Canadian Institute for Health Information

Institut canadien d'information sur la santé

DAD Data Elements 2016–2017

The following three tables provide a comparative list of DAD mandatory and optional data elements for **Acute Inpatient** and **Day Surgery** abstracts by submitting jurisdiction, along with a brief description of the data element.

Please refer to the *DAD Abstracting Manual, 2016–2017 Edition* for full details on each data element.

Table 1: DAD Data Elements 2016–2017 — Acute Care

Table 2: DAD Data Elements 2016–2017 — Day Surgery

Table 3: DAD Data Elements 2016–2017 — Group 19 Licensed Vendor Assigned Case Mix Values

Acute Inpatient

Table 1 DAD Data Elements 2016–2017 — Acute Care

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
Group 01 — Submission Control Data Elements															
01/01	Institution Number	A five-character code assigned to a reporting facility by a provincial/ territorial ministry of health identifying the facility and the level of care of the data submitted.	M	M	M	M	NA	M	M	M	M	M	M	M	M
01/02	Batch Count	Batch Count indicates the number of records contained within the batch.	M	M	M	M	NA	M	M	M	M	M	M	M	M
01/03	Batch Year	The year the patient was discharged from a facility according to the fiscal year.	M	M	M	M	NA	M	M	M	M	M	M	M	M
01/04	Batch Period	Batch Period identifies the date interval when the patient was discharged.	M	M	M	M	NA	M	M	M	M	M	M	M	M

Legend
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01/05	Batch Number	Identifies the group (batch) containing the abstract.	M	M	M	M	NA	M	M	M	M	M	M	M	M
01/06	Abstract Number	A unique identification number for each abstract within a batch.	M	M	M	M	NA	M	M	M	M	M	M	M	M
01/08	Coder Number	Identifies the person responsible for completing the abstract.	M	M	M	M	NA	M	M	M	M	M	M	M	M
01/09	Chart Number	The patient's unique identification number assigned by the reporting facility.	M	M	M	M	NA	M	M	M	M	M	M	M	M
01/10	Register Number	Facility derived and assigned number to associate the patient with a particular visit.	M	O	M	M	NA	M	O	O	O	O	O	M	O
01/11	Second Chart or Register Number	An additional chart number or register number that was previously assigned to the patient.	O	O	O	O	NA	O	O	O	O	O	O	O	O
01/12	Maternal/Newborn Chart Number	Chart number of the infant delivered by the patient during the current inpatient stay or the mother’s chart number for the newborn patient.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
Group 02 — Calculated Length of Stay															
02/02	Calculated Length of Stay	The difference, in days, between the Admission Date and Discharge Date.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 03 — Patient/Client Demographics															
03/01	Health Care Number	The patient’s health care insurance number assigned to the patient by the provincial/territorial/ federal government.	M	M	M	M	NA	M	M	M	M	M	M	M	M

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

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Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
03/02	Postal Code	The six-digit alphanumeric code assigned by Canada Post to identify the patient's place of residence.	M	M	M	M	NA	M	M	M	M	M	M	M	M
03/03	Residence Code	A jurisdiction-defined code that identifies the area in which the patient resides.	M	O	M	M	NA	M	O	NA	M	O	M	O	M
03/04	Gender	Alpha character describing the sex of the patient.	M	M	M	M	NA	M	M	M	M	M	M	M	M
03/05	Province/Territory Issuing Health Care Number	Represents the provincial/territorial government from which the Health Care Number was issued.	M	M	M	M	NA	M	M	M	M	M	M	M	M
03/06	Responsibility for Payment	Identifies the primary source responsible for payment of service(s) rendered.	M	M	M	M	NA	M	M	M	M	M	M	M	M
03/08	Birthdate	The Birthdate is the date the patient was born.	M	M	M	M	NA	M	M	M	M	M	M	M	M
03/09	Birthdate Is Estimated	A flag which indicates the Birthdate has unknown day/month or an estimated year of birth.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
03/ 11–27	Provincial/Territorial Ancillary Data	Used to collect data specific to a province/territory as defined by the provincial/ territorial ministries/ departments of health.	NA	NA	M*	O	NA	NA	NA	M*	M*	M*	NA	NA	NA
Derived	Age	Age is a derived variable that represents how old the patient is at the time of admission and is calculated using the Birthdate.	D	D	D	D	NA	D	D	D	D	D	D	D	D

