PCOC Version 3.0 Dataset

Data Dictionary and Technical Guidelines

Document version 1.2.0
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PCOC
palliative care
outcomes collaboration

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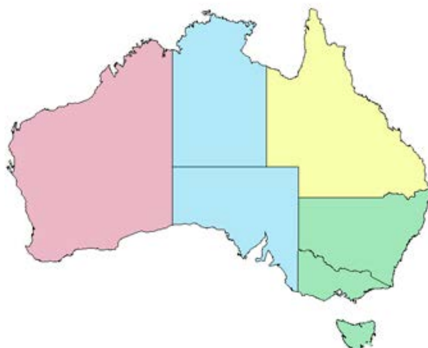
What is PCOC?

The Palliative Care Outcomes Collaboration (PCOC) is a national program that utilises standardised validated clinical assessment tools to benchmark and measure outcomes in palliative care. Participation in PCOC is voluntary and enables palliative care service providers to improve practice.

PCOC is a collaboration between four centres, each with a Chief Investigator, and is divided into four zones for the purpose of engaging with palliative care service providers. The four PCOC zones and their Chief Investigators are:



West Zone
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The National office, responsible for the PCOC National Longitudinal Database and routine reporting and analysis, is located within the Australian Health Services Research Institute at the University of Wollongong.

The items included in the PCOC Version 3.0 dataset serve the dual purpose of:

- Defining a common clinical language to allow communication between palliative care providers
- Facilitating the routine collection of nationally consistent palliative care data for the purpose of reporting and benchmarking to drive quality improvement

The development of the PCOC Version 3.0 data set has evolved after broad consultation with service providers and representatives of peak organisations from across Australia. Where possible, National Health Data Dictionary definitions have been used.

Palliative care services participating in PCOC routinely collect data, which is submitted to the PCOC National Office for the following two reporting periods.

Data is submitted to PCOC between:

- (1st Reporting Period) Jan 01 – Feb 28 for the most recent Jul 01 – Dec 31 period
- (2nd Reporting Period) Jul 01 – Aug 31 for the most recent Jan 01 – Jun 30 period

Submitting data to PCOC can be an iterative process.

The first set of data extracts from a service are loaded into the data base for the purpose of data quality checking. Services receive an error report, and are given the opportunity to amend their data, if required. Once corrected the data are again extracted and submitted to PCOC, to undergo the same process.

This process of error checking may be required to happen multiple times until the data are free of errors, the service determines that remaining errors cannot be fixed or the cut-off date is reached.

After the closing date for the database, PCOC undertakes a further data cleaning process before performing analysis and benchmarking and generating individualised reports for participating services.

For more information on PCOC visit www.pcoc.org.au

PCOC is funded under the *National Palliative Care Program* by the
Australian Government Department of Health

Introduction to the Data Dictionary and Technical Guidelines

The PCOC Version 3.0 Dataset Data Dictionary and Technical Guidelines provide a reference for:

- Palliative care service managers or data entry personnel wishing to have a better understanding of the technical aspects of the PCOC dataset
- Developers wishing to modify IT systems which have previously implemented the Version 2.0 PCOC dataset, or create new systems to collect Version 3.0 PCOC dataset

This document provides an understanding of the PCOC dataset, including the rules, dependencies and architecture of the dataset in the context of creating such applications.

Developers should note that the guidelines are not prescriptive in how applications should be created but specify the required clinical inputs and data outputs that PCOC requires in order for data to be accepted into the registry.

The guidelines do, however, recommend particular application functionalities that will minimise operator input and error and provide an efficient means to enter, find, revise and audit data.

The PCOC Version 3.0 Dataset

As with previous versions of the PCOC dataset, Version 3.0 consists of three levels of linked information – Patient, Episode and Phase. The remainder of this section provides information about the data items collected at each level:

1. Patient
2. Episode
3. Phase

Level 1: Patient

The information beings at the patient level and relates to patient demographics. Patient records acts as the reference point for lower levels. There will only be one record for each patient for each service.

Conceptually, the items collected at the patient level should not change. For example, Date of Birth and Country of Birth. However, the Postcode item is an exception to this, as a patient may change address.

Level 2: Episode

Across jurisdictions, the concept of an episode can have different meanings. For the purposes of PCOC, an Episode of care is defined as a continuous period of care for a patient in one setting (i.e. hospital, private residence, residential aged care facility etc).

To clarify this, an episode of palliative care begins:

- On the day the patient is assessed by the palliative care provider and there is agreement between the patient and the service that the patient is ready to receive palliative care.

The way an episode of palliative care ends depends on the setting in which the care is being provided. In the inpatient (overnight admitted) setting, an episode ends if the patient:

- Is discharged home
- Is discharged to residential aged care facility
- Is discharged to an acute hospital
- Dies
- Completes a sub-acute or non-acute episode of care and the start of an acute episode of care in another ward of the same hospital
- Completes a sub-acute or non-acute episode and the start of another sub-acute or non-acute episode of care remaining in the same ward

In the hospital based ambulatory and community settings, an episode ends if the patient:

- Is discharged from the care of the service
- Dies
- Is admitted/transferred to hospital as an overnight patient (inpatient)

Under this definition, a patient receiving palliative care is likely to have more than one episode.

Conceptually, the information collected at the episode level reflects the circumstances at the beginning and end of the particular episode. This information may be different in subsequent episodes.

Clinical information describing the condition of the patient during the episode is collected at the phase level.

Level 3: Phase

At the phase level the data items document clinical assessments of the patient, and describe the clinical stage/condition of the patient's illness within an episode. Patients receiving palliative care are likely to have more than one phase per episode due to their condition changing.

Similarly to the episode level, data captured at the phase level only relate to circumstances at the beginning and end of the phase. For example, whilst pain assessments may be performed and recorded on a daily basis, they are only reported to PCOC at the start and end of each phase.

Phase records should be contiguous within their associated episode. That is, there cannot be any time during an episode that is not accounted for by a phase record.

Minimum IT System Functionality

An IT system incorporating the PCOC Version 3.0 dataset should, at a minimum, allow users to:

- Create linked Patient, Episode and Phase records
- Enter the PCOC data items, restricting user input to the domains specified by PCOC
- Extract data from the system in the format required by PCOC
- Search for records in order to complete, update or correct entered data
- Manage service and team level identifiers and related information

The IT system should also incorporate the business rules outlined by PCOC, to ensure that data entry errors are minimised.

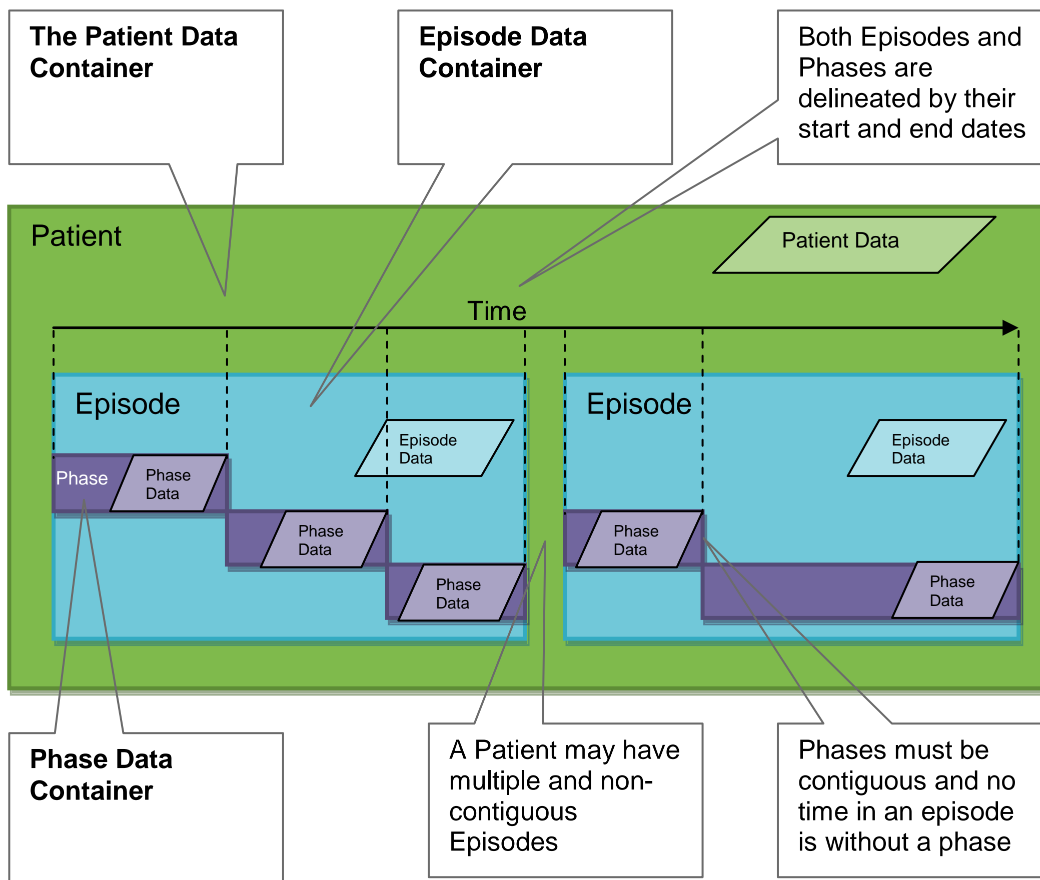
The structure of PCOC data at the Patient, Episode and Phase level determines the processes for data entry. Users will, at a minimum, create 3 linked records:

Table 1 The Patient, Episode and Phase Data Relationship

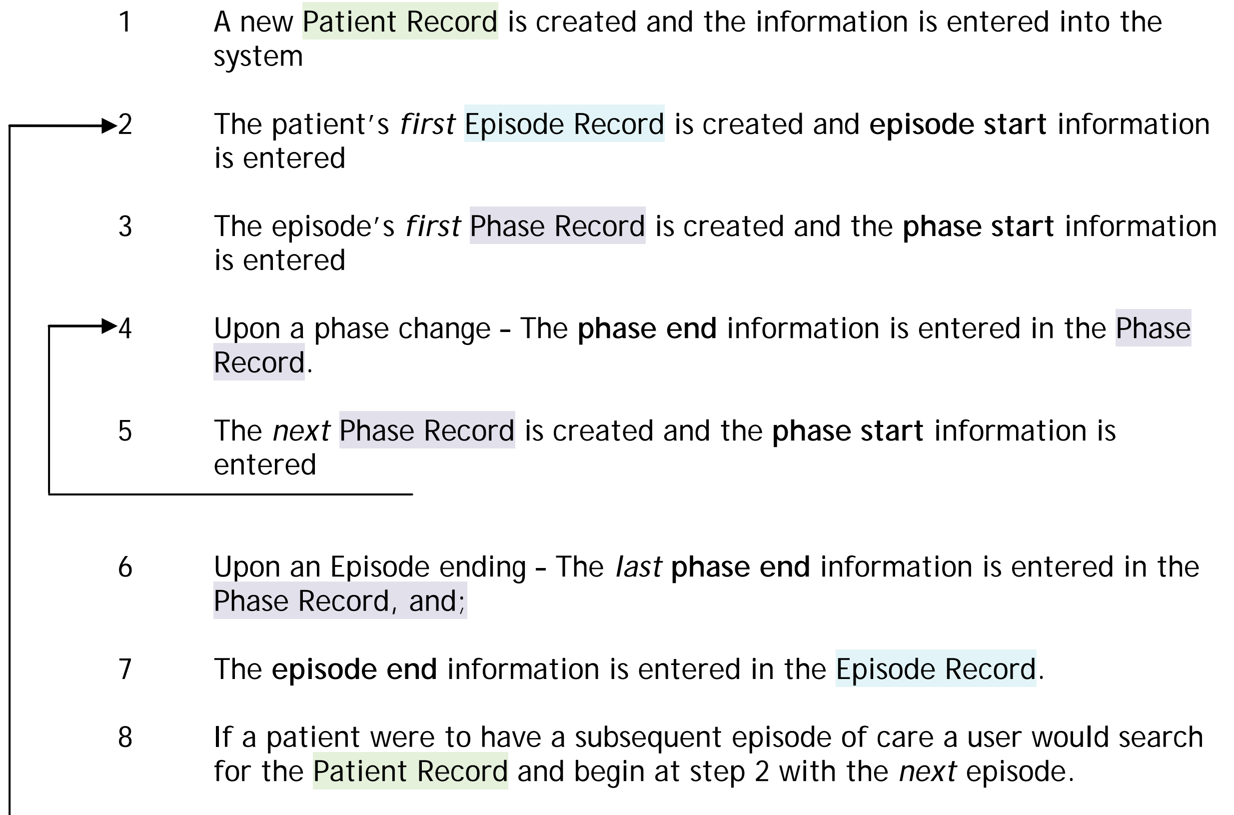
Record	Unique Identifier	Linked to	Linked by
Patient	Patient Identifier		
Episode	Episode ID (Unique for Patient)	Patient	Patient ID
Phase	Phase ID (Unique for Episode)	Episode and Patient	Patient ID and Episode ID

Developers can choose the structure in which they wish to store PCOC data. However the linking between Patient, Episode and Phase records must be considered, along with the data item and extract requirements (Specifications 1 and 2 in this document).

Figure 1 The Patient, Episode and Phase Data Relationship



A typical data entry procedure would be:



1. A new Patient Record is created and the information is entered into the system
2. The patient's *first* Episode Record is created and **episode start** information is entered
3. The episode's *first* Phase Record is created and the **phase start** information is entered
4. Upon a phase change – The **phase end** information is entered in the Phase Record.
5. The *next* Phase Record is created and the **phase start** information is entered
6. Upon an Episode ending – The *last* **phase end** information is entered in the Phase Record, and;
7. The **episode end** information is entered in the Episode Record.
8. If a patient were to have a subsequent episode of care a user would search for the Patient Record and begin at step 2 with the *next* episode.

NOTE: Incomplete Records

It is necessary to allow Episode and Phase records to be incomplete due to the nature of PCOC data recording at the clinical level. In cases where a Phase or Episode is not completed (that is phase end and episode end information is not complete) the record should be flagged as incomplete.

This flag may then be used in auditing to check if a phase or episode should be closed.

In addition, incomplete (open) Episodes and Phases should be extracted and submitted to PCOC, to ensure that the most up-to-date information is available for benchmarking. See Specification 2 for more information on data extraction.

A user may also use the system to view and amend data. Users should be able to search for records using:

- A combination of Patient, Episode and Phase Identifiers, depending on the type of record
- Service and Team Identifiers
- Episode Start Date and End Dates
- Phase Start and End Dates

Items that do not change (e.g. facility in most cases) or are system generated (e.g. new patient identifier) should not be editable by the user.

Overview of the PCOC Version 3.0 Data Items

This section provides a broad overview of the data items collected at each level of the PCOC Version 3.0 dataset relative to the Version 2.0 data items. New items and changes to existing items have been highlighted. To summarise the main changes are:

<u>At Patient Level</u>:

- There are two new items:

  The **Statistical Linkage Key** and
  The **Individual Health Care Identifier** (not activated)

- **Diagnosis** has moved from the Episode level and has a new code set
- **Preferred Language** replaced Main Language Spoken at Home and has a new code set
- **Country of Birth** has a code set change

<u>At Episode Level</u>:

- There are two new items: **Team Identifier** and **Date Ready for Care**
- The following items have new or modified code sets:

  Referral Source
  Episode Type
  Episode Start Mode
  Episode End Mode
  Accommodation at Episode Start
  Accommodation at Episode End

- **Place of Death** has a new code set and new completion rules
- The following items are no longer collected:

  Proposed Model of Care at Episode Start
  Reason for Consultative Service
  Location of Consultative Service
  Mode of Consultative Service
  Diagnosis – Collected at Patient Level
  Level of Support at Episode Start and End
  Level of Support at Episode End

<u>At Phase Level</u>:

- The **SAS**, **PCPSS**, **AKPS (Karnofsky)** and **RUG-ADL** clinical assessments have an <u>additional code</u> for "Not Assessed"
- **Phase End Reason** has a new code set
- **Number of Days Seen** has been inactivated, but remains as a placeholder for future activation
- **Provider Type** is a new inactive item, included as a placeholder for future activation.
- **Model of Care at Phase End** is no longer collected

Patient level items – with changes from Version 2.0 to Version 3.0

Version 3 Reference	Version 3 Item	Version 2 Item	Description of change
3.1.01	Patient Identifier	MRN	Name change
3.1.02	Service Identifier	Facility ID	Name change
3.1.03	Date of Birth	Date of Birth	No change
3.1.04	Statistical Linkage Key	-	New item
3.1.05	Sex	Sex	No change
3.1.06	Individual Healthcare Identifier	-	New item - inactive placeholder
3.1.07	Australian State	State Identifier	No change
3.1.08	Australian Postcode	Postcode	Name change
3.1.09	Indigenous Status	Indigenous Status	No change
3.1.10	Preferred Language	Main Language Spoken at Home	New item to replace existing item. New code set.
3.1.11	Country of Birth	Country of birth	Code set change
3.1.12	Diagnosis	-	Moved from Episode level to Patient level. New code set

Episode level items - with changes from Version 2.0 to Version 3.0

Version 3 Reference	Version 3 Item	Version 2 Item	Description of change
3.2.01	Episode Identifier	Episode Identifier	No change
3.2.02	Patient Identifier	MRN/UR/Person Identifier	Name change
3.2.03	Team Identifier	-	New item
3.2.04	Service Identifier	Facility ID	Name change
3.2.05	Referral Date	Referral date	No change
3.2.06	Referral Source	Referral Source	Code set change
3.2.07	First Contact Date	Date of First Contact	Name change
3.2.08	Date Ready for Care	-	New item
3.2.09	Episode Start Date	Episode Start Date	No change
3.2.10	Episode Type	Episode Type	New code set
3.2.11	Episode Start Mode	Mode of Episode Start	New code set
3.2.12	Accommodation at Episode Start	Accommodation at Episode Start	Reduced code set
3.2.13	Episode End Date	Episode End Date	No change
3.2.14	Episode End Mode	Mode of Episode End	New code set
3.2.15	Accommodation at Episode End	Accommodation at Episode End	Reduced code set
3.2.16	Place of Death		New code set New completion Rules
-	-	Proposed model of care at Episode Start	Item not collected in V3
-	-	Reason for Consultative Service	Item not collected in V3
-	-	Location of consultative service	Item not collected in V3
-	-	Mode of consultative service	Item not collected in V3
-	-	Diagnosis	Moved to Patient level with a code set change
-	-	Level of support at Episode Start	Item not collected in V3
-	-	Level of support at Episode End	Item not collected in V3

Phase level items - with changes from Version 2.0 to Version 3.0

Version 3 Reference	Version 3 Item	Version 2 Item	Description of change
3.3.01	Phase Identifier	Phase Identifier	No change
3.3.02	Episode Identifier	Episode Identifier	No change
3.3.03	Patient Identifier	MRN/URN/Person Identifier	Name change
3.3.04	Service Identifier	Facility ID	Name change
3.3.05	Phase Start Date	Phase Start Date	No change
3.3.06	Phase	Phase	No change
3.3.07	RUG-ADL at Phase Start: Bed Mobility	RUG Bed Mobility at Phase Start	Name standardised New code: 9–'Not assessed'
3.3.08	RUG-ADL at Phase Start: Toileting	RUG Toileting at Phase Start	Name standardised New code: 9–'Not assessed'
3.3.09	RUG-ADL at Phase Start: Transfers	RUG Transfers at Phase Start	Name standardised New code: 9–'Not assessed'
3.3.10	RUG-ADL at Phase Start: Eating	RUG Eating at Phase Start	Name standardised New code: 9–'Not assessed'
3.3.11	SAS at Phase Start: Insomnia	SAS Insomnia at Phase Start	Name standardised New code: 99–'Not assessed'
3.3.12	SAS at Phase Start: Appetite	SAS Appetite at Phase Start	Name standardised New code: 99–'Not assessed'
3.3.13	SAS at Phase Start: Nausea	SAS Nausea at Phase Start	Name standardised New code: 99–'Not assessed'
3.3.14	SAS at Phase Start: Bowels	SAS Bowels at Phase Start	Name standardised New code: 99–'Not assessed'
3.3.15	SAS at Phase Start: Breathing	SAS Breathing at Phase Start	Name standardised New code: 99–'Not assessed'
3.3.16	SAS at Phase Start: Fatigue	SAS Fatigue at Phase Start	Name standardised New code: 99–'Not assessed'
3.3.17	SAS at Phase Start: Pain	SAS Pain at Phase Start	Name standardised New code: 99–'Not assessed'
3.3.18	PCPSS at Phase Start: Pain	PC Problem Pain Start	Name standardised New code: 9–'Not assessed'
3.3.19	PCPSS at Phase Start: Other Symptoms	PC Problem Other symptom Start	Name standardised New code: 9–'Not assessed'
3.3.20	PCPSS at Phase Start: Psychological/Spiritual	PC Problem Psychological/Spiritual Start	Name standardised New code: 9–'Not assessed'
3.3.21	PCPSS at Phase Start: Family/Carer	PC Problem Family Carer Start	Name standardised New code: 9–'Not assessed'
3.3.22	AKPS at Phase Start	Karnofsky at Phase Start/Karnofsky Score Start	Name corrected Code set modified
3.3.23	Phase End Date	Phase End date	No change
3.3.24	Phase End Reason	Phase End Reason	New Code set
3.3.25	RUG-ADL at Phase End: Bed Mobility	RUG Bed Mobility at Phase End	Name standardised New code: 9–'Not assessed'
3.3.26	RUG-ADL at Phase End: Toileting	RUG Toileting at Phase End	Name standardised New code: 9–'Not assessed'
3.3.27	RUG-ADL at Phase End: Transfers	RUG Transfers at Phase End	Name standardised New code: 9–'Not assessed'

