

**Community Care Information Management (CCIM)  
Integrated Assessment Record (IAR) Project**

**Integrated Assessment Record (IAR)**

**RAI-MDS 2.0 Supplement to the Data Submission and  
Technical Specifications**

Document Version 1.3

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## Purpose of this document

The Integrated Assessment Record (IAR) has been implemented and is well under way with various participating health service providers (HSPs) across Ontario's Local Health Integration Networks (LHINs). As part of this initiative, HSPs have the ability to submit standardized, common assessments into the IAR and view assessment information across multiple sectors.

This document is intended to be a RAI-MDS 2.0 specific supplement to the existing "Data Submission and Technical Specifications" manual. Long Term Care Homes and their vendor(s) should read the supplement for a better understanding of the technical requirements for successful integration of their system to the IAR.

If there are further questions/concerns regarding this document, contact the Integrated Assessment Record (IAR) Project team at: [iar@ccim.on.ca](mailto:iar@ccim.on.ca)

## Intended Audience

This document is intended for Long Term Care, Continuing Care, Specialty Care and Nursing Homes that are completing the RAI-MDS 2.0 assessment and their vendor of choice that will be implementing the IAR solution.

**Vendors** will use this supplement along with all of the supporting documents to develop data feed for submitting assessment data to the IAR Provincial solution. The project team is available throughout the implementation phase via teleconferences for clarifications and questions about these requirements as needed. Any additional questions can be sent to the project team through the Support Centre.

**Organizations** should read and understand this supplement and all the supporting documents that make up the data submission requirements. Organizations are responsible for ensuring that their vendor delivers a solution that meets all the requirements outlined by CCIM.

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# Overview of IAR

iar@ccim.on.ca

The IAR enables health service providers within the circle of care to access common assessment data in a secure and accurate manner. It provides a single source of community-based assessment data that enables information management and planning for providers, LHINs and the MOHLTC. The IAR simplifies integration of assessment data into the electronic health record (EHR) It also facilitates collaborative client/patient care planning by allowing information to be viewed electronically within a client's circle of care. This helps coordinate community-based care planning to eliminate service gaps and overlaps.

This RAI-MDS 2.0 supplement will provide samples, definitions and a simple explanation of data submissions to the IAR.

## 1.0 CCRS (MDS 2.0) within and IAR Submission

```
1 <?xml version="1.0" encoding="UTF-8" standalone="no"?>
2 <iar:IARSubmission version="2.0" xsi:schemaLocation="http://iar.on.ca/types IARSubmissionDefinitions_v2.0.1.xsd" xmlns:iar
  = "http://iar.on.ca/types" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
3   <iar:TransmissionHeader>
4     <submissionId>CCR201101110001_DemoChange</submissionId>
5     <organization id="1100" name="CCIM Test"/>
6     <exportTimestamp>2012-06-27T09:30:47Z</exportTimestamp>
7     <assessmentType>RAI_MDS_2.0</assessmentType>
8     <application id="1" name="Product name" vendor="Vendor name" version="1.x"/>
9   </iar:TransmissionHeader>
10  <iar:SubmissionContent>
11    <Record mimeType="text/xml" recordType="Assessment" version="1.2">
12      <text><![CDATA[<CCRSSubmission version="1.2" specversion="2012"
  xsi:schemaLocation="http://www.ehealthontario.ca/CCIM IAR_CCRS_Submission_1.2.xsd"
  xmlns="http://www.ehealthontario.ca/CCIM" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
93      </Record>
94    <Record mimeType="text/xml" recordType="Consent" version="1.0.1">
120  </iar:SubmissionContent>
121 </iar:IARSubmission>
```

Figure 1 - Sample IAR/MDS 2.0 Submission Envelope

### 1.1 IAR Submission Envelope

The IAR Submission Envelope is a common xml message wrapper that is used to transport a set of assessments to the IAR (Integrated Assessment Record). This message structure is a container that allows for the inclusion of data generated by various assessment schemas. The use of a common message structure allows a vendor to create a single submission solution that can be re-used to submit data across multiple Health Service Provider sectors.