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Group 04 — Admission															
04/ 01–02	Admission Date/Time	The date and time that the patient was officially registered as an inpatient.	M	M	M	M	NA	M	M	M	M	M	M	M	M
04/04	Institution From	Identifies another health care facility or another level of care within the reporting facility from which the patient was transferred for further care.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
04/05	Admit Category	The initial status of the patient at the time of admission to the reporting facility.	M	M	M	M	NA	M	M	M	M	M	M	M	M
04/06	Entry Code	The point of entry to the reporting facility.	M	M	M	M	NA	M	M	M	M	M	M	M	M
04/07	Admit via Ambulance	Identifies whether a patient arrives at the health care facility via ambulance and the type of ambulance that was used.	M	M	M	M	NA	M	M	M	M	M	M	M	M
04/08	Readmission Code	Provides information about the patient's previous acute care admission or day surgery visit at the reporting facility.	M	M	M	O	NA	O	O	O	O	O	O	O	O
04/ 13–14	Patient Left ED Date/Time	The date and time the patient physically left the emergency department and was moved to the inpatient unit, operating room or diagnostic area and did NOT return to the ED.	M	O	M	O	NA	M	M	M	M	M	O	O	O

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

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04/15 Derived	Wait Time in ED	The difference, in hours, between the Admission Date/Time and the Date/Time Patient Left ED.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Derived	Institution From Type	Type of care assigned to institution entered in the Institution From field.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 05 — Separation															
05/ 01–02	Discharge Date/Time	The date and time when the patient was formally discharged.	M	M	M	M	NA	M	M	M	M	M	M	M	M
05/04	Institution To	Identifies the health care facility or another level of care within the reporting facility where the patient was transferred to for further care.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
05/05	Discharge Disposition	The location (01 to 05) where the patient was discharged to or the status of the patient on discharge (06 to 09 and 12).	M	M	M	M	NA	M	M	M	M	M	M	M	M
Derived	Institution To Type	Type of care assigned to institution entered in the Institution To field.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 07 — Patient Service															
07/01	Main Patient Service	Describes a group of similar patients with related diseases and treatments. The Main Patient Service is usually determined by the Most Responsible Diagnosis code.	M	M	M	M	NA	M	M	M	M	M	M	M	M
07/02	Main Patient Subservice	A facility-defined code that allows further differentiation for types of patients treated within the Main Patient Service.	O	O	M*	M*	NA	O	O	O	M*	O	O	O	O

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07/03	Weight	Weight of a newborn or neonate on admission to the facility.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
07/04	Abstract Overflow	An indicator that not all data can be accommodated on the abstract.	O	O	O	O	NA	O	O	O	O	O	O	O	O
Group 08 — Service Transfers (3 occurrences)															
08/01	Service Transfer Service	Identifies the service where the patient received additional care in the health care facility.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
08/02	Service Transfer Subservice	Defines a further specification of the patient Service Transfer as assigned by the health care facility.	O	O	O	M*	NA	O	O	O	O	O	O	O	O
08/03	Service Transfer Days	The number of days a patient spent on a service other than the Main Patient Service.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
Group 09 — Provider Information (8 occurrences)															
09/01	Provider Type	Identifies the role played by the health care providers during the patient's stay in the health care facility.	M	M	M	M	NA	M	M	M	M	M	M	M	M
09/02	Provider Number	The identification number associated with the provider responsible for provision of services to the patient during the visit.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
09/03	Provider Service	Identifies the service(s) of the health professional responsible for providing the services to the patient.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
Group 10 — Diagnosis Information (25 occurrences)															
10/01	Diagnosis Prefix	Provides additional information relating to the ICD-10-CA code to which it is assigned.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
10/02	Diagnosis Code	The ICD-10-CA classification code that describes the diagnoses, conditions, problems or circumstances of the patient during the length of stay in the health care facility.	M	M	M	M	NA	M	M	M	M	M	M	M	M
10/03	Diagnosis Cluster	A group of two or more valid ICD-10-CA Diagnosis Codes that relate to one another. Assigning the same diagnosis cluster links these codes together on the abstract.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
10/04	Diagnosis Type	Code meant to signify the impact the condition had on the patient's care as evidenced by the physician.	M	M	M	M	NA	M	M	M	M	M	M	M	M
10/ 05–07	Cancer Staging — Clinical Classification (Pre-Treatment Clinical Classification)	Clinical classification is based on evidence acquired before treatment. Such evidence arises from physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant examinations.	O	O	O	O	NA	O	O	O	O	O	O	O	O