Version 3 Reference	Version 3 Item	Version 2 Item	Description of change
3.3.28	RUG-ADL at Phase End: Eating	RUG Eating at Phase End	Name standardised New code: 9-'Not assessed'
3.3.29	SAS at Phase End: Insomnia	SAS Insomnia at Phase End	Name standardised New code: 99-'Not assessed'
3.3.30	SAS at Phase End: Appetite	SAS Appetite at Phase End	Name standardised New code: 99-'Not assessed'
3.3.31	SAS at Phase End: Nausea	SAS Nausea at Phase End	Name standardised New code: 99-'Not assessed'
3.3.32	SAS at Phase End: Bowels	SAS Bowels at Phase End	Name standardised New code: 99-'Not assessed'
3.3.33	SAS at Phase End: Breathing	SAS Breathing at Phase End	Name standardised New code: 99-'Not assessed'
3.3.34	SAS at Phase End: Fatigue	SAS Fatigue at Phase End	Name standardised New code: 99-'Not assessed'
3.3.35	SAS at Phase End: Pain	SAS Pain at Phase End	Name standardised New code: 99-'Not assessed'
3.3.36	PCPSS at Phase End: Pain	PC Problem Pain End	Name standardised New code: 9-'Not assessed'
3.3.37	PCPSS at Phase End: Other Symptoms	PC Problem Other Symptom End	Name standardised New code: 9-'Not assessed'
3.3.38	PCPSS at Phase End: Psychological/Spiritual	PC Problem Psychological/Spiritual End	Name standardised New code: 9-'Not assessed'
3.3.39	PCPSS at Phase End: Family/Carer	PC Problem Family Carer End	Name standardised New code: 9-'Not assessed'
3.3.40	AKPS at Phase End	Karnofsky at Phase End/ Karnofsky Score End	Name corrected Code set modified
3.3.41	Number of days seen	Number of days seen	Item inactive (placeholder)
3.3.42	Provider Type	-	New inactive item (placeholder)
-	-	Model of care at Phase End	Item not collected in V3

Specification 1: PCOC Version 3.0 Data Items

This section provides technical details for the data items at each level. For each data item the following flags may be present:

Mandatory

This flag identifies that the item field cannot be left blank under any circumstances

Rule Check

This flag highlights that there are consistency rules associated with the data item. The rules may be one of the following:

Code Set Rule:
The permissible code set for this item depends on values entered for previous data items.

Warning Error:
It is unlikely (based on clinical practice) that an entry is possible. The user can proceed by checking the error source and confirming that it is correct. Example: Birth Date places the age of the patient at 15 years or less.

Critical Error:
An entry cannot be made in this way. The user can proceed only by rectifying the error. Example: Date of Birth is in the future.

Dependencies

This flag highlights that the value entered for this data item will have an impact on subsequent data items. Types of impacts include data items:

- Having different permissible code sets
- No longer being applicable
- Having values auto-filled

Level 1: Patient Items

3.1.01 Patient Identifier

Mandatory	Rule Check	Dependencies

Conditions: The Patient Identifier must be unique within the IT system.

Definition: Unique person identifier established by the palliative care provider.

This is usually a medical record/unit record number which is generated for each patient within a service. This number must be used at *all times* when recording patient episode and phase level information for PCOC.

Data Type: Alphanumeric String

Data Domain: 0 to ZZZZZZZZZZZZ

Data Length: 1-12 characters

Usage: The positive and unique identification of a patient.

To ensure that each individual's health records will be associated with that individual and no other.

Source: -

3.1.02 Service Identifier

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: Unique service identifier assigned by PCOC.

Data Type: Alphanumeric String

Data Domain: 0000 to ZZZZ

Data Length: 4 characters

Usage: Unique service identifier necessary to link and group records in the PCOC National Longitudinal Database

Source: PCOC

3.1.03 Date of Birth

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The date of birth of the patient.

Data Type: Date in format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: To derive age for demographic analyses.

Rules: The Date of Birth must be less than the current date. Hence, the following situation causes a critical error:

```
Critical Error if [Date of Birth] > [Current Date (Today)]
```

It is *unlikely* that The Date of Birth would place the patient's age at 15 years of age or less. The following would be considered a warning error:

```
Warning if [Date of Birth] > [Current Date (Today)] - 15 years
```

However, if the service provides paediatric palliative care, then this error should disabled.

Source: National Health Data Dictionary (Meteor Identifier 287007)

3.1.04 Statistical Linkage Key

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The Statistical Linkage Key (SLK) enables patient data reported by different service providers to be matched, enabling a more accurate picture of client numbers and patterns of assistance. The Statistical Linkage Key preserves the anonymity of patient data collected by service providers.

The SLK is derived by joining the 'letters of name' (2nd, 3rd and 5th letters of the family name/surname, and 2nd and 3rd letters of the first given name), 'date of birth', and 'sex' to create a 14 character identifier. There are also some instances where the SLK information may be unknown, and substitute characters are used instead.

The key will be of the format XXXXXDDMMYYYYN where:

XXXXX — is the 2nd, 3rd and 5th letters of the family name and the 2nd and 3rd letters of the first name.
Example: John Smith becomes 'MIHOH'

DDMMYYYY — is the Patient's Date of Birth

N — is the Patients Sex

- Non Alphabetic Characters such as spaces and hyphens ("-") are ignored.
- If a name is too short to extract a character, a 2 is substituted for this character.
- If a patient is missing a surname or has a single name only, 999 is substituted for the family name/surname component

The SLK is not a unique identifier and is designed for the purposes of statistical analysis.

Data Type: Alphanumeric String in the format XXXXXDDMMYYYYN

Data Domain: 22222010119001 to ZZZZZ311221009

Data Length: 14 characters

Dependencies: The patient's name, date of birth and sex must be in the system:

[First Name] **(non PCOC data item)**
[Family Name] **(non PCOC data item)**
[Date of Birth]
[Sex]

Usage: The SLK is used for probabilistic linkage. In systems where names are recorded this item should be derived by the system and should not be editable by the user.

It is not necessary for the Statistical Linkage Key to be visible to users.

Source: National Health Data Dictionary (METeOR Identifier 349510)

Version Control: 1.2.0
Effective Date: 22 November 2012

3.1.05 Sex

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The gender of the patient.

Data Type: Numeric

Data Domain: Code set

Code	Description
1	Male
2	Female
3	Indeterminate
9	Not stated/ inadequately described

Usage: To enable standardisation of the collection of information relating to sex.

To analyse service utilisation, needs for services and in epidemiological studies.

Source: National Health Data Dictionary (METeOR Identifier 287316)

3.1.06 Individual Healthcare Identifier

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: Placeholder for future implementation of Individual Healthcare Identifier.

Data Type: Alphanumeric String in the format XXXXXXXXXXXXXXXX

Data Domain: 0000000000000000 to ZZZZZZZZZZZZZZZZ

Data Length: 16 characters

Usage: This item is used as a place holder for the Department of Health and Aging's transition to an Individual Healthcare Identifier.

It should not be visible to the user.

Source: Department of Health and Ageing - Individual Healthcare Identifier

3.1.07 Australian State

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The Australian State/Territory (or other country) that the patient usually resides in

Data Type: Numeric

Data Domain: Code set

Code	Description
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Other Australian territories
10	Not Australia
99	Unknown/not recorded

Usage: This is a geographic indicator to enable analysis of palliative care utilisation by state.

Dependencies: 3.1.08 Australian Postcode

Source: National Health Data Dictionary (METeOR Identifier 286919) with PCOC supplementary codes for 'Not Australia' and 'Unknown'

3.1.08 Australian Postcode

Mandatory	Rule Check	Dependencies

Conditions: Leave blank if Australian State = 9 or 10

Definition: The postcode of usual place of residence of the patient.

Data Type: Numeric

Data Domain: Valid Australian Postcode - Four digit postcode for usual residence of the patient. Leading 0's should be maintained for Northern Territory postcodes.

Data Length: 4 characters

Usage: Analysis of utilisation patterns of palliative care.

Rules: -

Source: National Health Data Dictionary (METeOR Identifier 302040)

3.1.09 Indigenous Status

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.

This data item is based on the Australian Bureau of Statistics (ABS) standard for indigenous status

Data Type: Numeric

Data Domain: Code set

Code	Description
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
9	Not stated / inadequately described

Data Length: 1 character

Usage: Analysis of access to palliative care by different population subgroups

Source: National Health Data Dictionary (METeOR Identifier 291036)

3.1.10 Preferred Language

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The language reported by a person as the most preferred for communication.

Data Type: Numeric

Data Domain: Australian Standard Classification of Languages (ASCL), ABS 2011

Data Length: 2 characters

Usage: An important indicator of ethnicity, especially for persons born in non-English-speaking countries.

Its collection will assist in the planning and provision of multilingual services and facilitate program and service delivery for migrants and other non-English speakers.

Source: National Health Data Dictionary (METeOR Identifier 460123)

Australian Standard Classification of Languages (ASCL), Australian Bureau of Statistics 2011 (ABS cat. no. 1270.0)

3.1.11 Country of Birth

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The country in which the patient was born

Data Type: Numeric

Data Domain: Australian Standard Classification of Countries (ASCC), ABS 2011

Data Length: 4 characters

Usage: Analysis of access to palliative care by different population subgroups

Source: National Health Data Dictionary (METeOR Identifier 459973)

Australian Standard Classification of Countries (ASCC),
Australian Bureau of Statistics 2011 (ABS cat. no. 1269.0)

3.1.12 Diagnosis

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The principal life limiting illness responsible for this patient requiring pall. care

Data Type: Numeric

Data Domain: Code set

Code	Definition
100	**Malignant - not further defined**
101	Bone and soft tissue
102	Breast
103	CNS
104	Colorectal
105	Other GIT
106	Haematological
107	Head and neck
108	Lung
109	Pancreas
110	Prostate
111	Other urological
112	Gynecological
113	Skin
114	Unknown Primary
180	Other primary malignancy
200	**Non Malignant - not further defined**
201	Cardiovascular disease
202	HIV/AIDS
203	End stage kidney disease
204	Stroke
205	Motor Neurone Disease
206	Alzheimer's dementia
207	Other dementia
208	Other neurological disease
209	Respiratory failure
210	End stage liver disease
211	Diabetes and its complications
212	Sepsis
213	Multiple organ failure
280	Other non-malignancy
999	Unknown

Data Length: 3 characters
Source: PCOC 2011

Version Control: 1.2.0
Effective Date: 22 November 2012

Level 2: Episode Items

3.2.01 Episode Identifier

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: A unique string that identifies and links the episode record

Data Type: Alphanumeric string

Data Domain: 0 to ZZZZZZZZZZZZ

Data Length: 1-12 characters

Usage: This item should be automatically generated by the system and not be editable by the user

3.2.02 Patient Identifier

Mandatory	Rule Check	Dependencies

Conditions: Refer to Item 3.1.01 for details of format and further usage rules.

