e	Vomiting			M							
	K2f	Problem Conditions 2+ Days — None of the Above			M							
	K3a	Chest Pain			M							
	K3b	No Bowel Movement in 3 Days			M							
	K3c	Dizziness/Lightheadedness			M							
	K3d	Edema			M							
	K3e	Shortness of Breath			M							
	K3f	Delusions			M							
	K3g	Hallucinations			M							
	K3h	Problem Conditions — None of the Above			M							
	K4a	Pain — Frequency			M							
	K4b	Pain — Intensity			M							
	K4c	Pain — Disrupts Usual Activities			M							
	K4d	Pain — Character			M							
	K4e	Pain — Adequate Medication			M							
	K5	Falls Frequency			M							
	K6a	Unsteady Gait			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	K6b	Client Limits Going Outdoors Because Afraid of Falling			M							
	K7a	Client Felt/Was Advised to Reduce Drinking/Smoking			M							
	K7b	Client Had to Have Drink First Thing in A.M., Was in Trouble Due to Drinking			M							
	K7c	Smoked or Chewed Tobacco Daily			M							
	K8a	Client Feels He/She Has Poor Health			M							
	K8b	Unstable Condition, ADL, Mood, or Behaviour			M							
	K8c	Flare-Up of a Recurrent or Chronic Problem			M							
	K8d	Treatment Changed in Last 30 Days			M							
	K8e	Prognosis of Less Than 6 Months to Live			M							
	K8f	Health Status — None of the Above			M							
	K9a	Fearful of Family Member/Caregiver			M							
	K9b	Unusually Poor Hygiene			M							
	K9c	Unexplained Injuries, Broken Bones, Burns			M							
	K9d	Neglected, Abused			M							
	K9e	Physically Restrained			M							
	K9f	Other Status — None of the Above			M							
	L1a	Weight Loss			M							
	L1b	Severe Malnutrition (Cachexia)			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	L1c	Morbid Obesity			M							
	L2a	One or Fewer Meals a Day			M							
	L2b	Noticeable Decrease in Amount of Food or Fluids Consumed			M							
	L2c	Insufficient Fluid			M							
	L2d	Enteral Tube Feeding			M							
	L3	Swallowing			M							
	M1a	Problem Chewing			M							
	M1b	Dry Mouth			M							
	M1c	Problem Brushing Teeth/Dentures			M							
	M1d	Oral Status — None of the Above			M							
	N1	Skin Problems			M							
	N2a	Pressure Ulcer			M							
	N2b	Stasis Ulcer			M							
	N3a	Burns			M							
	N3b	Open Lesions (Other Than Ulcers)			M							
	N3c	Skin Tears/Cuts			M							
	N3d	Surgical Wound			M							
	N3e	Corns, Calluses, Structural Problems, Infections, Fungi			M							
	N3f	Skin Problems — None of the Above			M							
	N4	Prior Pressure Ulcer			M							
	N5a	Antibiotics			M							
	N5b	Dressings			M							
	N5c	Surgical Wound Care			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	N5d	Other Wound/Ulcer Care			M							
	N5e	Wound Care — None of the Above			M							
	O1a	Lighting			E							
	O1b	Floors/Carpets			E							
	O1c	Bathroom/Toilet			E							
	O1d	Kitchen			E							
	O1e	Heating/Cooling			E							
	O1f	Personal Safety			E							
	O1g	Access to Home			E							
	O1h	Access to Rooms in House			E							
	O1i	Home Environment — None of the Above			E							
	O2a	Client Lives With Others			M							
	O2b	Client or Primary Caregiver Feels Client Be Better Off in Another Living Arrangement			M							
	P1aA	Home Health Aides — Days			E							
	P1aB	Home Health Aides — Hours			E							
	P1aC	Home Health Aides — Mins			E							
	P1bA	Visiting Nurses — Days			E							
	P1bB	Visiting Nurses — Hours			E							
	P1bC	Visiting Nurses — Mins			E							
	P1cA	Homemaking Services — Days			E							
	P1cB	Homemaking Services — Hours			E							
	P1cC	Homemaking Services — Mins			E							
	P1dA	Meals — Days			E							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	P1dB	Meals — Hours			E							
	P1dC	Meals — Mins			E							
	P1eA	Volunteer Services — Days			E							
	P1eB	Volunteer Services — Hours			E							
	P1eC	Volunteer Services — Mins			E							
	P1fA	Physical Therapy — Days			E							
	P1fB	Physical Therapy — Hours			E							
	P1fC	Physical Therapy — Mins			E							
	P1gA	Occupational Therapy — Days			E							
	P1gB	Occupational Therapy — Hours			E							
	P1gC	Occupational Therapy — Mins			E							
	P1hA	Speech Therapy — Days			E							
	P1hB	Speech Therapy — Hours			E							
	P1hC	Speech Therapy — Mins			E							
	P1iA	Day Care or Day Hospital — Days			E							
	P1iB	Day Care or Day Hospital — Hours			E							
	P1iC	Day Care or Day Hospital — Mins			E							
	P1jA	Social Worker in Home — Days			E							
	P1jB	Social Worker in Home — Hours			E							
	P1jC	Social Worker in Home — Mins			E							
	P2a	Oxygen			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	P2b	Respirator for Assistive Breathing			M							
	P2c	All Other Respiratory Treatments			M							
	P2d	Alcohol/Drug Treatment Program			M							
	P2e	Blood Transfusion(s)			M							
	P2f	Chemotherapy			M							
	P2g	Dialysis			M							
	P2h	IV Infusion — Central			M							
	P2i	IV Infusion — Peripheral			M							
	P2j	Medication by Injection			M							
	P2k	Ostomy Care			M							
	P2l	Radiation			M							
	P2m	Tracheostomy Care			M							
	P2n	Exercise Therapy			M							
	P2o	Occupational Therapy			M							
	P2p	Physical Therapy			M							
	P2q	Day Centre			M							
	P2r	Day Hospital			M							
	P2s	Hospice Care			M							
	P2t	Physician or Clinic Visit			M							
	P2u	Respite Care			M							
	P2v	Daily Nurse Monitoring			M							
	P2w	Nurse Monitoring Less Than Daily			M							
	P2x	Medical Alert Bracelet or Electronic Security Alert			M							
	P2y	Skin Treatment			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Organization (cont'd)	P2z	Special Diet			M							
	P2aa	Special Treatment — None of the Above			M							
	P3a	Oxygen			E							
	P3b	IV			E							
	P3c	Catheter			E							
	P3d	Ostomy			E							
	P4a	Number of Overnight Hospital Admissions			M							
	P4b	Number of ER Visits Without an Overnight Stay			M							
	P4c	Emergent Care			E							
	P5	Treatment Goals			E							
	P6	Overall Change in Care Needs			M							
	P7	Trade Offs			E							
	Q1	Number of Medications			M							
	Q2a	Antipsychotic/Neuroleptic			M							
	Q2b	Anxiolytic			M							
	Q2c	Antidepressant			M							
	Q2d	Hypnotics or Analgesics			M							
	Q3	Medical Oversight			E							
	Q4	Compliance/Adherence With Medications			E							
	R1c	Date Assessment Coordinator Signed as Complete			M							