Each submission envelope can contain only a single type of assessment – such as MDS 2.0, however the same IAR schema can and is used to submit OGAN 2, RAI-MH and RAI-CHA. The parameter values within the envelope change to reflect the type of assessment information contained. When the submission is received, the IAR reads the values to determine the type of assessments contained in the submission content so it can perform the appropriate validations and correctly import the assessment information.

The schema that defines the IAR Submission Envelope is called IARSubmissionDefinitions\_v2.0.1.xsd and is available through the Vendor portion of the CCIM Web site ([www.ccim.on.ca](http://www.ccim.on.ca)). For the full overall IAR Submission specifications refer to the “Data Submission and Technical Specifications”.

## 1.2 Common element values and attributes for all assessment submission types

“**iar**” **Namespace** - the top level *IARSubmission* element requires the use of a namespace which is to be defined as an xmlns attribute. There are several other attributes that need to be included, their names and values should appear within the xml as follows:

```
<iar:IARSubmission
xmlns:iar="http://iar.on.ca/types"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
version="2.0"
xsi:schemaLocation="http://iar.on.ca/types IARSubmissionDefinitions_v2.0.1.xsd">
```

## 1.3 Transmission Header Element

This portion of the *IARSubmission* contains values that identify the sending organization (HSP), the type of assessment data contained and the source system.

```
<iar:IARSubmission .....
<iar:TransmissionHeader>
  <submissionId>CCR2010025999902230936</submissionId>
  <organization id="9999" name="Top Level Organization (HSP) name" />
  <exportTimestamp>2012-06-23T09:45:23Z</exportTimestamp>
  <assessmentType>RAI_MDS_2.0</assessmentType>
  <application id="12345" name="Product Name" vendor="Vendor name" version="1.x"/>
</iar:TransmissionHeader>
```

**SubmissionId** : This value is a source system generated value to identify a single submission. This value has a **40 character limit** although it is not currently noted within the schema. The purpose of this value is to uniquely identify a single submission and to report back the success or failure of the submission to the sender. It is also used to detect duplicate submissions. The value can be a filename, a sequential number or any other type of identifying information. Each submission id must be unique per submission from a particular instance of the source system.

As an example, CIHI currently uses the following format that can be applied as the submission id:

CCRyyyypphhhhss.txt

Where yyyy = fiscal year

pp =fiscal period/quarter; 01 for 1<sup>st</sup> quarter  
02 for 2<sup>nd</sup> quarter  
03 for 3<sup>rd</sup> quarter  
04 for 4<sup>th</sup> quarter

hhhhh = submitting organization number

ss = mandatory submission sequence id (for e.g. 01, 02, 03, etc.)

The sequence must be unique for the year and the period due to the likelihood of daily submission, consider the sequence being as follows:

ssssss:ss:ss = month/day/time;      month = 01, 02,...12 etc.  
day = 01, 02,..... 31 etc.  
time = 10:45:27, 01:30:21, 14:26:43 etc.

**Sample name:** CCR20100459999022308:35:23

**Note:** There may be a need for milliseconds.

**Organization** : This element defines the sending Health Service Provider (HSP) and contains Facility Code (MIS Number) for the organization issued by the Ministry of Health. Do not confuse this with the use of a Facility Number (CIHI Number) contained within each assessment. The combination of the *SubmissionId* and the *Organization Id* values are used to identify a unique submission from a single overall organization. The submission will only be accepted from organization Id's that are known to the IAR and should not contain leading zeros. "123" is valid, "0123" will be invalid.

The *name* attribute is used for display purposes to the clinicians using the system and should be populated with the HSP's full name.

**Note:** The Organization Id is typically 3 or 4 digits in length and will display as follows: <organization id="999" name="Organization Full Name"/>.