Usage: The patient identifier is used to link the episode record to the relevant patient and phase records. This item should be automatically populated by the system from the patient level item. It should not be editable by the user

Dependencies: Must match a Patient Identifier (3.1.01)

3.2.03 Team Identifier

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: Unique team identifier assigned by PCOC

Data Type: Alphanumeric string

Data Domain: 0000 to ZZZZ

Data Length: 4 characters

Usage: Unique identification of a team within a service

3.2.04 Service Identifier

Mandatory	Rule Check	Dependencies

Conditions: **Refer to Item 3.1.02 for details of format and further usage rules**

Definition: Unique service identifier assigned by PCOC

Data Type: Alphanumeric string

Data Domain: 0000 to ZZZZ

Data Length: 4 characters

Usage: Unique service identifier necessary to link and group records in the PCOC National Longitudinal Database

3.2.05 Referral Date

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The date a service receives a referral to provide palliative care for a patient for this episode. The referral can be either written or verbal.

Data Type: Date in format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: Key benchmarking variable. Used to measure the elapsed time between referral and subsequent date fields

Rules: Referral Date being later than the First Contact Date should cause a warning error

```
Warning if [Referral Date] > [First Contact Date]
```

Referral Date being later than Date Ready for Care should cause a warning error

```
Warning if [Referral Date] > [Date Ready for Care]
```

Referral Date being later than the Episode Start date should cause a warning error

```
Warning if [Referral Date] > [Episode Start Date]
```

Referral Date being later than the current date should cause a warning error

```
Warning if [Referral Date] > [Current Date (Today)]
```

A Referral Date earlier than one year ago should produce a warning error:

```
Warning if [Referral Date] < [Current Date (Today)] – 1 Year
```

Source: PCOC 2007

3.2.06 Referral Source

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The facility/organisation from which the patient was referred this particular episode.

Data Domain: Code set

Code	Description
10	Public hospital - not further defined
11	Public hospital - palliative care unit/team
12	Public hospital - oncology unit/team
13	Public hospital - medical unit/team
14	Public hospital - surgical unit/team
15	Public hospital - emergency department
20	Private hospital - not further defined
21	Private hospital - palliative care unit/team
22	Private hospital - oncology unit/team
23	Private hospital - medical unit/team
24	Private hospital - surgical unit/team
25	Private hospital - emergency department
30	Outpatient clinic
40	General Practitioner
50	Specialist Practitioner
60	Community Palliative Care Service
61	Community Generalist Service
70	Residential Aged Care Facility
80	Self, carer(s), family, friends
90	Other
99	Unknown/inadequately described

Usage: To assist in understanding the patient flow and service planning.

Source: PCOC 2011

3.2.07 First Contact Date

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The date the clinical team makes contact with the patient and undertakes a "triage type" assessment

Data Type: Date in format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: **Key benchmarking variable.** Used to measure response time.

Rules:

Referral Date being later than the First Contact Date should cause a warning error:
```
Warning if [Referral Date] > [First Contact Date]
```

First Contact Date being later than the Episode Start date should cause a warning error:
```
Warning if [First Contact Date] > [Episode Start Date]
```

First Contact Date being later than the current date should cause a warning error:
```
Warning if [First Contact Date] > [Current Date (Today)]
```

A First Contact Date earlier than one prior to the current date should produce a warning error:
```
Warning if [First Contact Date] < [Current Date (Today)] – 1 Year
```

Source: PCOC 2007

3.2.08 Date Ready for Care

Mandatory	**Rule Check**	Dependencies

Conditions: -

Definition: The date the patient needs, and is available, to receive palliative care

Data Type: Date in format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: **Key benchmarking variable.** Used to identify and account for "early referrals"

Rules: A Referral Date later than Date Ready for Care should cause a warning error:

```
Warning if [Referral Date] > [Date Ready for Care]
```

A Date Ready for Care later than the Episode Start date should cause a warning error:

```
Warning if [Date Ready for Care] > [Episode Start Date]
```

A Date Ready for Care earlier than one prior to the current date should produce a warning error:

```
Warning if [Date Ready for Care] < [Current Date (Today)] – 1 Year
```

Source: PCOC 2011

3.2.09 Episode Start Date

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The date that clinical care commences for this episode

Data Type: Date in format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: The date is required to determine the length of stay of each episode of care

Rules: Critical Error(s):

Referral Date later than Episode Start Date should cause a warning error:
`Warning Error if [Referral Date] > [Episode Start Date]`

First Contact Date later than Episode Start Date should cause a warning error:
`Warning Error if [First Contact Date] > [Episode Start Date]`

Date Ready for Care later than Episode Start Date should cause a warning error:
`Warning Error if [Date Ready for Care] > [Episode Start Date]`

Episode Start Date later than the current date should cause a critical error:
`Critical Error if [Episode Start Date] > [Current Date (Today)]`

Episode Start Date earlier than one year ago should cause a warning error:
`Warning if [Episode Start Date] < [Current Date (Today)] – 1 Year`

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

3.2.10 Episode Type

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: A description of the setting and circumstances in which the patient is receiving palliative care for this episode.

Data Type: Number

Data Domain: Code set

Code	Description
10	Overnight Admitted – Not Further Specified
11	Overnight Admitted – Designated Palliative Care Bed
12	Overnight Admitted - Non-designated Palliative Care Bed
20	Hospital Ambulatory - Not Further Specified
21	Same Day Admitted
22	Outpatient
30	Community – Not Further Specified
31	Private Residence
32	Residential Aged Care Facility

Data Length: 2 characters

Usage: Key grouping and reporting variable

Dependencies: 3.2.11 Episode Start Mode
3.2.14 Episode End Mode

Source: PCOC 2011

3.2.11 Episode Start Mode

Mandatory	Rule Check	Dependencies

Conditions: Permissible code set depends on data entered for Episode Type (3.2.10)
See data domain below

Definition: Describes how this episode of palliative care commenced

Data Type: Number

Data Domain: Code set

Episode Types 10, 11 and 12	
Code	**Description**
11	Admitted from usual accommodation
12	Admitted from other than usual accommodation
13	Admitted (transferred) from another hospital
14	Admitted (transferred) from acute care in another ward
15	Change from acute care to palliative care while remaining on same ward
16	Change of sub-acute/non-acute care type
19	Other
99	Not recorded

Episode Types 20, 21, 22, 30, 31, 32	
Code	**Description**
21	Patient transferred from being an overnight admitted palliative care patient
22	Patient was not transferred from being an overnight palliative care patient
99	Not recorded

Data Length: 2 characters

Usage: To gain information about a patient's circumstances prior to the episode of care

Dependencies: 3.2.12 Accommodation at Episode Start

Source: PCOC 2011

3.2.12 Accommodation at Episode Start

Mandatory	Rule Check	Dependencies

Conditions: Becomes mandatory if 3.2.11 Episode Start Mode = 11, 12, 21, 22
Otherwise, leave blank

Definition: The physical accommodation the patient at the start of the episode.

Data Type: Number

Data Domain: Code set

Code	Description
1	Private residence (including unit in retirement village)
2	Residential aged care – low level care (hostel)
3	Residential aged care – high level care (nursing home)
7	Other
9	Unknown

Data Length: 1 character

Usage: Describes the patient's residential accommodation immediately prior to the start of the episode.

Source: PCOC 2011

3.2.13 Episode End Date

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: The date a patient's episode of palliative care ends

Data Type: Date in format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: To identify the period in which the patient's episode of care occurred and for derivation of length of episode

Dependencies: 3.2.14 Episode End Mode
3.2.15 Accommodation at Episode End

Rules: Episode End Date before Episode Start Date should cause a critical error:

```
Critical error if [Episode End Date] < [Episode Start Date]
```

Episode End Date in the future should cause a critical error:

```
Critical error if [Episode End Date] > [Current Date (Today)]
```

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

3.2.14 Episode End Mode

Mandatory	Rule Check	**Dependencies**

Conditions: Item becomes mandatory if Episode End Date (3.2.13) is entered

Definition: The reason that this episode of palliative care ended

Data Type Number

Data Domain: Code set

Episode Types 10, 11 and 12

Code	Description
11	Discharged to usual accommodation
12	Discharged to other than usual accommodation
13	Death
14	Discharged to another hospital
15	Change from palliative care to acute care – different ward
16	Change from palliative care to acute care – same ward
17	Change in sub-acute care type
18	End of consultative episode – inpatient episode ongoing
19	Other
99	Not recorded

Episode Types 20, 21, 22, 30, 31, 32

Code	Description
21	Discharge/case closure
22	Death
23	Discharged for inpatient palliative care
24	Discharged for inpatient acute care
25	Discharged to another palliative care service
26	Discharged to primary health care (e.g. GP)
29	Other
99	Not recorded

Data Length: 2 characters
Usage: Describes how the episode ended

Dependencies: 3.2.15 Accommodation at Episode End
3.2.16 Place of Death

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

Version Control: 1.2.0
Effective Date: 22 November 2012

3.2.15 Accommodation at Episode End

Mandatory	Rule Check	Dependencies

Conditions: Only completed if Episode End Mode (3.2.14) = 11, 12, 21, 25 or 26

Definition: The accommodation of the patient upon discharge

Data Type: Number

Data Domain: Code set

Code	Description
1	Private residence (including unit in retirement village)
2	Residential aged care – low level care (hostel)
3	Residential aged care – high level care (nursing home)
7	Other
9	Unknown

Data Length: 1 character

Usage: Describes the patient's residential accommodation immediately following discharge

Source: PCOC 2011

3.2.16 Place of Death

Mandatory	Rule Check	Dependencies

Conditions: Only completed if Episode End Mode (3.2.14) = 13 or 22

Definition: The setting in which the patient dies

Data Domain: Code set

Code	Description
1	Home
2	Residential Aged Care Facility
3	Hospital
9	Unknown

Data Length: 1 character

Source: PCOC 2011

Level 3: Phase Items

3.3.01 Phase Identifier

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: A unique string that identifies and links the phase records

Data Type: Alphanumeric string

Data Domain: 0 to ZZZZZZZZZZZZ

Data Length: 1-12 Characters

Usage: This item should be automatically generated by the system and not be editable by the user.