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
10/ 08–10	Cancer Staging — Pathological Classification (Post-Surgical Histo-Pathological Classification)	Pathological classification is based on the surgical findings.	O	O	O	O	NA	O	O	O	O	O	O	O	O
10/11	Cancer Staging — Summary Stage	A grouping of the TNM information.	O	O	O	O	NA	O	O	O	O	O	O	O	O
Group 11 — Intervention Information (20 occurrences)															
11/01 11/17	Intervention Episode Start Date/Time	The date and time when the patient enters a physical area (intervention location) to have a service(s) (intervention) initiated.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/02	Intervention Code	A valid CCI code(s) describing the services (procedures/intervention) performed for or on behalf of the patient to improve health.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/ 03–05	Attributes: Status Location Extent	CCI intervention attributes identify additional circumstances which may impact on the intervention resources required.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/06	Intervention Provider Number	A unique identifier of the health care providers (physicians and allied health care professionals) involved in each intervention.	M*	O	M*	M*	NA	O	M*	M*	O	M*	M*	M*	M*
11/07	Intervention Provider Service	Reflects the specialty of the physician or allied healthcare professional involved in performing services (interventions).	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
11/08	Tissue Code	Records the pathology results documented in the patient's chart regarding material (tissue) removed from a patient during an intervention.	O	O	O	O	NA	O	O	O	O	O	O	O	O
11/10	Intervention Location Code	Records the physical area in the health care facility where a service(s) (intervention) took place.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/11	Anaesthetist	Records the Provider Number of the physician(s) who administers the anaesthesia during the service (intervention).	M*	O	O	M*	NA	M*	M*	O	O	M*	M*	O	O
11/12	Anaesthetic Technique	The method used to administer anaesthesia to the patient during the service (intervention).	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/13	Out-of-Hospital Indicator	A flag used to indicate an intervention episode was performed in the ambulatory care setting of another facility during the current inpatient stay in the reporting facility.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/14	Out-of-Hospital Institution Number	Identifies the ambulatory setting of another facility where the out-of-hospital services (interventions) for or on behalf of the patient were performed during the current inpatient stay.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/15	Unplanned Return to Intervention Location	A flag that identifies an inpatient's unexpected (not elective) return to the physical area (intervention location).	M*	O	O	O	NA	O	O	M*	M*	M*	O	O	O

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11/16	Died During Intervention	A flag indicating the patient expired during the performance of services (interventions) or during the post-anesthetic recovery period for the intervention episode.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/ 18–19	Intervention Episode End Date/Time	The date and time when the patient exits the physical area (Intervention Location) after service(s) ended.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/20	Intervention Pre-Admit Flag	A flag indicating a service performed was initiated prior to admission and in some cases continued into the acute inpatient stay.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
11/21 Derived	Intervention Episode Duration	It is the difference, in minutes, between Intervention Episode Start Date/Time and Intervention Episode End Date/Time.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 13 — Special Care Unit Information (6 occurrences)															
13/01	Special Care Unit Death Indicator	A flag indicating a patient expired in a special care unit of the health care facility.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
13/02	SCU Unit Number	A code identifying the type of special care unit where the patient receives critical care.	M	M	M	M	NA	M	M	M	M	M	M	M	M
13/ 03–04	SCU Admit Date/Time	Date and time when the patient is admitted to a special care unit (SCU).	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
13/ 05–06	SCU Discharge Date/Time	Date and time when the patient is discharged from or expired on a special care unit (SCU).	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*