**assessmentType:** This is a key value to tell the IAR what type of assessment data is contained within the submission. For MDS 2.0 assessments this value must be "**RAI\_MDS\_2.0**". This value is for all assessment data submitted that meet MDS 2.0 requirements for years 2010, 2011 and 2012 inclusive.

**application:** This element contains identifying information about the source system. It is vendor related and should contain the business name, product used and version. The *id* does not have significance regarding MDS 2.0 submissions however it is recommended that this value contain a vendor related installation number or client id value if possible.

e.g. <application id="1" name="Product name" vendor="Vendor name" version="1.x"/>

## 2.0 Encapsulating the RAI-MDS 2.0 assessment data within the IAR Submission

The **SubmissionContent** element is used to embed assessment data within the IAR Submission Envelope. The assessment itself is stored in its native format, meaning it is standalone xml document on its own created to its corresponding schema.

There are 2 methods of accomplishing this, one to wrap the xml within CDATA segment to contain the unaltered MDS 2.0 xml or to encode the MDS 2.0 xml using Base64 encoding. Each approach has its merits and the use of either method is up to the vendor.

With the CDATA method, the standard XML processing instruction can be suppressed at the "Record" element level. This instruction typically appears as follows <?xml version="1.0" encoding="UTF-8" ?>. It should not contain the standalone attribute if present.

**Note:** One thing to watch out for when choosing this method is to ensure that inherent xml *special character* or *predefined entity* function does not interfere with the writing of the xml data to the element. This involves the automatic replacement characters such as "<", ">", quotes etc. This typically affects the CDATA wrapper itself which renders the document unusable.

Example of CDATA embedded MDS 2.0 assessment data with in a text element:

```
<iar:IARSubmission >
  <iar:TransmissionHeader>
    <iar:SubmissionContent>
      <Record mimeType="text/xml" recordType="Assessment" version="1.2">
        <text><![CDATA[<CCRSSubmission xmlns="http://www.ehealthontario.ca/CC
```

```

<?xml version="1.0" encoding="UTF-8" standalone="no"?>
<iar:IARSubmission xmlns:iar="http://iar.on.ca/types" xmlns:xsi="http://www.w3.org/2001/XMLSchema"
  <iar:TransmissionHeader>
  <iar:SubmissionContent>
    <Record mimeType="text/xml" recordType="Assessment" version="1.1">
      <text><i>[CDATA[<CCRSSubmission xmlns="http://www.ehealthontario.ca/CCIM" xmlns:xsi=
    </Record>
  </iar:SubmissionContent>
</iar:IARSubmission>

```

CCRSSubmission structure  
CDATA within a text record

Example of Base64 encoded MDS 2.0 assessment data within a binary element:

```

<?xml version="1.0" encoding="UTF-8" standalone="no"?>
<iar:IARSubmission xmlns:iar="http://iar.on.ca/types" xmlns:xsi="http://www.w3.org/2001/XMLSchema"
  <iar:TransmissionHeader>
  <iar:SubmissionContent>
    <Record mimeType="text/xml" recordType="Assessment" version="1.1">
      <binary compressionType="none">PENDULNTdWJtaXNzaW9uIHZ1cnNpb249IjEjEUM8Igc3B1Y3Z1cnNpb249IjEjE
    </Record>
  </iar:SubmissionContent>
</iar:IARSubmission>