3.3.02 Episode Identifier

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: A unique string that identifies and links the episode records

Data Type: Alphanumeric string

Data Domain: 0 to ZZZZZZZZZZZZ

Data Length: 1-12 Characters

Usage: The episode identifier is used to link the phase record to the episode record. This item should be automatically populated by the system from the episode level item. It should not be editable by the user.

Dependencies: Must match an Episode identifier (3.2.01)

3.3.03 Patient Identifier

Mandatory	Rule Check	Dependencies

Conditions: **Refer to Item 3.1.01 for details of format and further usage rules.**

Usage: The patient identifier is used to link the phase record to the episode and patient records. This item should be automatically populated by the system from the episode level item. It should not be editable by the user.

Dependencies: Must match a Patient Identifier (3.1.01)

3.3.04 Service Identifier

Mandatory	Rule Check	Dependencies

Conditions: **Refer to Item 3.1.02**

Definition: Unique service identifier assigned by PCOC.

Data Type: Alphanumeric String

Data Domain: 0000 to ZZZZ

Data Length: 4 characters

Usage: Unique service identifier necessary to identify and link records in the PCOC Reporting Database

Source: PCOC

3.3.05 Phase Start Date

Mandatory	Rule Check	Dependencies

Conditions: The first Phase Start Date is equal to the associated Episode Start Date

Subsequent Phase Start Dates are equal to the previous Phase End Date

Definition: The date on which the phase of care started

Data Type: Date in format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: Identifies the time period in which the phase of care occurred and is used in the derivation of length of phase

Rules: Phase Start Date earlier than its associated Episode Start Date should cause a critical error:

```
Critical error if [Phase Start Date] < [Episode Start Date]
```

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

3.3.06 Phase Type

Mandatory	Rule Check	Dependencies

Conditions: -

Definition: Stage of the patient illness in terms of 5 phases.

Data Type: Integer

Data Domain: Code set

Code	Description
1	Stable
2	Unstable
3	Deteriorating
4	Terminal
5	Bereavement/Post death support

Data Length: 1 character

Usage: Identifies the stage of a patient's illness

Dependencies: Items 3.3.07 – 3.3.40

Rules: A phase record should not have the same Phase Type as the previous or next phase record within an episode.

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

NOTE: In clinical terminology, this item is referred to as simply "Phase". However, to avoid confusion between this item and Phase level records, we will refer to this item as Phase Type throughout this document.

3.3.07 -3.3.10 Resource Utilisation Group-Activities of Daily Living (RUG-ADL) Scores at Phase Start

Mandatory	Rule Check	Dependencies

Conditions: Permissible code set depends on value entered for item Phase Type (3.3.06). See rules below.

Definition: The RUG-ADL is a 4 item scale measuring motor function with activities of daily living including bed mobility, toileting, transfer and eating

Data Type: Integer

Data Domain: Code set (3.3.10 has a different code set to 3.3.07-3.3.09)

3.3.07 Bed Mobility

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
9	Not assessed

3.3.08 Toileting

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
9	Not assessed

3.3.09 Transfer

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
9	Not assessed

3.3.10 Eating

Code	Description
1	Independent or supervision only
2	Limited assistance
3	Extensive assistance/total dependence/tube fed
9	Not assessed

Data Length: 1 character for each of the four items

Usage: Measures the functional dependency of the patient at the start of the Phase

Rules: <u>Code Set Rule</u>

RUG-ADL Assessments Not Performed for Bereavement Phases

```
If [Phase Type] = 5 then [RUG-ADL at Phase Start] = 9 (Not
Assessed)
```

Sources: Fries, B. E., Scheider, D.P., Foley, W. J., Gavazzi, M., Burke, R., Cornelius, E. (1994). Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III). Medical Care 32(7): 668-685.

Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

3.3.11 - 3.3.17 Symptom Assessment Score (SAS) at Phase Start

Mandatory	Rule Check	Dependencies

Conditions: Permissible code set depends on value entered for item Phase Type (3.3.06). See rules below.

Definition: A seven-item patient rated, valid and reliable tool developed in Western Australia by Kristjanson et al to measure symptom distress in cancer or palliative care patients.

It comprises seven key symptoms:

- insomnia
- appetite problems
- nausea
- bowels
- breathing
- fatigue
- pain

Data Type: Number

Data Domain: Code set (scale)

None at all ↓ ... Worst Possible ↓

0 1 2 3 4 5 6 7 8 9 10 99 (Not Assessed)

Record separately for the 7 key symptoms:

3.3.11 **Insomnia**
3.3.12 **Appetite problems**
3.3.13 **Nausea**
3.3.14 **Bowels**
3.3.15 **Breathing**
3.3.16 **Fatigue**
3.3.17 **Pain**

Data Length: Up to 2 Characters for each item

Usage: **Key benchmarking variable.** A measure of symptom distress at phase start

Rules: Code Set Rule

SAS Assessments Not Performed for Bereavement Phases

```
If [Phase Type] = 5 then [SAS at Phase Start] = 99 (Not
Assessed)
```

Source: Kristjanson, L. J. Pickstock, S., Yuen, K., Davis, S., Blight, J., Cummins, A., et al. (1999). Development and testing of the revised Symptom Assessment Scale. Perth: Edith Cowan University.

Version Control: 1.2.0
Effective Date: 22 November 2012

3.3.18-3.3.21 Palliative Care Problem Severity Scores (PCPSS) at Phase Start

Mandatory	Rule Check	Dependencies

Conditions: Permissible code set depends on value entered for item Phase Type (3.3.06). See rules below.

Definition: A measurement of distress at phase start within the domains

- Pain
- Other Symptoms
- Psychological/Spiritual
- Family/Carer

Data Type: Number

Data Domain: Code set

3.3.18 PCPSS at Phase Start: Pain

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

3.3.19 PCPSS at Phase Start: Other Symptoms

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

3.3.20 PCPSS at Phase Start: Psychological/Spiritual

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

3.3.21 PCPSS at Phase Start: Family/Carer

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

Data Length: 1 character for each item

Version Control: 1.2.0
Effective Date: 22 November 2012

Usage: **Key benchmarking variable.** A measurement of distress within each of the four domains

Rules: <u>Code Set Rule</u>

PCPSS Assessments Not Performed for Bereavement Phases

```
If [Phase Type] = 5 then [PCPSS at Phase Start] = 9 (Not
Assessed)
```

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

3.3.22 Australia-Modified Karnofsky Performance Scale (AKPS) Score at Phase Start

Mandatory	Rule Check	Dependencies

Conditions: Permissible code set depends on value entered for item Phase Type (3.3.06). See rules below.

Definition: An assessment of the patient's performance across the dimensions of activity, work and self-care at phase start.

Data Type: Number

Data Domain: Code set

Code	Description
100	Normal; no complaints; no evidence of disease
90	Able to carry on normal activity; minor signs or symptoms
80	Normal activity with effort; some signs or symptoms of disease
70	Cares for self; unable to carry on normal activity or to do active work
60	Requires occasional assistance but is able to care for most of his needs
50	Requires considerable assistance and frequent medical care
40	In bed more than 50% of the time
30	Almost completely bedfast
20	Totally bedfast and requiring extensive nursing care by professionals and/or family
10	Comatose or barely rousable
999	Not assessed

Usage: Analysis of performance at phase start

Rules: <u>Code Set Rule</u>

AKPS Assessments Not Performed for Bereavement Phases

```
If [Phase Type] = 5 then [AKPS at Phase Start] = 999 (Not
Assessed)
```

Source: Abernethy, A. P., Shelby-James, T., Fazekas, B. S., Woods, D., & Currow, D. C. (2005). *The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice* [Electronic Version]. BioMed Central Palliative Care, 4, 1-12.

3.3.23 Phase End Date

Mandatory	Rule Check	Dependencies

Conditions: The Phase End Date is equal to the next Phase Start Date.

The last Phase End Date is equal to the Episode End Date (linked by the Episode Identifier)

Definition: The date the phase of care ended

Data Type: Date in the format DD/MM/YYYY

Data Domain: 01/01/1900 to 31/12/2100

Data Length: 10 characters (including "/" characters)

Usage: Identifies the time period in which the phase of care occurred and used to derive length of phase.

Dependencies: Items 3.3.24 - 3.3.41

Rules: A Phase End Date which is earlier than the associated Phase Start Date should cause a critical error:

```
Critical error if [Phase End Date] < [Phase Start Date]
```

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

3.3.24 Reason for Phase End

Mandatory	Rule Check	Dependencies

Conditions: Item becomes mandatory if Phase End Date (3.3.23) is entered
Permissible code set depends on value entered for item Phase Type (3.3.06). See rules below.

Definition: Describes the reason for the palliative care phase ending

Data Type: Number

Data Domain: Code set

Code	Description
10	Phase changed to Stable
20	Phase changed to Unstable
30	Phase changed to Deteriorating
40	Phase changed to Terminal
50	Death
60	End Bereavement Phase (Post Death Support)
70	Discharge/Case Closure
99	Not recorded

Data Length: 2 characters

Usage: Enables analysis of phase progression

Dependencies: Items 3.3.25 - 3.3.41

Rules: Code Set Rules

Can't move from stable phase to stable phase

```
If [Phase Type] = 1 then [Phase End Reason] cannot = 10
```

Can't move from unstable phase to unstable phase

```
If [Phase Type] = 2 then [Phase End Reason] cannot = 20
```

Can't move from deteriorating phase to deteriorating phase

```
If [Phase Type] = 3 then [Phase End Reason] cannot = 30
```

Can't move from terminal phase to terminal phase

```
If [Phase Type] = 4 then [Phase End Reason] cannot = 40
```

Bereavement Phases and ONLY Bereavement Phases can end in "End Bereavement Phase"

```
If [Phase Type] = 5 then [Phase End Reason] MUST EQUAL 60
If [Phase Type] = 1,2,3,4 then [Phase End Reason] cannot = 60
```

Source: PCOC 2011

Version Control: 1.2.0
Effective Date: 22 November 2012

3.3.25 -3.3.28 Resource Utilisation Group-Activities of Daily Living (RUG-ADL) Scores at Phase End

Mandatory	**Rule Check**	Dependencies

Conditions: Item becomes mandatory if Reason for Phase End (3.3.24) = 70

Permissible code set depends on value entered for item Phase Type (3.3.06) and Phase End Reason (3.3.24). See rules below.

Definition: The RUG-ADL is a 4 item scale measuring motor function with activities of daily living including bed mobility, toileting, transfer and eating.