Legend
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Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
13/09	Glasgow Coma Scale	A clinical scoring system used to assess the response of a neurologically impaired patient.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
Derived	SCU Hours	SCU Hours is the difference, in hours, between the SCU Admit Date/Time and the SCU Discharge Date/Time. Total SCU Hours is the sum of the hours from the first six occurrences of the special care units.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 14 — Basic Options															
14/ 01–19	Basic Options	Basic Options are defined by the facility or Provincial/Territorial Ministry/Department of Health and are used to collect supplemental information required to meet the needs of the reporting facility.	O	O	O	O	NA	O	O	O	O	O	O	O	O
Group 15 — Mental Health Indicators															
15/02	MH — Source of Referral	Identifies a person or an agency that referred the patient for treatment at the reporting facility.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/03	MH — Method of Admission	The status of the patient at the time of admission to the health care facility.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/04	MH — Change in Legal Status From Admission	Describes the outcome of any psychiatric assessment that may affect the status of the patient during the current admission in the reporting facility.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

			Field Status												
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15/05	MH — AWOL	AWOL indicates that a patient is absent without leave from the reporting facility.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/06	MH — Suicide	Suicide identifies the patient's intentional taking of his or her own life by self-inflicted methods.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/07	MH — Previous Psychiatric Admission	Identifies whether the patient had any previous psychiatric admissions prior to the current admission to the reporting facility.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/08	MH — Referred To	Describes a person or an agency to which the patient was referred after discharge from the reporting facility.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/09	MH — ECT Treatment	To identify whether the patient received any electroconvulsive therapy (ECT) treatments during the current inpatient visit.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/10	MH — Number of ECT Treatments	Identifies the number of electroconvulsive therapy (ECT) treatments the patient received.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/12	MH — Education	Education identifies the highest level of education completed by the patient.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
15/13	MH — Employment Status	Employment Status identifies the status of the patient's employment at the time of admission to the reporting facility.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
15/14	MH — Financial Support	Financial Support identifies the source of income for the patient at the time of admission.	M*	M*	M*	M*	NA	M*	O	O	O	O	O	O	O
Group 16 — Projects Information															
16/ 01–24	Project Information	Used to collect supplemental data required to meet the information needs of CIHI, the provinces/ territories and health care facilities.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
Group 17 — Blood Transfusion Information															
17/01	Blood Transfusion Indicator	Indicates whether or not a patient received a blood transfusion in the reporting facility during the current episode of care.	M	M	M	M	NA	M	M	M	M	O	M	M	M
17/ 02–06	Blood Products	The type of blood product/ component that the patient received via transfusion during his or her stay in the reporting facility.	O	O	O	M*	NA	M*	M*	M*	O	O	O	O	O
17/07	Autologous Blood Transfusion	A flag that identifies whether or not the patient was transfused with his or her own blood.	O	O	O	M*	NA	M*	M*	M*	O	O	O	O	O
Group 18 — Reproductive Care Information															
18/01	Number of Previous Term Deliveries	This field identifies the number of previous full-term deliveries, meaning 37 or more completed weeks.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*
18/02	Number of Previous Pre-Term Deliveries	This field identifies the number of previous pre-term deliveries, meaning 20 to 36 completed weeks.	M*	M*	M*	M*	NA	M*	M*	M*	M*	M*	M*	M*	M*