Identifier type	Element ID	Element name	AD	UC	RH	MD	SS	SD	SE	ER	OT	DC
Detailed medication information	X40	Medication Sequence Number				M						
	X41	DIN				O						
	Q5a	Medication Name				E						
	Q5b	Medication Dose				M						
	Q5c	Medication Form				M						
	Q5d	Medication Frequency				M						
	Q5e	Number of Doses in Last 7 Days				E						

Non-client records

Identifier type	Element ID	Element name	SP	OP	CI	PP
Organization	Z1	Organization Identifier		A	A	
	Z1b	Submission Organization Identifier	A			
	Z1c	Organization Effective Date	O	O	O	
Record	Y1	Unique Record ID	A	A	A	A
	Y2	Record Type	A	A	A	A
	Y3	Submission Type		A	A	A
Submission information	Y10y	Data Submission Vendor Code	M			
	Z6	Province	M			
	Y11	Date of Submission	M			
	Y12	Reporting Fiscal Year	M			
	Y14	Number of Records in Transmission File	M			
Organization information	Z2	Organization Name		M		
	Z3	Organization Address Line 1		M		
	Z4	Organization Address Line 2		M		
	Z5	Organization City/Town		M		
	Z7	Organization Postal Code		M		

Identifier type	Element ID	Element name	SP	OP	CI	PP
Organization information (cont'd)	Z8	Organization Roles		M		
	Z9	Provincial/Territorial Ministry		M		
	Z10a	Contact/Reporting in English		M		
	Z10b	Contact/Reporting in French		M		
	Y10a	Vendor Code 1		M		
	Y10b	Vendor Code 2		O		
	Y10c	Vendor Code 3		O		
	Y10d	Vendor Code 4		O		
	Y10e	Vendor Code 5		O		
Contact details	Z20	Contact Name			M	
	Z21	Contact Telephone Number			M	
	Z22	Contact Telephone Extension Number			M	
	Z23	Contact Fax Number			O	
	Z24	Contact Email Address			M	
	Z25	Contact Output Notification			M	
Provincial processing information	ZP1	Number of Reporting Periods				M
	ZP2	Number of Submission Periods				M
	ZP3	Flow of Client-Specific Data to CIHI				M
	ZP4	Health Card Number Encryption				M
Provincial mandate for Admission records	ZP5	Province-Wide Client Identifiers (X1a) — Submission Mandated				M
	ZP6	Subregion Identifier — Submission Mandated				M
	ZP7	Program Identifier — Submission Mandated				M
	ZP10a	Referral Source for Acute Home Care Client Group Mandated				M
	ZP10b	Referral Source for End-of-Life Client Group Mandated				M
	ZP10c	Referral Source for Rehabilitation Client Group Mandated				M
	ZP10d	Referral Source for Long-Term Supportive Care Client Group Mandated				M

Identifier type	Element ID	Element name	SP	OP	CI	PP
Provincial mandate for Admission records (cont'd)	ZP10e	Referral Source for Maintenance Client Group Mandated				M
	ZP11a	Acceptance Date for Acute Home Care Client Group Mandated				M
	ZP11b	Acceptance Date for End-of-Life Client Group Mandated				M
	ZP11c	Acceptance Date for Rehabilitation Client Group Mandated				M
	ZP11d	Acceptance Date for Long-Term Supportive Care Client Group Mandated				M
	ZP11e	Acceptance Date for Maintenance Client Group Mandated				M
	ZP12a	Primary Language for Acute Home Care Client Group Mandated for Admission Record				M
	ZP12b	Primary Language for End-of-Life Client Group Mandated for Admission Record				M
	ZP12c	Primary Language for Rehabilitation Client Group Mandated for Admission Record				M
	ZP12d	Primary Language for Long-Term Supportive Care Client Group Mandated for Admission Record				M
	ZP12e	Primary Language for Maintenance Client Group Mandated for Admission Record				M
Provincial mandate for RAI-HC assessment	ZP20d	Mandate for RAI Assessment of Long-Term Supportive Care Client Group				M
	ZP20e	Mandate for RAI Assessment of Maintenance Client Group				M
Provincial mandate for home care service utilization records	ZP30a	Home Care Service Utilization Records — Submission Mandated for Acute Home Care Client Group				M
	ZP30b	Home Care Service Utilization Records — Submission Mandated for End-of-Life Client Group				M
	ZP30c	Home Care Service Utilization Records — Submission Mandated for Rehabilitation Client Group				M
	ZP30d	Home Care Service Utilization Records — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP30e	Home Care Service Utilization Records — Submission Mandated for Maintenance Client Group				M
	ZP31a	Service Type — Submission Mandated for Acute Home Care Client Group				M

Identifier type	Element ID	Element name	SP	OP	CI	PP
Provincial mandate for home care service utilization records (cont'd)	ZP31b	Service Type — Submission Mandated for End-of-Life Client Group				M
	ZP31c	Service Type — Submission Mandated for Rehabilitation Client Group				M
	ZP31d	Service Type — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP31e	Service Type — Submission Mandated for Maintenance Client Group				M
	ZP32a	Home Care Discipline — Submission Mandated for Acute Home Care Client Group				M
	ZP32b	Home Care Discipline — Submission Mandated for End-of-Life Client Group				M
	ZP32c	Home Care Discipline — Submission Mandated for Rehabilitation Client Group				M
	ZP32d	Home Care Discipline — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP32e	Home Care Discipline — Submission Mandated for Maintenance Client Group				M
	ZP33a	Service Delivery Setting — Submission Mandated for Acute Home Care Client Group				M
	ZP33b	Service Delivery Setting — Submission Mandated for End-of-Life Client Group				M
	ZP33c	Service Delivery Setting — Submission Mandated for Rehabilitation Client Group				M
	ZP33d	Service Delivery Setting — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP33e	Service Delivery Setting — Submission Mandated for Maintenance Client Group				M
	ZP34a	Acute Services Flag — Submission Mandated for Acute Home Care Client Group				M
	ZP34b	Acute Services Flag — Submission Mandated for End-of-Life Client Group				M
	ZP34c	Acute Services Flag — Submission Mandated for Rehabilitation Client Group				M