Data Type: Number

Data Domain: Code set (3.3.28 has a different code set to 3.3.25-3.3.27)

3.3.25 Bed Mobility

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
9	Not assessed

3.3.26 Toileting

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
9	Not assessed

3.3.27 Transfer

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
9	Not assessed

3.3.28 Eating

Code	Description
1	Independent or supervision only
2	Limited assistance
3	Extensive assistance/total dependence/tube fed
9	Not assessed

Data Length: 1 character for each of the four items

Usage: Analysis of the functional dependency of the patient at phase end

Rules: <u>Code Set Rules</u>

RUG-ADL Assessments Not Performed at Death

```
If [Phase Type] = 1,2,3,4 and [Phase End Reason] = 50 then
     [RUG-ADL at Phase End] = 9 (Not Assessed)
```

RUG-ADL Assessments Not Performed for Bereavement Phases

```
If [Phase Type] = 5 then [RUG-ADL at Phase End] = 9 (Not
Assessed)
```

Sources:

Fries, B. E., Scheider, D.P., Foley, W. J., Gavazzi, M., Burke, R., Cornelius, E. (1994). Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III). Medical Care 32(7): 668-685.

Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

3.3.29-3.3.35 Symptom Assessment Score (SAS) at Phase End

Mandatory	**Rule Check**	Dependencies

Conditions: Item becomes mandatory if Reason for Phase End (3.3.24) = 70

Permissible code set depends on value entered for item Phase Type (3.3.06) and Phase End Reason (3.3.24). See rules below.

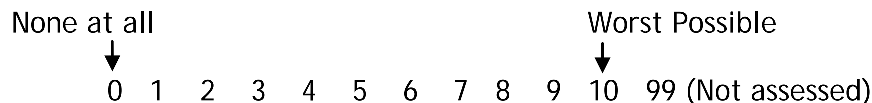
Definition: A seven-item patient rated, valid and reliable tool developed in Western Australia by Kristjanson et al to measure symptom distress in cancer or palliative care patients. The scale is based on the revised symptom distress scale originally developed by McCorkle and Young (1978).

Comprises seven key symptoms:

- insomnia
- appetite problems
- nausea
- bowels
- breathing
- fatigue
- pain

Data Type: Number

Data Domain: Code set (scale)



Record separately for the 7 key symptoms:

3.3.29	Insomnia
3.3.30	Appetite Problems
3.3.31	Nausea
3.3.32	Bowels
3.3.33	Breathing
3.3.34	Fatigue
3.3.35	Pain

Data Length: 1- 2 Characters for each item

Usage: **Key benchmarking variable.** A measure of symptom distress at the end of the phase

Rules: <u>Code Set Rules</u>

SAS Assessments Not Performed at Death

```
If [Phase Type] = 1,2,3,4 and [Phase End Reason] = 50 then
      [SAS at Phase End] = 99(Not Assessed)
```

SAS Assessments Not Performed for Bereavement Phases

```
If [Phase Type] = 5 then [SAS at Phase End] = 99 (Not Assessed)
```

Source: Kristjanson, L. J. Pickstock, S., Yuen, K., Davis, S., Blight, J., Cummins, A., et al. (1999). Development and testing of the revised Symptom Assessment Scale. Perth: Edith Cowan University.

3.3.36-3.3.39 Palliative Care Problem Severity Scores (PCPSS) at Phase End

Mandatory	Rule Check	Dependencies

Conditions: Item becomes mandatory if Reason for Phase End (3.3.24) = 70

Permissible code set depends on value entered for item Phase (3.3.06) and Phase End Reason (3.3.24). See rules below.

Definition: A measurement of distress (at the end of the phase) within the domains:

- Pain
- Other Symptoms
- Psychological/Spiritual
- Family/Carer

Data Type: Number

Data Domain: Code set

3.3.36 PCPSS at Phase End: Pain

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

3.3.37 PCPSS at Phase End: Other Symptoms

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

3.3.38 PCPSS at Phase End: Psychological/Spiritual

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

3.3.39 PCPSS at Phase End: Family/Carer

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
9	Not assessed

Data Length: 1 character for each item

Usage: **Key benchmarking variable.** A measurement of distress within each of the four domains

Rules: Code Set Rules

PCPSS Assessments not performed at death

```
If [Phase Type] = 1,2,3,4 and [Phase End Reason] = 50 then
     [PCPSS at Phase End] = 9 (Not Assessed)
```

PCPSS Assessments not performed for Bereavement Phases

```
If [Phase Type] = 5 then [PCPSS at Phase End] = 9(Not Assessed)
```

Source: Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

3.3.40 Australia-Modified Karnofsky Performance Scale (AKPS) Score at Phase End

Mandatory	**Rule Check**	Dependencies

Conditions: Item becomes mandatory if Reason for Phase End (3.3.24) = 70

Permissible code set depends on value entered for item Phase Type (3.3.06) and Phase End Reason (3.3.24). See rules below.

Definition: An assessment of the patient's performance across the dimensions of activity, work and self-care at phase end

Data Type: Number

Data Domain: Code set

Code	Description
100	Normal; no complaints; no evidence of disease
90	Able to carry on normal activity; minor signs or symptoms
80	Normal activity with effort; some signs or symptoms of disease
70	Cares for self; unable to carry on normal activity or to do active work
60	Requires occasional assistance but is able to care for most of his needs
50	Requires considerable assistance and frequent medical care
40	In bed more than 50% of the time
30	Almost completely bedfast
20	Totally bedfast and requiring extensive nursing care by professionals and/or family
10	Comatose or barely rousable
999	Not assessed

Usage: Provides information on the stage of a patient's illness.

Rules: <u>Code Set Rules</u>

PCPSS Assessments not performed at Death

```
If [Phase Type] = 1,2,3,4 and [Phase End Reason] = 50 then
     [AKPS at Phase End] = 999 (Not Assessed)
```

PCPSS Assessments not performed for Bereavement Phases

```
If [Phase Type] = 5 then [AKPS at Phase End] = 999 (Not
Assessed)
```

Source: Abernethy, A. P., Shelby-James, T., Fazekas, B. S., Woods, D., & Currow, D. C. (2005). *The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice* [Electronic Version]. BioMed Central Palliative Care, 4, 1-12.

Version Control: 1.2.0
Effective Date: 22 November 2012

3.3.41 Number of Days Seen within the Phase

Mandatory	Rule Check	Dependencies

Conditions: **Inactive data item. Place holder for future activation**

Definition: For palliative care phases, the number of days is calculated by counting the number of days that a patient is seen.

Data Type: Number

Data Domain: 1-999

Data Length: Up to 3 Characters

Usage: Analysis of service utilisation and information for service planning.

Multiple visits on one day are counted as one day that the patient is seen.

Source: PCOC 2007

3.3.42 Provider Type

Mandatory	Rule Check	Dependencies

Conditions: **Inactive NEW data item. Place holder for future activation**

Definition: -

Data Type: -

Data Domain: -

Data Length: -

Usage: -

Source: -

Specification 2: PCOC Data Extraction

Palliative Care services participating in PCOC submit data for reporting twice a year. As a result, users will require an interface that allows them to:

1. Specify a "date range" for the data to be extracted
2. Extract their data in the predefined format specified by PCOC
3. Save the extracts in a predefined file type to a local drive

File Type

The PCOC National Longitudinal Database requires data to be submitted in three comma separated files. That is, one file each for:

- Patient records
- Episode records and
- Phase records

There should be exactly:

- 11 commas for each record in the Patient file
- 15 commas for each record in the Episode file
- 41 commas for each record in the Phase file

Naming Convention

Each of the three files should conform to the following naming convention:

Patient record file: XXXXPatientHHMMddmmyyyy.txt
Episode record file: XXXXEpisodeHHMMddmmyyyy.txt
Phase record file: XXXXPhaseHHMMDddmmyyyy.txt

Where:

- XXXX denotes the Service ID of the palliative care service
- Patient, Episode and Phase denote the relevant level of the file
- HHMM denotes the time that the extracts were created
- ddmmyyyy represents the date that the extracts were created

As an example, consider the service identified by Service ID "A333". If a system user extracted PCOC data at 9:33 am on 05/01/2012, the extracts should look like:

Patient record file: A333Patient093305012012.txt
Episode record file: A333Episode093305012012.txt
Phase record file: A333Phase093305012012.txt

Order of data items in extracts

Table A1 Order of Data Items in Patient Extract

Item No.	Item Description	Data Type	Format	Min. Field Width	Max. Field Width
3.1.01	Patient Identifier	String	XXXXXXXXXXXX	1	12
3.1.02	Service Identifier	String	XXXX	4	4
3.1.03	Date of Birth	Date	DD/MM/YYYY	10	10
3.1.04	Statistical Linkage Key	String	XXXXXDDMMYYYYN	14	14
3.1.05	Sex	Number	N	1	1
3.1.06	Individual Healthcare Identifier	String	XXXXXXXXXXXXXXXX	16	16
3.1.07	Australian State	Number	NN	1	2
3.1.08	Postcode	Number	NNNN	4	4
3.1.09	Indigenous Status	Number	N	1	1
3.1.10	Preferred Language	Number	NN	2	2
3.1.11	Country of Birth	Number	NNNN	2	4
3.1.12	Diagnosis	Number	NNN	3	3

Table A2 Order of Items in Episode Extract

Item No.	Item Description	Data Type	Format	Min. Field Width	Max. Field Width
3.2.01	Episode Identifier	String	XXXXXXXXXXXX	1	12
3.2.02	Patient Identifier	String	XXXXXXXXXXXX	1	12
3.2.03	Team Identifier	String	XXXX	4	4
3.2.04	Service Identifier	String	XXXX	4	4
3.2.05	Referral Date	Date	DD/MM/YYYY	10	10
3.2.06	Referral Source	Number	NN	2	2
3.2.07	First Contact Date	Date	DD/MM/YYYY	10	10
3.2.08	Date Ready for Care	Date	DD/MM/YYYY	10	10
3.2.09	Episode Start Date	Date	DD/MM/YYYY	10	10
3.2.10	Episode Type	Number	NN	2	2
3.2.11	Episode Start Mode	Number	NN	2	2
3.2.12	Accommodation at Episode Start	Number	N	1	1
3.2.13	Episode End Date	Date	DD/MM/YYYY	10	10
3.2.14	Episode End Mode	Number	NN	2	2
3.2.15	Accommodation at Episode End	Number	N	1	1
3.1.16	Place of Death	Number	N	1	1