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
18/03	Number of Previous Spontaneous Abortions	This field identifies the number of previous spontaneous abortions (miscarriages).	M*	O	M*	M*	NA	M*	M*	M*	M*	O	M*	M*	M*
18/04	Number of Previous Therapeutic Abortions	This field identifies the number of previous (legal) therapeutic abortions.	M*	O	M*	M*	NA	M*	M*	M*	M*	O	M*	M*	M*
18/05	Number of Previous Live Births	This field identifies the number of previous live births.	O	O	O	O	NA	M*	M*	M*	M*	O	M*	M*	M*
18/06	Gestational Age	Gestational Age records the duration of the gestation.	M	M*	M	M	NA	M	M	M	M	M*	M*	M	M
18/07	Delivery Time	The time recorded on the mother's abstract to identify when the baby was born.	M*	M*	M*	M*	NA	M*	M*	M*	M*	O	M*	M*	M*
18/08	Date of Last Menses	Date of Last Menses is the calendar date of the patient's last menses.	M*	O	M*	M*	NA	M*	M*	M*	M*	O	O	M*	M*
18/09	Breastfeeding on Discharge	Indicates whether a mother was breastfeeding her infant at the time of discharge from the facility.	M*	O	O	O	NA	O	O	M*	O	O	O	O	O
18/12 Derived	Pre-Delivery Days	The Pre-Delivery Days are the difference in days between the Admission Date and the Intervention Episode Start Date	D	D	D	D	NA	D	D	D	D	D	D	D	D

Day Surgery

Table 2 DAD Data Elements 2016–2017 — Day Surgery

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
Group 01 — Submission Control Data Elements															
01/01	Institution Number	A five-character code assigned to a reporting facility by a provincial/ territorial ministry of health identifying the facility and the level of care of the data submitted.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/02	Batch Count	Batch Count indicates the number of records contained within the batch.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/03	Batch Year	The year the patient was discharged from a facility according to the fiscal year.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/04	Batch Period	The month in which the patient was discharged according to the fiscal year.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/05	Batch Number	Identifies the group (batch) containing the abstract.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/06	Abstract Number	A unique identification number for each abstract within a batch.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/08	Coder Number	Identifies the person responsible for completing the abstract.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/09	Chart Number	The patient's unique identification number assigned by the reporting facility.	M	—	—	M	NA	—	M	M	—	M	M	M	M
01/10	Register Number	Facility derived and assigned number to associate the patient with a particular visit.	M	—	—	M	NA	—	O	O	—	O	O	M	O

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
01/11	Second Chart or Register Number	An additional chart number or register number that was previously assigned to the patient.	O	—	—	O	NA	—	O	O	—	O	O	O	O
Group 02 — Calculated Length of Stay															
02/02 Derived	Calculated Length of Stay	The difference, in hours, between the Admission Date/Time and Discharge Date/Time.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 03 — Patient/Client Demographics															
03/01	Health Care Number	The patient's health care insurance number assigned to the patient by the provincial/territorial/federal government.	M	—	—	M	NA	—	M	M	—	M	M	M	M
03/02	Postal Code	The six-digit alphanumeric code assigned by Canada Post to identify the patient's place of residence.	M	—	—	M	NA	—	M	M	—	M	M	M	M
03/03	Residence Code	A jurisdiction-defined code that identifies the area in which the patient resides.	M	—	—	M	NA	—	O	NA	—	O	M	O	M
03/04	Gender	Alpha character describing the sex of the patient.	M	—	—	M	NA	—	M	M	—	M	M	M	M
03/05	Province/Territory Issuing Health Care Number	Represents the provincial/territorial government from which the Health Care Number was issued.	M	—	—	M	NA	—	M	M	—	M	M	M	M
03/06	Responsibility for Payment	Identifies the primary source responsible for payment of service(s) rendered.	M	—	—	M	NA	—	M	M	—	M	M	M	M
03/08	Birthdate	The Birthdate is the date the patient was born.	M	—	—	M	NA	—	M	M	—	M	M	M	M

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
03/09	Birthdate Is Estimated	A flag which indicates the Birthdate has unknown day/month or an estimated year of birth.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
03/ 11–27	Provincial/Territorial Ancillary Data	Used to collect data specific to a province/territory as defined by the provincial/ territorial ministries/ departments of health.	NA	—	—	O	NA	—	NA	M*	—	M*	NA	NA	NA
Derived	Age	Age is a derived variable that represents how old the patient is at the time of admission and is calculated using the Birthdate.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 04 — Admission															
04/ 01–02	Admission Date/Time	The date and time that the patient was officially registered as a day surgery patient.	M	—	—	M	NA	—	M	M	—	M	M	M	M
04/04	Institution From	Identifies another health care facility or another level of care within the reporting facility from which the patient was transferred for further care.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
Derived	Institution From Type	Type of care assigned to institution entered in the Institution From field.	D	D	D	D	NA	D	D	D	D	D	D	D	D
04/05	Admit Category	The initial status of the patient at the time of admission to the reporting facility.	M	—	—	M	NA	—	M	M	—	M	M	M	M
04/06	Entry Code	The point of entry to the reporting facility.	M	—	—	M	NA	—	M	M	—	M	M	M	M