Identifier type	Element ID	Element name	SP	OP	CI	PP
Provincial mandate for home care service utilization records (cont'd)	ZP34d	Acute Services Flag — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP34e	Acute Services Flag — Submission Mandated for Maintenance Client Group				M
	ZP35a	Service Visits — Submission Mandated for Acute Home Care Client Group				M
	ZP35b	Service Visits — Submission Mandated for End-of-Life Client Group				M
	ZP35c	Service Visits — Submission Mandated for Rehabilitation Client Group				M
	ZP35d	Service Visits — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP35e	Service Visits — Submission Mandated for Maintenance Client Group				M
	ZP36a	Minutes of Service — Submission Mandated for Acute Home Care Client Group				M
	ZP36b	Minutes of Service — Submission Mandated for End-of-Life Client Group				M
	ZP36c	Minutes of Service — Submission Mandated for Rehabilitation Client Group				M
	ZP36d	Minutes of Service — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP36e	Minutes of Service — Submission Mandated for Maintenance Client Group				M
Provincial mandate for ER Visits records	ZP40a	ER Visits Records — Submission Mandated for Acute Home Care Client Group				M
	ZP40b	ER Visits Records — Submission Mandated for End-of-Life Client Group				M
	ZP40c	ER Visits Records — Submission Mandated for Rehabilitation Client Group				M
	ZP40d	ER Visits Records — Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP40e	ER Visits Records — Submission Mandated for Maintenance Client Group				M

Identifier type	Element ID	Element name	SP	OP	CI	PP
Provincial mandate for Discharge records	ZP50a	Service Goals Met Submission Mandated for Acute Home Care Client Group				M
	ZP50b	Service Goals Met Submission Mandated for End-of-Life Client Group				M
	ZP50c	Service Goals Met Submission Mandated for Rehabilitation Client Group				M
	ZP50d	Service Goals Met Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP50e	Service Goals Met Submission Mandated for Maintenance Client Group				M
	ZP51a	Reason for Discharge Submission Mandated for Acute Home Care Client Group				M
	ZP51b	Reason for Discharge Submission Mandated for End-of-Life Client Group				M
	ZP51c	Reason for Discharge Submission Mandated for Rehabilitation Client Group				M
	ZP51d	Reason for Discharge Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP51e	Reason for Discharge Submission Mandated for Maintenance Client Group				M
	ZP52a	Referred to Other Health Services Submission Mandated for Acute Home Care Client Group				M
	ZP52b	Referred to Other Health Services Submission Mandated for End-of-Life Client Group				M
	ZP52c	Referred to Other Health Services Submission Mandated for Rehabilitation Client Group				M
	ZP52d	Referred to Other Health Services Submission Mandated for Long-Term Supportive Care Client Group				M
	ZP52e	Referred to Other Health Services Submission Mandated for Maintenance Client Group				M

Appendix B — Error messages

Error #	Error message	Applicable data elements
000040	Format of AA3a (Health Card Number) inconsistent with (AA3b) Province/Territory Issuing Health Card Number	AA3a
000070	Invalid Postal Code format: format must be ANA or ANANAN with first character not equal to D, F, I, O, Q, U, or W	AA4
000110	BB2a (Birth Date) must be on or before Year and Month of CC1 (Date Case Opened/Reopened)	BB2a
000210	All elements BB8a–BB8j are coded 0: BB8k (Payment Unknown/Unavailable) must be coded 1	BB8k
000350	A1 (Assessment Reference Date) must be on or after CC1 (Date Case Opened/Reopened)	A1
000410	When elements E1a–E1i are coded 0, E2 (Mood Decline) is expected to be coded 0.	E2
000450	No Informal Helpers are recorded (G1eA = 2). Data element not applicable and must be blank.	G1fA–G1lA, G1fB–G1lb, G2b, G2c
000460	Both informal helpers are coded as client's spouse/partner (G1fA and G1fB coded 1).	G1fB
000490	All elements G2a–G2c are coded 0: G2d (Caregiver Status-None of the Above) must be coded 1	G2d
000510	Time for receipt of prepared meals is recorded in P1d. H1aA (Meal Preparation–Self Performance) expected to be coded 0, 1, 2 or 3.	H1aA
000540	Client coded as wandering (E3a coded 1 or 2). Client expected to be able to perform some locomotion H2c (Locomotion in Home) expected to be coded 0, 1, 2, 3, 4, or 5	H2c
000570	H2c (Locomotion in Home) is coded as "Did not occur". H4a (Mode of Locomotion: Indoors) must also be coded as "Did not occur"	H4a
000580	H2d (Locomotion Outside Home) is coded as "Did not occur" H4b (Mode of Locomotion: Outdoors) must also be coded as "Did not occur"	H4b
000590	Both H2c (Locomotion in Home) and H2d (Locomotion Outside Home) coded as "did not occur" (code 8). H5 (Stair Climbing) expected to be coded as 2	H5

Error #	Error message	Applicable data elements
000610	All elements H7a–H7c are coded 0: H7d (Functional Potential—None of the above) must be coded 1	H7d
000630	I2a and I2b are coded 0: I2c (None of the above) must be coded 1	I2c
000650	All elements J1a–J1ab are coded 0: J1ac (Disease—None of the above) must be coded 1	J1ac
000660	P2g (Dialysis Treatment) is coded 1, 2 or 3. J1aa (Renal Failure) expected to be coded 1 or 2	J1aa
000680	All elements K1a–K1d are coded 0: K1e (None of the above) must be coded 1	K1e
000700	All elements K2a–K2e are coded 0: K2f (None of the above) must be coded 1	K2f
000720	All elements K3a–K3g are coded 0: K3h (None of the above) must be coded 1	K3h
000730	I3 (Bowel Continence) is coded 8: K3b (No Bowel Movement in 3 Days) expected to be coded 1	K3b
000750	K4a Pain Frequency coded 0 (No pain). K4b–K4e must be coded 0.	K4b–K4e
000770	All elements K8a–K8e are coded 0: K8f (None of the above) must be coded 1	K8f
000790	All elements K9a–K9e are coded 0: K9f (None of the above) must be coded 1	K9f
000800	H2g (Eating) is coded 8: L2a (One or fewer meals a day) expected to be coded 1	L2a
000810	L2d (Enteral tube feeding) is coded 1: L3 (Swallowing) expected to be coded 3 or 4	L3
000830	All elements M1a–M1c are coded 0: M1d (None of the above) must be coded 1	M1d
000850	All elements N3a–N3e are coded 0: N3f (None of the above) must be coded 1	N3f
000870	All elements N5a–N5d are coded 0: N5e (None of the above) must be coded 1	N5e
000890	All elements O1a–O1h are coded 0: O1i (None of the above) must be coded 1	O1i