```

CCRSSubmission Structure encoded in  
Base64 within the binary element

## 2.1 CCRS Submission structure (RAI MDS 2.0 in CCIM xml format)

Primary Submission Element and common Submission Header

The Submission Header contains information regarding the source, year and number of the assessments contained within the submission.

```

3  <CCRSSubmission version="1.2" specversion="2012" xsi:schemaLocation="http://www.ehealthontario.ca/CCIM
    IAR_CCRS_Submission_1.2.xsd" xmlns="http://www.ehealthontario.ca/CCIM" xmlns:xsi="
    http://www.w3.org/2001/XMLSchema-instance">
4  <SubmissionHeader>
5  <FacilityNumber>51123</FacilityNumber>
6  <FiscalYearOfSubmission>2012</FiscalYearOfSubmission>
7  <FiscalQuarterForThisSubmission>1</FiscalQuarterForThisSubmission>
8  <NumberOfRecordsInTransmissionFile>1</NumberOfRecordsInTransmissionFile>
9  <DateTimeOfSubmission>2012-06-17T09:30:47Z</DateTimeOfSubmission>
10 </SubmissionHeader>
11 <SubmissionContent>

```

## 2.2 CCRSSubmission

The CCRSSubmission element must have the following attribute values:

version	1.2
specversion	2012
xmlns	<a href="http://www.ehealthontario.ca/CCIM">http://www.ehealthontario.ca/CCIM</a>
xmlns:xsi	<a href="http://www.w3.org/2001/XMLSchema-instance">http://www.w3.org/2001/XMLSchema-instance</a>

**Element Submission Header** – Matches CIHI standard Submission Header values. (Control Record)

**Facility Number** “59999”- This is the 5 digit MOH number (5+ Master Number) identifying the location/program where the assessments originate from. It is not the same number as the 3-4 digit Organization number used within the IAR Submission Envelope which denotes the sending organization of the data. Only assessments for the same facility number defined within the Submission Header should appear within the assessment xml. It is important to always use the correct Facility Number for submissions from organizations with multiple facilities, as this value is used by the IAR to generate unique client ID’s. A separate submission needs to occur for each facility within an organization.

**Fiscal Year of Submission** – 2012. Only assessments created for the fiscal year (April1-March31) can be included in the submission. A separate submission is required for each year and each quarter.

**Date Time of Submission** “2012-06-01T09:30:47”- Should be a date falling within the Fiscal Year of Submission and the Fiscal Quarter; e.g. Fiscal Year “2012” Fiscal Quarter “1”. This field should always have a time component, this is used by the IAR to help identify the most recent version of an assessment should it be uploaded more than once.

**Note:** The Facility Number in the Submission Header and the Facility Number in the Assessment Header must match.

## 2.3 Submission Content Section

The Submission Content element contains individual assessments. Each assessment is contained within its own assessment element.

```
3  <CCRSSubmission version="1.2" specversion="2012" xsi:schemaLocation="http://www.ehealthontario.ca/CCIM
   IAR_CCRS_Submission_1.2.xsd" xmlns="http://www.ehealthontario.ca/CCIM" xmlns:xsi="
   http://www.w3.org/2001/XMLSchema-instance">
4  <SubmissionHeader>
5  <SubmissionContent>
6  <Assessment>
7  <AssessmentHeader>
8  <AssessmentID>text</AssessmentID>
9  <SubmissionType>N</SubmissionType>
10 <UniqueRegID>String</UniqueRegID>
11 <ReasonForAssessment>07</ReasonForAssessment>
12 <FacilityNumber>51123</FacilityNumber>
13 </AssessmentHeader>
```

### Assessment Header Section

Contains identifying information for the assessment contained. Present for all assessment records.

**Assessment ID** - This is a unique identifying number for an individual assessment. This is part of the primary key value used by the IAR. No 2 assessments can have the same assessment ID. Any assessment that is modified slightly or deleted and re-submitted must use the same assessment ID. The IAR will only display the latest copy to the user. If for some reason an assessment is sent twice within a submission (it has been first created then updated or deleted) the latest version should be the last within the submission.

**Submission Type** - Can be N for New, U for Update and D for Delete. The submission type is used along with the Assessment ID to control the action taken upon the assessment.

**UniqueRegID** – Is the Unique Registration Identifier it is the 20 characters in length uniquely identifies the resident admission. It is composed of a facility number, a date and seven characters. E.g., “59999201102230000123”.