Legend
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Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
04/07	Admit via Ambulance	Identifies whether a patient arrives at the health care facility via ambulance and the type of ambulance that was used.	M	—	—	M	NA	—	M	M	—	M	M	M	M
Group 05 — Separation															
05/ 01–02	Discharge Date/Time	The date and time when the patient was formally discharged	M	—	—	M	NA	—	M	M	—	M	M	M	M
05/04	Institution To	Identifies the health care facility or another level of care within the reporting facility where the patient was transferred to for further care.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
05/05	Discharge Disposition	The location (01 to 05) where the patient was discharged to or the status of the patient on discharge (06 to 09 and 12).	M	—	—	M	NA	—	M	M	—	M	M	M	M
Derived	Institution To Type	Type of care assigned to institution entered in the Institution To field.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 07 — Patient Service															
07/01	Main Patient Service	Describes a group of similar patients with related diseases and treatments. The Main Patient Service is usually determined by the Most Responsible Diagnosis code.	M	—	—	M	NA	—	M	M	—	M	M	M	M
07/02	Main Patient Subservice	A facility-defined code that allows further differentiation for types of patients treated within the Main Patient Service.	O	—	—	O	NA	—	O	O	—	O	O	O	O
07/03	Weight	Weight of a newborn or neonate on admission to the facility.	M*	—	—	M*	—	M*	M*	M*	—	M*	M*	M*	M*

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
Group 09 — Provider Information (8 occurrences)															
09/01	Provider Type	Identifies the role played by the health care providers during the patient's stay in the health care facility.	M	—	—	M	NA	—	M	M	—	M	M	M	M
09/02	Provider Number	The identification number associated with the provider responsible for provision of services to the patient during the visit.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
09/03	Provider Service	Identifies the service(s) of the health professional responsible for providing the services to the patient.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
Group 10 — Diagnosis Information (25 occurrences)															
10/02	Diagnosis Code	The ICD-10-CA classification code that describes the diagnoses, conditions, problems or circumstances of the patient during the length of stay in the health care facility.	M	—	—	M	NA	—	M	M	—	M	M	M	M
10/03	Diagnosis Cluster	A group of two or more valid ICD-10-CA Diagnosis Codes that relate to one another. Assigning the same diagnosis cluster links these codes together on the abstract.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
10/04	Diagnosis Type	Code meant to signify the impact the condition had on the patient’s care as evidenced by the physician.	M	—	—	M	NA	—	M	M	—	M	M	M	M

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
Group 11 — Intervention Information (20 occurrences)															
11/01 11/17	Intervention Episode Start Date/Time	The date and time when the patient enters a physical area (intervention location) to have a service(s) (intervention) initiated.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/02	Intervention Code	A valid CCI code(s) describing the services (procedures/intervention) performed for or on behalf of the patient to improve health.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/ 03–05	Attributes: Status Location Extent	CCI intervention attributes identify additional circumstances which may impact on the intervention resources required.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/06	Intervention Provider Number	A unique identifier of the health care providers (physicians and allied health care professionals) involved in each intervention	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/07	Intervention Provider Service	Reflects the specialty of the physician or allied healthcare professional involved in performing services (interventions).	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/08	Tissue Code	Records the pathology results documented in the patient's chart regarding material (tissue) removed from a patient during an intervention.	O	—	—	O	NA	—	O	O	—	O	O	O	O
11/10	Intervention Location Code	Records the physical area in the health care facility where a service(s) (intervention) took place.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
11/11	Anaesthetist	Records the Provider Number of the physician(s) who administers the anaesthesia during the service (intervention).	M*	—	—	M*	NA	—	M*	O	—	M*	M*	O	O
11/12	Anaesthetic Technique	The method used to administer anaesthesia to the patient during the service (intervention).	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/16	Died During Intervention	A flag indicating the patient expired during the performance of services (interventions) or during the post-anesthetic recovery period for the intervention episode.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/ 18–19	Intervention Episode End Date/Time	The date and time when the patient exits the physical area (Intervention Location) after service(s) ended.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
11/21 Derived	Intervention Episode Duration—Derived	It is the difference, in minutes, between Intervention Episode Start Date/Time and Intervention Episode End Date/Time.	D	D	D	D	NA	D	D	D	D	D	D	D	D
Group 14 — Basic Options															
14/ 01–19	Basic Options	Basic Options are defined by the facility or Provincial/Territorial Ministry/Department of Health and are used to collect supplemental information required to meet the needs of the reporting facility.	O	—	—	O	NA	—	O	O	—	O	O	O	O