Error #	Error message	Applicable data elements
000900	Time recorded in P1aB (Hours) or P1aC (Minutes). P1aA (Days) must be greater than 0	P1aA
000920	All elements P2a–P2z are coded 0: P2aa (None of the above) must be coded 1	P2aa
000940	P1gA (Occupational Therapy) is greater than 0: P2o (Occupational Therapy) expected to be coded 1 or 2	P2o
000950	P1fA (Physical Therapy) is greater than 0: P2p (Physical Therapy) expected to be coded 1 or 2	P2p
000970	H1dA (Managing Medications–Self Performance) = 0, 1, 2, or 3: Q1 Number of Medications expected to be 1 or more	Q1
001070	Client's sex is recorded as male. K1d (Received breast examination or mammography) must be coded 0.	K1d
001090	R1c (Date Assessment Signed as Complete) is before A1 (Assessment Reference Date)	R1c
001110	R1c (Date Assessment Signed as Complete) is before CC1 (Date Case Opened/Reopened)	R1c
001150	AA3b (Province/Territory issuing Health Card Number) is coded as "not applicable" (-90). AA3a (Health Card Number) must also be coded as "not applicable"—code 1	AA3a
001160	AA3b (Province/Territory issuing Health Card Number) is coded as "not available" or "asked, unknown" (-50 or -70). AA3a (Health Card Number) must also be coded as "asked, unknown"—code 0	AA3a
001170	Calculated Age at Date Case Opened/Reopened is greater than 120 years. Check BB2a (Birth Date) and CC1 (Date Case Opened/Reopened)	BB2a
001180	At least one element in BB8a–BB8j is coded 1. BB8k must be coded as 0	BB8k
001190	All elements in section CC of client's initial RAI-HC assessment must be completed when X2 Client Group on Admission Record is Long-Term Supportive Care or Maintenance and A1 Assessment Reference Date is <= to a year of CC1 Date Case Opened/Reopened.	CC2, CC3a, CC3b, CC3c, CC3d, CC3e, CC3f, CC4, CC5, CC7

Error #	Error message	Applicable data elements
001200	No caregivers were recorded in Section G (G1eA is coded 2). O2b (Better Off Elsewhere) should be coded 0 or 1	G1eA, O2b
001210	A Primary Informal Helper has been recorded (G1eA coded 0 or 1) and the assessment has been completed in a private home. Data element must not be blank.	G1jA–G1lA
001220	A Secondary Informal Helper has been recorded (G1eB coded 0 or 1) and the assessment has been completed in a private home. Data element cannot be blank	G1fB, G1jB, G1kB, G1lB
001230	No Primary Informal Helper has been recorded (G1eA coded 2). Cannot have a Secondary Informal Helper: G1eB must be coded 2	G1eB
001240	No Secondary Informal Helper is recorded (G1eB coded 2). Data element not applicable and must be blank.	G1fB–G1lB
001250	At least one Informal Helper has been recorded (G1eA coded 0 or 1). Data element must not be blank.	G2b, G2c
001260	At least one element in G2a–G2c is coded 1. G2d (None of the above) must be coded as 0	G2d
001270	At least one element in H7a–H7c is coded 1. H7d (None of the above) must be coded as 0	H7d
001280	At least one of I2a and I2b is coded 1. I2c (None of the above) must be coded as 0	I2c
001290	At least one element J1a–J1ab is coded 1 or 2. J1ac (None of the above) must be coded as 0	J1ac
001310	Value submitted in J2b (ICD-10-CA code 2). Value expected in J2a (ICD-10-CA code 1)	J2a
001320	Value submitted in J2c (ICD-10-CA code 3). Value expected in J2b (ICD-10-CA code 2)	J2b
001330	Value submitted in J2d (ICD-10-CA code 4). Value expected in J2c (ICD-10-CA code 3)	J2c
001550	CC1 (Date Case Opened/Reopened) for Long-Term Supportive Care client, Maintenance client, or client group not provided (X2 coded 4, 5 or 9) is more than 30 years ago	CC1
001560	CC1 (Date Case Opened/Reopened) for Acute Home Care, End-of Life or Rehabilitation client (X2 coded 1, 2 or 3) is more than one year ago	CC1

Error #	Error message	Applicable data elements
001580	A client must have a valid sex (BB1 = M or F) before a RAI-HC record can be accepted.	Y2
001590	A client must have a valid Primary Language (BB5a) before a RAI-HC record can be accepted.	Y2
001600	A1 (Assessment Reference Date) must be between dates of Reporting Period (Y13)	A1
001610	A Contact Information record with Z25 = 1 (Data Submission/Single Point of Contact) cannot be deleted. If contact details need to be changed—submit a Correction to the original record	Y3
001620	An Organization Profile cannot be deleted. If changes need to be made—submit a Correction to the original record	Y3
001630	A Provincial Profile cannot be deleted. If changes need to be made—submit a Correction to the original record	Y3
001640	Invalid format for an email address: it must contain one and only one @	Z24
001650	Invalid format for an email address: last three characters must contain '.' followed by two alpha characters (e.g. .ca) or last four characters must be '.' followed by three alpha characters (e.g. .com)	Z24
001660	Invalid Organization Identifier	Z1, Z1a, Z1b, Z1p
001670	Invalid combination of Organization Identifier and Organization Effective Date	Z1, Z1a, Z1b, Z1p
001680	Y11 (Date of Submission) is after CIHI processing date	Y11
001690	Y12 (Reporting Fiscal Year) must be on or before Active Fiscal Year	Y12
001700	Number of records must match number stated in Y14 (Number of Records)	Y14
001710	A "New" client record must have a combination of Z1a (Source Organization Identifier), Y2 (Record Type) and Y1 (Record ID) that does not already exist in the database	Y1
001720	A "New" client record must have a combination of Z1a (Source Organization Identifier), Z1c (Effective Date), Y2 (Record Type) and Y1 (Record ID) that does not already exist in the database	Y1