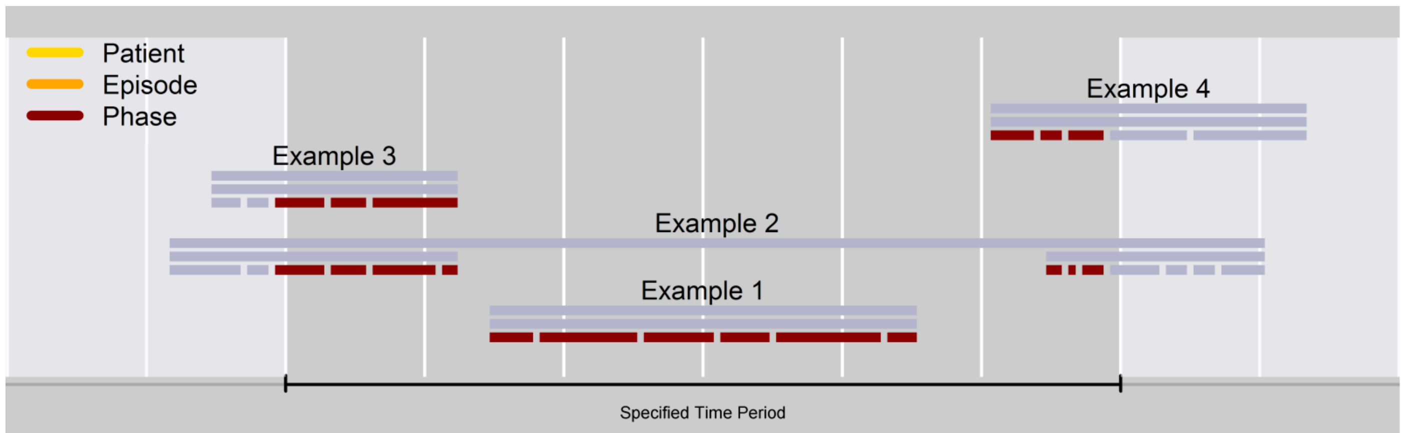
Table A3 Order of Items in Phase Extract

Item No.	Item Description	Data Type	Format	Min. Field Width	Max. Field Width
3.3.01	Phase Identifier	String	XXXXXXXXXXXX	1	12
3.3.02	Episode Identifier	String	XXXXXXXXXXXX	1	12
3.3.03	Patient Identifier	String	XXXXXXXXXXXX	1	12
3.3.04	Service Identifier	String	XXXX	4	4
3.3.05	Phase Start Date	Date	DD/MM/YYYY	10	10
3.3.06	Phase Type	Number	N	1	1
3.3.07	RUG-ADL at Phase Start: Mobility	Number	N	1	1
3.3.08	RUG-ADL at Phase Start: Toileting	Number	N	1	1
3.3.09	RUG-ADL at Phase Start: Transfer	Number	N	1	1
3.3.10	RUG-ADL at Phase Start: Eating	Number	N	1	1
3.3.11	SAS at Phase Start: Insomnia	Number	NN	1	2
3.3.12	SAS at Phase Start: Appetite Problems	Number	NN	1	2
3.3.13	SAS at Phase Start: Nausea	Number	NN	1	2
3.3.14	SAS at Phase Start: Bowels	Number	NN	1	2
3.3.15	SAS at Phase Start: Breathing	Number	NN	1	2
3.3.16	SAS at Phase Start: Fatigue	Number	NN	1	2
3.3.17	SAS at Phase Start: Pain	Number	NN	1	2
3.3.18	PCPSS at Phase Start: Pain	Number	N	1	1
3.3.19	PCPSS at Phase Start: Other Symptoms	Number	N	1	1
3.3.20	PCPSS at Phase Start: Psychological /Spiritual	Number	N	1	1
3.3.21	PCPSS at Phase Start: Family/Carer	Number	N	1	1
3.3.22	AKPS at Phase Start	Number	NNN	2	3
3.3.23	Phase End Date	Date	DD/MM/YYYY	10	10
3.3.24	Phase End Reason	Number	NN	2	2
3.3.25	RUG-ADL at Phase End: Mobility	Number	N	1	1
3.3.26	RUG-ADL at Phase End: Toileting	Number	N	1	1
3.3.27	RUG-ADL at Phase End: Transfer	Number	N	1	1
3.3.28	RUG-ADL at Phase End: Eating	Number	N	1	1
3.3.29	SAS at Phase End: Insomnia	Number	NN	1	2
3.3.30	SAS at Phase End: Appetite Problems	Number	NN	1	2
3.3.31	SAS at Phase End: Nausea	Number	NN	1	2
3.3.32	SAS at Phase End: Bowels	Number	NN	1	2
3.3.33	SAS at Phase End: Breathing	Number	NN	1	2
3.3.34	SAS at Phase End: Fatigue	Number	NN	1	2
3.3.35	SAS at Phase End: Pain	Number	NN	1	2
3.3.36	PCPSS at Phase End: Pain	Number	N	1	1
3.3.37	PCPSS at Phase End: Other Symptoms	Number	N	1	1
3.3.38	PCPSS at Phase End: Psychological /Spiritual	Number	N	1	1
3.3.39	PCPSS at Phase End: Family/Carer	Number	N	1	1
3.3.40	AKPS at Phase End	Number	NNN	2	3
3.3.41	Number of Days Seen	Number	Leave Blank	1	3
3.3.42	Provider Type	Number	Leave Blank	1	1

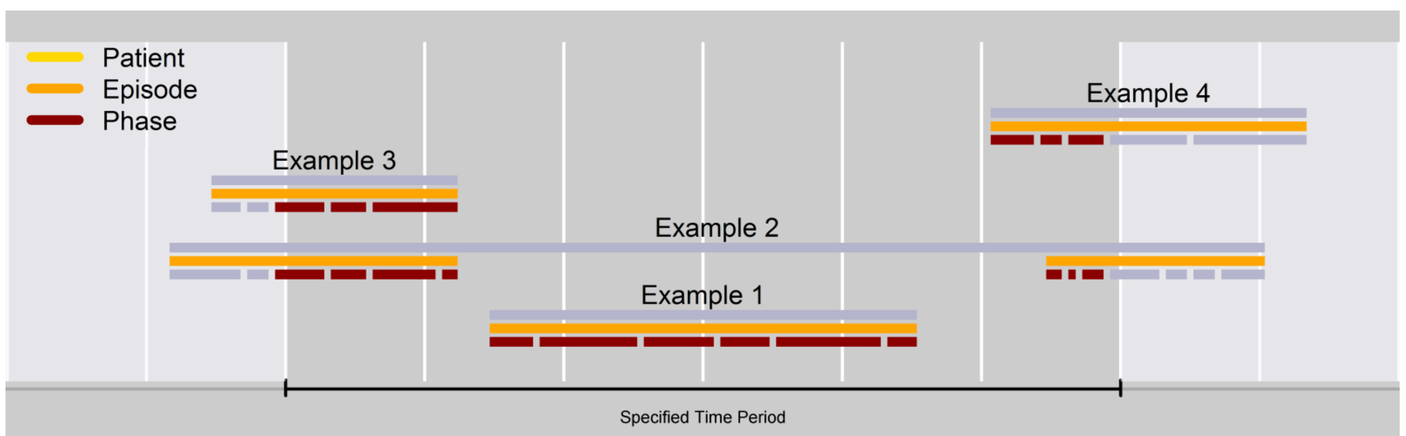
What data to extract?

For a specified time period, the system should extract data based on the following logic:

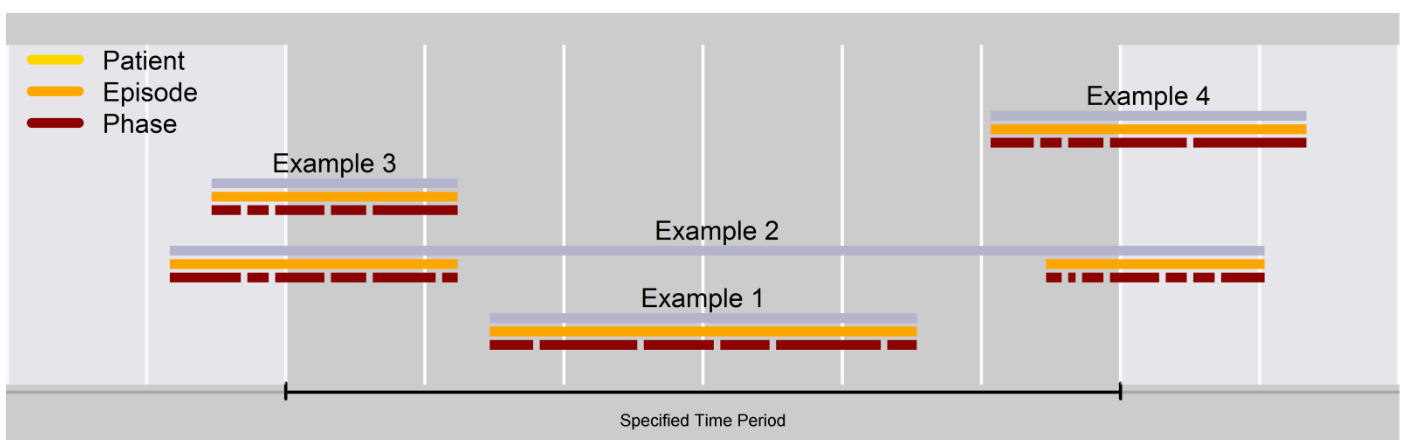
Step 1: All Phase records where Phase End Date (3.3.23) falls within the specified period should be kept – these form the interim set of phases.



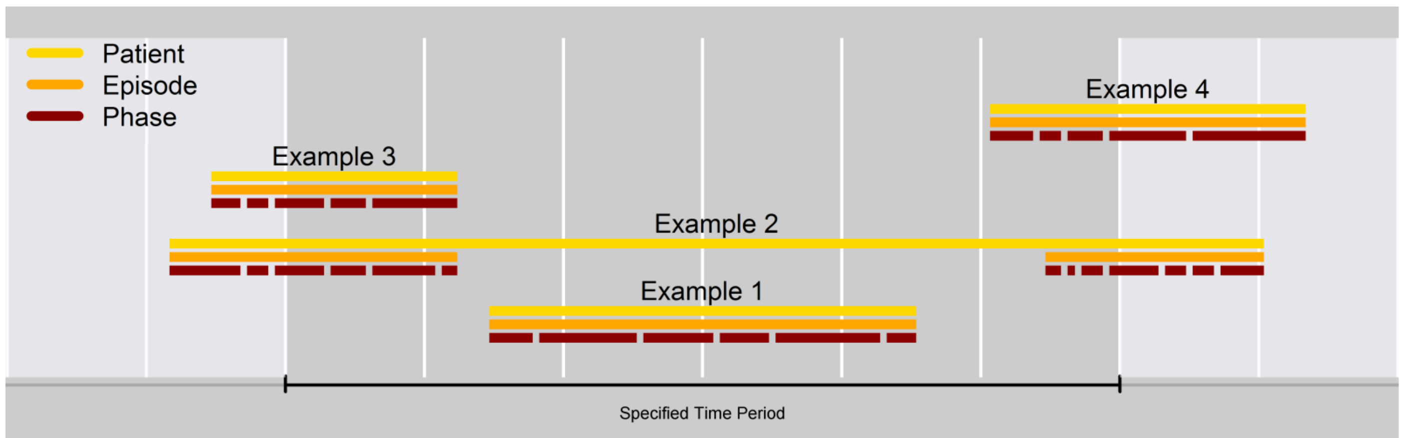
Step 2: Keep all associated episode Records based on the Patient ID and Episode ID from of the interim set of phases selected in Step 1.