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
Group 16 — Projects Information															
16/ 01–24	Project Information	Used to collect supplemental data required to meet the information needs of CIHI, the provinces/ territories and health care facilities.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
Group 17 — Blood Transfusion Information															
17/01	Blood Transfusion Indicator	Indicates whether or not a patient received a blood transfusion in the reporting facility during the current episode of care.	O	—	—	M	NA	—	M	O	—	O	O	O	O
17/ 02–06	Blood Products	The type of blood product/ component that the patient received via transfusion during his or her stay in the reporting facility.	O	—	—	M*	NA	—	M*	O	—	O	O	O	O
17/07	Autologous Blood Transfusion	A flag that identifies whether or not the patient was transfused with his or her own blood.	O	—	—	M*	NA	—	M*	O	—	O	O	O	O
Group 18 — Reproductive Care Information															
18/01	Number of Previous Term Deliveries	This field identifies the number of previous full-term deliveries, meaning 37 or more completed weeks.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
18/02	Number of Previous Pre-Term Deliveries	This field identifies the number of previous pre-term deliveries, meaning 20 to 36 completed weeks.	M*	—	—	M*	NA	—	M*	M*	—	M*	M*	M*	M*
18/03	Number of Previous Spontaneous Abortions	This field identifies the number of previous spontaneous abortions (miscarriages).	M*	—	—	M*	NA	—	M*	M*	—	O	M*	M*	M*

Legend
M — mandatory; O — optional; M* — conditional mandatory ; D — derived; NA — not applicable
Note: DAD data elements that are not applicable for day surgery in any jurisdiction are not included.

			Field Status												
Group/ Field	**Data Element Name**	**Description**	**N.L.**	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**N.W.T.**	**Y.T.**	**Nun.**
18/04	Number of Previous Therapeutic Abortions	This field identifies the number of previous (legal) therapeutic abortions.	M*	—	—	M*	NA	—	M*	M*	—	O	M*	M*	M*
18/06	Gestational Age	Gestational Age records the duration of the gestation.	M	—	—	M	NA	—	M	M	—	M*	M*	M	M
18/08	Date of Last Menses	Date of Last Menses is the calendar date of the patient's last menses.	M*	—	—	M*	NA	—	M*	M*	—	O	O	M*	M*
19/ 01–25	Licensed Vendor Assigned Values	Facilities with vendor grouper software will have these licensed vendor assigned values automatically populated according to the CMG+ and CACS grouping methodology.	O	—	M	M	NA	—	M	O	—	O	O	O	O

Licensed Vendor Assigned Case Mix Values

Table 3 DAD Data Elements 2016–2017 — Group 19 Licensed Vendor Assigned Case Mix Values

Facilities with vendor grouper software will have these licensed vendor assigned values automatically populated according to the CMG+ and CACS grouping methodology.
Vendor assigned values are mandatory in New Brunswick, Nova Scotia and Manitoba.