Error #	Error message	Applicable data elements
001730	A “Correction” client record must have a combination of Z1a (Source Organization Identifier), Y2 (Record Type) and Y1 (Record ID) that already exists in the database	Y1
001740	A “Correction” client record must have a combination of Z1a (Source Organization Identifier), Z1c (Effective Date), Y2 (Record Type) and Y1 (Record ID) that already exists in the database	Y1
001750	A “Deletion” client record must have a combination of Z1a (Source Organization Identifier), Y2 (Record Type) and Y1 (Record ID) that already exists in the database	Y1
001760	A “Deletion” client record must have a combination of Z1a (Source Organization Identifier), Z1c (Effective Date), Y2 (Record Type) and Y1 (Record ID) that already exists in the database	Y1
001770	Admission cannot be deleted. At least one other record exists that is related to this admission which must be deleted first.	Y3
001780	RAI-HC Assessment cannot be deleted. At least one Medication Record exists that is related to this assessment which must be deleted first.	Y3
001790	Service Start cannot be deleted. At least one other record (Service Detail and/or Service End) exists that is related to this Service Start which must be deleted first.	Y3
001800	At least one element in K1a–K1d is coded 1. K1e (None of the above) must be coded as 0	K1e
001810	At least one element in K2a–K2e is coded 1. K2f (None of the above) must be coded 0	K2f
001820	At least one element in K3a–K3g is coded 1: K3h (None of the above) must be coded 0	K3h
001830	At least one element in K8a–K8e is coded 1: K8f (None of the above) must be coded 0	K8f
001840	At least one element in K9a–K9e is coded 1: K9f (None of the above) must be coded 0	K9f
001850	At least one element in M1a–M1c is coded 1: M1d (None of the above) must be coded 0	M1d
001860	At least one element in N3a–N3e is coded 1: N3f (None of the above) must be coded 0	N3f

Error #	Error message	Applicable data elements
001870	At least one element in N5a–N5d is coded 1: N5e (None of the above) must be coded 0	N5e
001880	At least one element in O1a–O1h is coded 1: O1i (None of the above) must be coded 0	O1i
001890	Time recorded in P1jB (Hours) or P1jC (Minutes): P1jA (Days) must be greater than 0	P1jA
001900	Time recorded in P1bB (Hours) or P1bC (Minutes): P1bA (Days) must be greater than 0	P1bA
001910	Time recorded in P1cB (Hours) or P1cC (Minutes): P1cA (Days) must be greater than 0	P1cA
001920	Time recorded in P1dB (Hours) or P1dC (Minutes): P1dA (Days) must be greater than 0	P1dA
001930	Time recorded in P1eB (Hours) or P1eC (Minutes): P1eA (Days) must be greater than 0	P1eA
001940	Time recorded in P1fB (Hours) or P1fC (Minutes): P1fA (Days) must be greater than 0	P1fA
001950	Time recorded in P1gB (Hours) or P1gC (Minutes): P1gA (Days) must be greater than 0	P1gA
001960	Time recorded in P1hB (Hours) or P1hC (Minutes): P1hA (Days) must be greater than 0	P1hA
001970	Time recorded in P1iB (Hours) or P1iC (Minutes): P1iA (Days) must be greater than 0	P1iA
001980	Both P1aB (Hours) and P1aC (Minutes) coded 0. P1aA (Days) must also be coded 0	P1aA
001990	Both P1bB (Hours) and P1bC (Minutes) coded 0. P1bA (Days) must also be coded 0	P1bA
002000	Both P1cB (Hours) and P1cC (Minutes) coded 0. P1cA (Days) must also be coded 0	P1cA
002010	Both P1dB (Hours) and P1dC (Minutes) coded 0. P1dA (Days) must also be coded 0	P1dA
002020	Both P1eB (Hours) and P1eC (Minutes) coded 0. P1eA (Days) must also be coded 0	P1eA
002030	Both P1fB (Hours) and P1fC (Minutes) coded 0. P1fA (Days) must also be coded 0	P1fA

Error #	Error message	Applicable data elements
002040	Both P1gB (Hours) and P1gC (Minutes) coded 0. P1gA (Days) must also be coded 0	P1gA
002050	Both P1hB (Hours) and P1hC (Minutes) coded 0. P1hA (Days) must also be coded 0	P1hA
002060	Both P1iB (Hours) and P1iC (Minutes) coded 0. P1iA (Days) must also be coded 0	P1iA
002070	Both P1jB (Hours) and P1jC (Minutes) coded 0. P1jA (Days) must also be coded 0	P1jA
002090	P2p (Physical Therapy) is coded 1 or 2: P1fA (Physical Therapy) should be greater than 0	P1fA
002100	P2o (Occupational Therapy) is coded 1 or 2: P1gA (Occupational Therapy) should be greater than 0	P1gA
002110	P2r (Day Hospital) is coded 1 or 2 and Coding Standards for RAI-HC in Hospital Settings does not apply. P1iA (Day Care/Day Hospital) should be greater than 0.	P1iA
002120	P2q (Day Centre) is coded 1 or 2 and Coding Standards for RAI-HC in Hospital Settings does not apply. P1iA (Day Care/Day Hospital) should be greater than 0.	P1iA
002130	At least one element in P2a–P2z is coded 1: P2aa (None of the above) must be coded 0	P2aa
002140	If X41 (DIN) is blank: elements Q5a–Q5c must be recorded	Q5a
002160	X2 (Client Group) on Update Client Profile is the same as Client Group currently in effect	X2
002170	It is unusual to change X2 (Client Group) from End-of-Life to another group.	X2
002180	X10 (Service Start Date) must be on or after CC1 (Date Case Opened/Reopened)	X10
002190	A Discharge Record for this Admission exists, X10 (Service Start Date) must be on or before X30 (Discharge Date)	X10
002210	X17 (Service End Date) must be on or after X10 (Service Start Date)	X17
002220	X17 (Service End Date) must be on or after CC1 (Date Case Opened/Reopened)	X17
002240	X30 (Discharge Date) must be on or after CC1 (Date Case Opened/Reopened)	X30

Error #	Error message	Applicable data elements
002280	Effective Client Group is Acute Home Care: according to Provincial Profile element is mandatory for this client group	BB5a, X15, X16, X31, X32, X33, X5, X6
002290	Effective Client Group is End-of-Life: according to Provincial Profile element is mandatory for this client group	BB5a, X5, X6, X15, X16, X31, X32, X33,
002300	Effective Client Group is Rehabilitation: according to Provincial Profile element is mandatory for this client group	BB5a, X5, X6, X15, X16, X31, X32, X33
002310	Effective Client Group is Long-Term Supportive Care: according to Provincial Profile element is mandatory for this client group	BB5a, X5, X6, X15, X16, X31, X32, X33
002320	Effective Client Group is Maintenance: according to Provincial Profile element is mandatory for this client group	BB5a, X5, X15, X16, X31, X32, X33,
002330	According to Provincial Profile element is mandatory—it must contain a value	X1a, X3, X4
002341	Provincial Profile indicates Quarterly Reporting. Y13 must be coded 1–4	Y13
002350	Provincial Profile indicates Monthly (12 Period) Reporting. Y13 must be coded 1–12	Y13
002370	Effective Client Group is Acute Home Care: according to Provincial Profile data element cannot be coded as 'not specified/not collected' (e.g. 9, 99, or 999)	X11–X14
002380	Effective Client Group is End-of-Life: according to Provincial Profile data element cannot be coded as 'not specified/not collected' (e.g. 9, 99, or 999)	X11, X12, X13, X14
002390	Effective Client Group is Rehabilitation: according to Provincial Profile data element cannot be coded as 'not specified/not collected' (e.g. 9, 99, or 999)	X11–X14
002400	Effective Client Group is Long-Term Supportive Care: according to Provincial Profile data element cannot be coded as 'not specified/not collected' (e.g. 9, 99, or 999)	X11–X14
002410	Effective Client Group is Maintenance: according to Provincial Profile data element cannot be coded as 'not specified/not collected' (e.g. 9, 99, or 999)	X11–X14
002420	Collection of Service Start/Details/End records is not mandated for this client group: this data element must be coded 0	ZP31a–ZP36e
002430	At least one language preference must be specified in Z10a/Z10b	Z10a