Step 3: Looking back at the phase level, keep all phase records associated with the episodes selected in Step 2.



Step 4: Keep all patient level records associated with the selected episodes and phases.



Such a methodology may mean that records ending before or after the specified period, or episode records that have not yet ended (i.e. open Episodes) are extracted.

However, such a methodology ensures that all data related to a particular Episode is loaded into the PCOC National Longitudinal Database and reduces the chance of records "falling between the cracks" of reporting periods.

Additional scoping for reporting purposes will be performed by PCOC.

Mapping from Version 2.0 to Version 3.0

Patient Level Items

Item	Mapping Description
Patient ID	No Mapping Required
Service ID	No mapping required
DOB	No Mapping Required
Statistical Linkage Key	New item. May be populated if required details are already in the system
Sex	No mapping required
Individual Healthcare Identifier	New inactive item.
State	No mapping required
Australian Postcode	No mapping required
Indigenous status	No mapping required
Preferred language	New item. May be populated if item already exists in the system
Country of Birth	Mapping may be required depending upon the Version 2.0 code set used in your system. **Contact PCOC for more information.**
Diagnosis	New item from level and code set change. Mapping not possible. Hence, no mapping required.

Episode Level Items

Item	Mapping Description
Episode ID	No mapping required
Patient ID	No mapping required
Team ID	New Item, to be left blank in Version 2.0 records
Service ID	No mapping required
Referral Date	No mapping required
Referral Source	Mapping required – See following mapping tables
First Contact Date	No mapping required
Date Ready for Care	New Item – Left blank in Version 2.0 records
Episode Start Date	No mapping required
Episode Type	Mapping required – See following mapping tables
Episode Start Mode	Mapping required – See following mapping tables
Accommodation at Episode Start	Mapping required – See following mapping tables
Episode End Date	No mapping required
Episode End Mode	Mapping required – See following mapping tables
Accommodation at Episode End	Mapping required – See following mapping tables
Place of Death	Mapping required – See following mapping tables

Phase Level Items

Item	Mapping Description
Phase ID	No mapping required
Episode ID	No mapping required
Patient ID	No mapping required
Service ID	No mapping required
Phase Start Date	No mapping required
RUG-ADL at Phase Start and Phase End	Missing fields are mapped to "9 - Not assessed". Otherwise, no mapping required
SAS at Phase Start and Phase End	Missing fields are mapped to "99 - Not assessed". Otherwise, no mapping required
PCPSS at Phase Start and Phase End	Missing fields are mapped to "9 - Not assessed". Otherwise, no mapping required
AKPS (Karnofsky) at Phase Start and Phase End	Missing fields and 0 are mapped to "999 - Not assessed". Otherwise, no mapping required
Phase End Reason	Mapping required – See following mapping tables
Number of Days Seen	No mapping required

Referral Source

<u>Mapping table:</u>

Version 2.0 Code	Version 3.0 Map
1	10
2	20
3	11
4	21
5	40
6	50
7	60
8	61
9	70
10	80
11	90
Missing	99

<u>Mapping logic:</u>

```
if [V2_Referral_Source] = 1 then [V3_Referral_Source] = 10
else if  [V2_Referral_Source] = 2 then [V3_Referral_Source] = 20
else if  [V2_Referral_Source] = 3 then [V3_Referral_Source] = 11
else if  [V2_Referral_Source] = 4 then [V3_Referral_Source] = 21
else if  [V2_Referral_Source] = 5 then [V3_Referral_Source] = 40
else if  [V2_Referral_Source] = 6 then [V3_Referral_Source] = 50
else if  [V2_Referral_Source] = 7 then [V3_Referral_Source] = 60
else if  [V2_Referral_Source] = 8 then [V3_Referral_Source] = 61
else if  [V2_Referral_Source] = 9 then [V3_Referral_Source] = 70
else if  [V2_Referral_Source] = 10 then [V3_Referral_Source] = 80
else if  [V2_Referral_Source ]= 11 then [V3_Referral_Source] = 90
else [V3_Referral_Source] = 99
```

Episode Type

Mapping table:

Version 2.0 Code	Version 3.0 Map
0	12
1	11
3	20
4	30
5	Depends on value of Version 2.0 Item Location of Consultative service. See logic below

Mapping logic:

```
if [V2_Episode_Type] = 0 then [V3_Episode_Type] = 12
else if [V2_Episode_Type] = 1 then [V3_Episode_Type] = 11
else if [V2_Episode_Type] = 3 then [V3_Episode_Type] = 20
else if [V2_Episode_Type] = 4 then [V3_Episode_Type] = 30
else if [V2_Episode_Type] = 5 then
      if [V2_Location of consultative service] = 1 then [V3_Episode_Type] = 11
      else if [V2_Location of consultative service] = 2 then [V3_Episode_Type] = 12
      else if [V2_Location of consultative service] = 3 then [V3_Episode_Type] = 20
      else if [V2_Location of consultative service] = 4 then [V3_Episode_Type] = 30
      else if [V2_Location of consultative service] = 5 then [V3_Episode_Type] = 32
      else if [V2_Location of consultative service] = 6 then [V3_Episode_Type] = 31
      else [V3_Episode_Type] = 99
else [V3_Episode_Type] = 99
```

Please note: The 99 code is not in the permissible code set to be used by clinicians. It is simply a flag for PCOC to look into this further

Episode Start Mode

Mapping table:

Version 2.0 Code	Version 3.0 Map
1	11
2	12
3	13
4	14
5	15
6	16
7	19
9	19
A	22
B	21
Missing	99

Mapping logic:

```
if [V2_Episode_Start_Mode] = 1 then [V3_Episode_Start_Mode] = 11
else if [V2_Episode_Start_Mode] = 2 then [V3_Episode_Start_Mode] = 12
else if [V2_Episode_Start_Mode] = 3 then [V3_Episode_Start_Mode] = 13
else if [V2_Episode_Start_Mode] = 4 then [V3_Episode_Start_Mode] = 14
else if [V2_Episode_Start_Mode] = 5 then [V3_Episode_Start_Mode] = 15
else if [V2_Episode_Start_Mode] = 6 then [V3_Episode_Start_Mode] = 16
else if [V2_Episode_Start_Mode] = 7 then [V3_Episode_Start_Mode] = 19
else if [V2_Episode_Start_Mode] = 9 then [V3_Episode_Start_Mode] = 19
else if [V2_Episode_Start_Mode] = A then [V3_Episode_Start_Mode] = 22
else if [V2_Episode_Start_Mode] = B then [V3_Episode_Start_Mode] = 21
else [V3_Episode_Start_Mode] = 99
```

Accommodation at Episode Start <u>and</u> Accommodation at Episode End

Mapping table:

Version 2.0 Code	Version 3.0 Map
1	1
2	2
3	3
4	7
5	7
6	7
7	7
9	9
Missing	9

Mapping logic (Same applies for Accommodation at Episode End):

```
if [V2_Accom_Episode_Start] = 1 then [V3_Accom_Episode_Start] = 1
else if [V2_Accom_Episode_Start] = 2 then [V3_Accom_Episode_Start] = 2
else if [V2_Accom_Episode_Start] = 3 then [V3_Accom_Episode_Start] = 3
else if [V2_Accom_Episode_Start] = 4 then [V3_Accom_Episode_Start] = 7
else if [V2_Accom_Episode_Start] = 5 then  [V3_Accom_Episode_Start] = 7
else if [V2_Accom_Episode_Start] = 6 then [V3_Accom_Episode_Start] = 7
else if [V2_Accom_Episode_Start] = 7 then [V3_Accom_Episode_Start] = 7
else [V3_Accom_Episode_Start] = 9
```

Episode End Mode

Mapping table:

Version 2.0 Code	Version 3.0 Map
1	11
2	12
3	13
4	14
5	15
6	16
8	19
99	99
A	21
B	22
C	23
D	24
E	26
G	99

Pseudo code logic:

```
if [V2_Ep_End_Mode] = 1 then [V3_Ep_End_Mode] = 11
else if [V2_Ep_End_Mode] = 2 then [V3_Ep_End_Mode] = 12
else if [V2_Ep_End_Mode] = 3 then [V3_Ep_End_Mode] = 13
else if [V2_Ep_End_Mode] = 4 then [V3_Ep_End_Mode] = 14
else if [V2_Ep_End_Mode] = 5 then  [V3_Ep_End_Mode] = 15
else if [V2_Ep_End_Mode] = 6 then [V3_Ep_End_Mode] = 16
else if [V2_Ep_End_Mode] = 8 then [V3_Ep_End_Mode] = 19
else if [V2_Ep_End_Mode] = 99 then [V3_Ep_End_Mode] = 99
else if [V2_Ep_End_Mode] = A then [V3_Ep_End_Mode] = 21
else if [V2_Ep_End_Mode] = B then  [V3_Ep_End_Mode] = 22
else if [V2_Ep_End_Mode] = C then [V3_Ep_End_Mode] = 23
else if [V2_Ep_End_Mode] = D then [V3_Ep_End_Mode] = 24
else if [V2_Ep_End_Mode] = E then  [V3_Ep_End_Mode] = 26
else if [V2_Ep_End_Mode] = G then [V3_Ep_End_Mode] = 99
else [V3_Ep_End_Mode] = 99
```

Place of Death

Mapping table:

Version 2.0 Code	Version 3.0 Map
1	1
2	2
3	9
Missing	9

Pseudo code logic:

```
if [V2_Place_of_Death] = 1  then [V3_ Place_of_Death] = 1
else if [V2_ Place_of_Death] = 2 then [V3_ Place_of_Death] = 2
else if [V2_ Place_of_Death] = 3 then [V3_ Place_of_Death] = 9
else [V3_ Place_of_Death] = 9
```

Phase End Reason

Mapping table:

Version 2.0 Code	Version 3.0 Map
1	99
2	70
3	50
4	60
Missing	99

Pseudo code logic:

```
if [V2_End_Reason] = 1  then [V3_End_Reason] = 99
else if [V2_End_Reason] = 2 then [V3_End_Reason] = 70
else if [V2_End_Reason] = 3 then [V3_End_Reason] = 50
else if [V2_End_Reason] = 4 then [V3_End_Reason] = 60
else [V3_End_Reason] = 99
```

Contacts

If developers have any technical queries regarding this document, or require more information, please contact:

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