Group/Field	Data Element Name	Description
19/01	MCC	Major Clinical Category (MCC) assigned according to Case Mix Grouping (CMG+) methodology. An MCC is a large grouping of diagnoses generally related to a body system, specific conditions, or trauma.
19/02	CMG	Crossover Case Mix Grouping assigned by the Case Mix Grouping (CMG+) methodology. CMG+ is a grouping methodology developed by CIHI that categorizes acute care patients into groups based on similarities of diagnosis, intervention, LOS and resource requirements.
19/04	RIW	Resource Intensity Weight (RIW) assigned to the abstract from the CMG+ methodology. All RIW cost weights are relative to the average cost of a typical acute inpatient case, such that the sum of typical cases is equal to the sum of the typical weighted cases.
19/06	Grouping Vendor ID	ID number of vendor assigning the Case Mix Grouping (CMG+) methodology.
19/07	CMG Age Category	Age Category assigned by the Case Mix Grouping (CMG+) methodology. The CMG Age Category is the alphabetic age group code that represents the age group and category to which the case is assigned for RIW calculation.
19/08	Comorbidity Level	The Comorbidity Levels reflect the cumulative resource impact of comorbidities on the patient's stay as assigned by the Case Mix Grouping (CMG+) methodology.
19/10	Intervention Event Count	Intervention Event Count is a number that represents the intervention events associated with the case as assigned by the Case Mix Grouping (CMG+) methodology. An intervention event (IE) is an intervention that occurred during the patient's stay in a facility.
19/11	OOH Factor Count	Out-of-Hospital (OOH) Interventions Factor Count is a number that indicates if the patient had an OOH intervention or if OOH is applicable to the patient's case as assigned by the Case Mix Grouping (CMG+) methodology.
19/12	RIW Atypical Code	Resource Intensity Weight (RIW) Atypical Code is a measure used to determine a patient's typical or atypical status for the calculation of RIW and ELOS as assigned to abstract by the Case Mix Grouping (CMG+) methodology.
19/13	ELOS	Expected length of stay (ELOS) value represents the length of time a patient is expected to stay in a facility as assigned by the Case Mix Grouping (CMG+) methodology.

Facilities with vendor grouper software will have these licensed vendor assigned values automatically populated according to the CMG+ and CACS grouping methodology.
Vendor assigned values are mandatory in New Brunswick, Nova Scotia and Manitoba.

Group/Field	Data Element Name	Description
19/14	RI Level	Resource intensity level (RIL) for the abstract as assigned according to Case Mix Grouping (CMG+) methodology. The RIL is a derived variable created for reporting purposes. It is a way of further distinguishing patients with higher resource use.
19/15	Abstracting Vendor ID	ID number of licensed software vendor.
19/20	CACS	The Comprehensive Ambulatory Classification System (CACS) code is an outpatient grouping methodology for ambulatory data and is based on the ICD-10-CA and CCI classifications.
19/21	MAC	Major Ambulatory Cluster is a high level grouping of the Comprehensive Ambulatory Classification System (CACS) cells generally related to body system or functional grouping.
19/22	CACS age category	The Comprehensive Ambulatory Classification System (CACS) age category assigned to the abstract.
19/23	CACS anaesthetic code	The Comprehensive Ambulatory Classification System (CACS) anaesthetic code identifies the anaesthetic type recorded.
19/24	CACS investigative technology total count	A distinct count of the total number of Investigative Technology categories found on each abstract as assigned according to the Comprehensive Ambulatory Classification System (CACS).
19/25 **NEW**	Flagged Intervention Status	The Flagged Intervention Status differs from the CIHI assignment. If the Vendor Assigned Flagged Intervention Status is not blank, it should be the same as the CIHI assigned Flagged Intervention Status. Because this is a warning message, no change was made to the data. The original data recorded on the abstract appears on the Submission Detailed Error File as “Original Data Submitted.” The CIHI value also appears on the report. The first value recorded on the Submission Detailed Error File is the Vendor Assigned value and the value following it, separated by a forward slash, is the CIHI assigned value. For example, if the Vendor Assigned a value of 4 and CIHI assigned a value of 1, “4/1” appears on the Submission Detailed Error File. For an explanation of Flagged Intervention Status, please refer to the Introduction and Flagged Intervention sections of the CMG+ Directory.