Error #	Error message	Applicable data elements
002450	Element to be updated (as indicated in X50) must have a value	AA3a, AA3b, AA4, BB4, BB5a, X2, X3, X4
002460	All Service received under previous Client Group should have a Service End with Service End Date before Effective Date of Client Group change (X51). New Service Start records should be submitted for service received under new Client Group.	X51
002490	Both P2q (Day Centre) and P2r (Day Hospital) are coded 0 and Coding Standards for RAI-HC in Hospital Settings does not apply. P1iA (Day Care/Day Hospital—Days) is expected to be 0.	P1iA
002510	Q5d (Medication Frequency) coded 'as necessary' (PRN). Q5e (Number of Doses in Last 7 Days) must be recorded	Q5e
002520	A1 (Assessment Reference Date) is after X30 (Discharge Date) that already exists in database	A1
002530	RAI-HC Assessment Record for client with same A1 (Assessment Reference Date) and A2 (Reason for Assessment) already exists in database	A1
002540	CC1 (Date Case Opened/Reopened), A1 (Assessment Reference Date) and A2 (Reason for Assessment) of a Medication Record must match an existing RH record in the database	A1
002550	A Medication Record with the same X40 (Medication Sequence Number) for this assessment already exists in database	X40
002560	Q1 of the associated RH record did not record any medications. Medication Records for this assessment are not expected to be submitted.	X40
002570	This client does not exist in database: Z1a (Source Organization) and X1b (Source Organization Client Identifier) must match an existing client	X1b
002580	CC1 (Date Case Opened/Reopened) does not match an existing client's admission in the database	CC1
002590	Client's previous Admission must have an associated Discharge Record before a new Admission can be submitted	Y2
002610	Provincial Profile for Fiscal Year must exist before client records can be submitted	Y12

Error #	Error message	Applicable data elements
002620	A Database Contact for Submission Organization (for Fiscal Year) must exist before any records can be submitted	Z1b
002630	CC1 (Date Case Opened/Reopened) of latest admission must be after X30 (Discharge Date) of previous admission	CC1
002640	CC1 (Date Case Opened/Reopened) of corrected admission record must be on or before of all A1 (Assessment Reference Date) of existing RAI-HC records	CC1
002650	CC1 (Date Case Opened/Reopened) of corrected admission record must be before all X10 (Service Start Date) of existing Service Start records	CC1
002660	CC1 (Date Case Opened/Reopened) of corrected admission record must be before X30 (Discharge Date) of existing Discharge Record	CC1
002670	Fiscal Year & Period of CC1 (Date Case Opened/Reopened) of corrected admission record must be before all Fiscal Year & Period (Y12, Y13) of existing ER Visit records	CC1
002680	X6 (Date of Acceptance to Home Care) must be on or greater than CC1 (Date Case Opened/Reopened)	X6
002690	R1c (Date Signed Complete) is expected to be on or before X30 Discharge Date	R1c
002700	Service Start Record with Service Start Date (X10), Service Type (X11) and Home Care Discipline (X12) already exists	X10
002710	A Service Start Record with the same Service Type (X11) and Home Care Discipline (X12) already exists. Usually a Service End record is submitted before another Service Start record submitted	Y2
002730	Fiscal Year & Period of X10 (Service Start Date) for correction record must be on or before Fiscal Year & Period (Y12, Y13) of all associated Service Details record	X10
002740	A Service Start-Service End record pair with the same Service Type (X11) and Home Care Discipline (X12) already exists. Usually, the Service Start Date (X10) of an incoming record is after the Service End Date (X17) of the existing record pair.	X10
002750	Service Start Record with Service Start Date (X10), Service Type (X11) and Home Care Discipline (X12) must exist in database	X12

Error #	Error message	Applicable data elements
002760	Service Detail Record with Service Delivery Setting, Acute Services Flag, Fiscal Year & Period (X13, X14, Y11, Y12) already exists for the Service Start	X13
002770	Fiscal Year & Period of Service Detail record must be on or after Fiscal Year & Period of Service Start Date (X10)	Y13
002780	Fiscal Year & Period of Service Detail record must be on or before Fiscal Year & Period of existing Service End Date (X17)	Y13
002790	Fiscal Year & Period of Service Detail record must be on or before Fiscal Year & Period of existing Discharge Date (X30)	Y13
002810	Service End record already exists for Service Start	Y2
002830	Service End Date must be on or before existing Discharge Date (X30)	X17
002840	Another Service Start record with the same Service Type (X11) and Home Care Discipline (X12) already exists. Usually, the Service End Date (X17) is before the Service Start Date (X10) of this existing Service Start Record	X17
002850	ER Visits record already exists	Y13
002860	Fiscal Year & Period (Y12, Y13) of ER Visit record must be on or greater than Fiscal Year & Period of CC1 (Date Case Opened/Reopened)	Y13
002870	Fiscal Year & Period of ER Visit record must be on or before Fiscal Year & Period of existing Discharge Date (X30)	Y13
002900	An Update Client Profile record with combination of X50 (Element to be updated) and X51 (Effective Date) already exists	X50
002910	X51 (Effective Date) must be after CC1 (Date Case Opened/Reopened) of latest admission	X51
002920	X51 (Effective Date) must be before X30 (Discharge Date) of latest admission	X51
002930	A Discharge record already exists for the Admission	Y2
002940	X51 (Effective Date) must be between dates of Reporting Period (Y13)	X51
002950	X30 (Discharge Date) must be between dates of Reporting Period (Y13)	X30

Error #	Error message	Applicable data elements
002960	X17 (Service End Date) must be between dates of Reporting Period (Y13)	X17
002970	X30 (Discharge Date) is expected to be on or after X6 (Date of Acceptance to Home Care)	X30
002980	A later Admission record for this client exists in the database. The Discharge Date (X30) of this record must be before the CC1 of the existing Admission	X30
002990	X30 (Discharge Date) must be on or after A1 (Assessment Reference Date) for existing RAI-HC records	X30
003000	X30 (Discharge Date) must be on or after X10 (Service Start Date) for existing Service records	X30
003010	Fiscal Year & Period of X30 (Discharge Date) must be on or after Fiscal Year & Period (Y12, Y13) of existing Service Detail records	X30
003020	X30 (Discharge Date) must be on or after X17 (Service End Date) for existing Service End records	X30
003030	Fiscal Year & Period of X30 (Discharge Date) must be on or after Fiscal Year & Period (Y12, Y13) of existing ER Visits records	X30
003050	Provincial Profile for Fiscal Year already exists	Y2
003060	Organization Profile for Fiscal Year already exists	Y2
003070	A Contact Information record with value of Z25 (Output Notification) already exists. If information needs to be changed—submit a Correction record	Z25
003080	Organization Profile for Fiscal Year must exist before Contact Information can be submitted	Z1
003090	A NEW Provincial Profile record for a Fiscal Year must have a unique Record Id (Y1) that does not already exist in database	Y1
003100	A Correction to an existing Provincial Profile must have a unique Record Id (Y1) that already exists in database	Y1
003110	Submission must contain only unique record identifiers (Y1 and Y2) for each organization	Y1
003130	Y12 (Fiscal Year) has closed.	Y11

Error #	Error message	Applicable data elements
003141	Client records from this Source Organization (Z1a) cannot be submitted by the Organization identified in element Z1b (Submission Organization) of Submission Profile	Z1a
003151	Organization identified in Z1a is not a Source Organization	Z1a
003160	Case Management should only be carried out by licensed or regulated health disciplines	X12
003170	X1b (Source Organization Client Identifier) matches an existing client in the database. AA3a (Health Card Number) must also match this client's information. Check all Personal Identifiers.	AA3a
003180	X1b (Source Organization Client Identifier) and AA3a (Health Card Number) match an existing client in the database. AA3b (P/T Issuing Health Card Number), BB1 (Sex) and BB2a (Birth Date) must also match this client's information.	AA3b
003190	When X1b (Source Organization Client Identifier) does not match an existing client but AA3a (Health Card Number) and AA3b (P/T Issuing Health Card Number) do match, AA3a must be coded 0 or 1. Check all Personal Identifiers.	AA3a
003200	When X1b (Source Organization Client Identifier) and AA3b (P/T Issuing Health Card Number) do not match an existing client but AA3a (Health Card Number) does match, AA3a is expected to be coded 0 or 1. Check all Personal Identifiers.	AA3a
003210	Q5d (Medication Frequency) is not coded "PRN". Q5e must be blank	Q5e
003220	An admission record with CC1 (Date Case Opened) already exists for this client	CC1
003230	Service Start has an associated Service End record. X10 (Service Start Date) must be on or before (X17) Service End Date	X10
003240	New organization records must have a combination of Z1 (Organization Identifier), Y2 (Record Type) and Y1 (Record ID) that does not already exist in the database	Y1
003250	New organization records must have a combination of Z1 (Organization Identifier), Z1c (Effective Date) Y2 (Record Type) and Y1 (Record ID) that does not already exist in the database	Y1

Error #	Error message	Applicable data elements
003260	Correction records for Organization Profile & Contact Information must have a combination of Z1 (Organization Identifier), Y2 (Record Type) and Y1 (Record ID) that already exist in the database	Y1
003270	Correction records for Organization Profile & Contact Information must have a combination of Z1 (Organization Identifier), Z1c (Effective Date), Y2 (Record Type) and Y1 (Record ID) that already exist in the database	Y1
003280	Deletions for Contact Information records must have a combination of Z1 (Organization Identifier), Y2 (Record Type) and Y1 (Record ID) that already exist in the database	Y1
003290	Deletions for Contact Information records must have a combination of Z1 (Organization Identifier), Z1c (Effective Date) Y2 (Record Type) and Y1 (Record ID) that already exist in the database	Y1
003300	ICD-10-CA code is not valid for client's Age (derived from Birth Date (BB2a) and Assessment Reference Date (A1)) and/or Sex (BB1).	J2a–J2d
003320	Invalid format for an email address: it cannot contain consecutive dots (e.g. '..' or '...')	Z24
003330	Z1p (Previous Source Organization) and X1p (Previous Source Organization Client Identifier) must match an existing client in the database	X1p
003340	Combination of current and previous Source organizations: Z1a and Z1p (and Z1c/Z1pc if necessary) is invalid	Z1p
003350"	Invalid Postal Code format: format must be ANANAN with first character not equal to D, F, I, O, Q, U, or W	Z7
003360	Invalid Vendor Code	Y10a–Y10e, Y10x, Y10y
010010	Invalid value for Alphanumeric format	All alphanumeric elements
010020	Invalid value for Date format	All date elements
010030	Submitted date must be before Date of Submission (Y11)	All date elements
010040	Invalid value for Numeric format	All numeric elements
010050	Invalid value for Year-Month format	All date–month elements
010060	Submitted value must be before Year and Month of Date of Submission (Y11)	All date–month elements

Error #	Error message	Applicable data elements
010070	Submitted date must be on or before the last day of the fiscal period (Y13)	All date elements
010110	Data length is too short	All elements
010120	Data length is too long	All elements
010211	Submitted data is not a valid value/code for this data element	All elements with specified valid values
010310	Element must contain a value on new and correction records	All elements
010320	Element must contain a value	All elements
010330	Vendor Code (Y10x) is not listed in Source Organization's Organization Profile	Y10x
010340	Data element must be blank	AA3a, AA3b, AA4, BB4, BB5a, X2, X3, X4
010350	An OT record for the previous client (as specified by Z1p/X1p) already exists	Y2
010360	Client Transfer Date (X60) must be between dates of Reporting Period (Y13)	X60
010370	The Reporting Period (Y13) of the client transfer must be on or after the fiscal period the organization change took place	Y13
010380	Client Transfer Date (X60) must be on or after the Date Case Opened/Reopened (CC1) of Previous Client's last admission	X60
010390	Client Transfer Date (X60) must be on or after the Element Effective Date (X51) of Previous Client's last Update Client Profile (UC) record	X60
010400	Client Transfer Date (X60) must be on or after the Assessment Reference Date (A1) of Previous Client's last RAI-HC assessment (RH) record	X60
010410	Client Transfer Date (X60) must be on or after the Service Start Date (X10) of Previous Client's last Service Start (SS) record	X60
010420	The Reporting Period (Y13) of the client transfer must be on or after the fiscal period of Previous Client's last Service Details (SD) record	Y13
010430	Client Transfer Date (X60) must be on or after the Service End Date (X17) of Previous Client's last Service End (SE) record	X60

Error #	Error message	Applicable data elements
010440	The Reporting Period (Y13) of the client transfer must be on or after the fiscal period of Previous Client's last ER Visits (ER) record	Y13
010450	A Discharge (DC) record exists for this Previous Client (X1p): an OT record is expected only for current clients who have not been discharged from their last admission	X1p
010460	Client Transfer Date (X60) must be on or after the Discharge Date (X30) of Previous Client's last admission	X60
010470	An OT record or AD record for this client (as specified by X1b) already exists	Y2
010480	The Source Organization Unique Client Identifier (X1b) cannot be changed on a correction to an Admission record. If a mistake has been made in X1b, the AD record must be deleted and a new record with the correct X1b submitted	X1b
010490	Only an interrater reliability assessment (Reason for Assessment A2 = 8) can be submitted with the same Assessment Reference Date (A1) as an RH record that is already in the database	A2
010500	An interrater reliability assessment (Reason for Assessment A2 = 8) can be submitted only if there is an RH record with the same or earlier Assessment Reference Date (A1) already in the database.	A1
010510	An Organization Profile record for this organization must exist before Client records can be submitted	Z1a
010520	Information submitted in the Submission Profile record must match the filename	Y12, Z1b
010530	CC1 (Date Case Opened/Reopened) of corrected admission record must be before all X51 (Element Effective Date) of existing UC records	CC1
010540	Record contains duplicate data elements	All elements
010550	Submission file must contain a Submission Profile (SP) record	Y2
010560	First record in submission file must be a Submission Profile (SP) record	Y2
010570	Submission file must contain one and only one Submission Profile (SP) record	Y2
010580	File must contain at least one record	File processing rules

Error #	Error message	Applicable data elements
010590	All data elements in the Submission Profile record (SP) must contain valid data	Y2
010600	XML declaration is incorrect	File processing rules
010610	XML root element is incorrect	File processing rules
010620	XML file is invalid (not well-formed)	File processing rules
010630	File name is invalid (does not meet CIHI standard naming convention)	File processing rules
010660	Record exceeds maximum length specified for this record type	Y2
010670	Element to be updated (as indicated in X50) must be coded 1-5	X2
010680	Submitted data is not a valid value/code for this data element for this province/territory	BB7a, BB7b
010690	Duplicate Vendor Code	Y10b–Y10e
010700	Location of assessment is not a private residence, date of admission to facility setting must be provided.	X71
010710	Data element is mandatory if location of assessment is completed in community.	F3a, G3a, G3b, H1aA–H1gA, K1a–K1e, O1a, O1b, O1h, P1aA–P1eA, P1iA, P1aB–P1eB, P1iB, P1aC–P1eC, P1iC, P3a–P3d, P4c, P5, P7, Q3
010720	In ON, CC8 of client's initial RAI-HC assessment must be completed when X2 Client Group on Admission Record is Long-Term Supportive Care or Maintenance and A1 is <= to a year of CC1 and the assessment has been completed in a private residence.	CC8
010730	Assessment has been completed in a private residence or less than 90 days after admission to a facility setting. Data element must not be blank.	F3a, O1a–O1i, P7, Q4
010740	A Primary Informal Helper has been recorded (G1eA coded 0 or 1) and the assessment has been completed in a private home or less than 90 days after admission to a facility setting. Data element must not be blank.	G1gA–G1lA
010760	Service End Date (X17) must be within or after the reporting fiscal period (Y12/Y13) of associated SD record.	X17

Error #	Error message	Applicable data elements
010770	CC6 on initial assessment must be completed when X2 on AD record is Long-Term Supportive Care or Maintenance and A1 is <= to 1 year of CC1 and assessment is completed in a private home or less than 90 days after admission to facility setting.	CC6
010780	CC8 on initial assessment must be completed when X2 on AD record is Long-Term Supportive Care or Maintenance and A1 is <= to 1 year of CC1 and assessment is completed in a private home or less than 90 days after admission to facility setting.	CC8
010790	X32 (Reason for Discharge) is not coded 2 (Client Referred to other health services). X33 (Referred to other health services) must be blank.	X33, X32
010800	A Secondary Informal Helper has been recorded (G1eB coded 0 or 1) and the assessment has been completed less than 90 days after admission to a facility setting. Data element cannot be blank.	G1gB, G1hB, G1iB
010830	Data element is mandatory if location of assessment is completed in community.	BB3, BB6, F2, F3b, K1a–K1e, P1fA, P1gA, P1hA, P1jA, P1fB, P1gB, P1hB, P1jB, P1fC, P1gC, P1hC, P1jC, P4c
010840	CC4 on initial assessment must be completed when X2 on AD record is Long-Term Supportive Care or Maintenance and A1 is <= to 1 year of CC1 and assessment is completed in a private home or less than 90 days after admission to facility setting.	CC4
010850	CC5 on initial assessment must be completed when X2 on AD record is Long-Term Supportive Care or Maintenance and A1 is <= to 1 year of CC1 and assessment is completed in a private home or less than 90 days after admission to facility setting.	CC5
010870	On an initial assessment, if X70 (Location of Assessment) indicates the assessment was completed at home (code 1), CC4 would not usually be coded as 0 (presently in hospital).	X70, CC4
010880	On an initial assessment, if X70 (Location of Assessment) indicates the assessment was completed in hospital (code 2), CC4 would usually be coded as 0 (presently in hospital).	X70, CC4
108090	CC1 (Date Case Opened/Reopened) on the second AD record does not usually match X51 (Effective Date) of the existing UC record	CC1, X51

Error #	Error message	Applicable data elements
010891	A residents identifiable personal health information (i.e Health Card Number, first name, last name, full date of birth) should not be contained in data element	X1b
010892	Only assessment records with an assessment reference date (A1) on or after April 1, 2002 are accepted in the Home Care Reporting system (HCRS)	A1

Appendix C — Text alternative for image

Text alternative for decision tree

Use this process to assign a client group. First, determine whether the client, although being assessed by a home care program (e.g., for long-term care placement), will not be receiving any other home care services. If yes, then the client group is Not Applicable. If no, then determine whether death is anticipated within 6 months. If yes, then the client group is End of Life. If no, then determine whether the client has a primary need for immediate or urgent but time-limited intervention, with a goal to improve and/or stabilize a medical or a post-surgical condition, and whether the client also does not need rehabilitation or ongoing support to remain in the community. If this is the case, then the client group is Acute. If this is not the case, then determine whether the client has a stable health condition that is expected to improve with a time-limited focus on goal-oriented, functional rehabilitation. If yes, then the client group is Rehabilitation. In this case, also apply the Acute Services Flag. If this is not the case, then determine whether there is a significant risk for institutionalization due to unstable chronic health conditions, living conditions or personal resources. If yes, then the client group is Long-Term Supportive Care. If no, then the client group is Maintenance. In either of these last 2 cases, also apply the Acute Services Flag.

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