**ReasonForAssessment** - Identifies the type of CCRS assessment record contained this is equal to the MDS value of element AA8. Valid codes for element AA8 are 00-10, 17 and 18. Each Assessment element can only contain a single CCRS assessment record.

**FacilityNumber** – note this must be the same as the Facility Number contained within the SubmissionHeader

## 2.4 Resident Section

```
1 <CCRSSubmission version="1.2" specversion="2012" xsi:schemaLocation="http://www.ehealthontario.ca/CCIM
  IAR_CCRS_Submission_1.2.xsd" xmlns="http://www.ehealthontario.ca/CCIM" xmlns:xsi="
  http://www.w3.org/2001/XMLSchema-instance">
2 <SubmissionHeader>
9 <SubmissionContent>
10 <Assessment>
11 <AssessmentHeader>
18 <Resident ClientID="12345">
19 <ClientName>
20 <FirstName>John</FirstName>
21 <MiddleName>Alan</MiddleName>
22 <LastName>Kapusta</LastName>
23 <PreferredName>John</PreferredName>
24 </ClientName>
```

The Resident element contains details Personal Information (PI or demographic) and Personal Health Information (PHI) regarding the client that the assessment belongs to. Resident section is used to provide access by a clinician to all assessments stored within the IAR for a particular individual. A minimum of the First and Last name values are required in order to successfully find an individual within the system.

**Note:** If there is any difficulty searching for a resident in IAR add the following fields : Date of Birth, Gender, and or Health Card Number this will narrow the search. Names such as John and Jane Doe are excluded from any search. Use of common names such as these should not be included in any test data, otherwise the resident and associated assessments will not be found.

## 2.5 Assessment Record Content Element

All assessment types have their own unique record structure. Below is a sample CCRS Admission assessment record. All CCRS assessment records have common elements: Each assessment record has "IdentInfo" although the list of elements contained in "IdentInfo" may vary slightly. An optional RecordType attribute is available to store the equivalent to CCRS' Z1 Data Record Type value. E.g.

```
<AdmissionBackground RecordType="10">
  <IdentInfo>
    <ReasonForAssessment>01</ReasonForAssessment>
```

For details regarding this and all elements contained within a particular CCRS assessment record refer to the Continuing Care Reporting Systems Specifications Manual available from CIHI.

```

1  <CCRSSubmission version="1.2" specversion="2012" xsi:schemaLocation="http://www.ehealthontario.ca/CCIM
   IAR_CCRS_Submission_1.2.xsd" xmlns="http://www.ehealthontario.ca/CCIM" xmlns:xsi="
   http://www.w3.org/2001/XMLSchema-instance">
2  <SubmissionHeader>
9  <SubmissionContent>
10 <Assessment>
11 <AssessmentHeader>
18 <Resident ClientID="12345">
53 <Admission RecordType="AD">
54 <IdentInfo>
55 <ReasonForAssessment>01</ReasonForAssessment>
56 <UniqRegistID>1100201005011234567</UniqRegistID>
57 <Sex>M</Sex>
58 <BirthDate>1967-08-13</BirthDate>
59 <EstBirthdate>>true</EstBirthdate>
60 <TreatyBand>abcdefg</TreatyBand>
61 <HealthCardNum>1234123123AB</HealthCardNum>
62 <ProvlssHlthCrd>ON</ProvlssHlthCrd>
63 <HealthRecNum>String</HealthRecNum>
64 <HealthRegNum>String</HealthRegNum>
65 <FacilityNum>1100</FacilityNum>
66 <ResidentName>John Doe</ResidentName>
67 <MaritalStatus>1</MaritalStatus>
68 <AboriginalIdentity IsAboriginal="0">
73 <RoomNum>
77 <ResponsibilityForPayment>
90 <AdmissionType>01</AdmissionType>
91 </IdentInfo>

```

Figure 2 Sample of Admission Background IdentInfo

## **3.0 Schema Update – Version 1.2**

### ***3.1 Description of Changes***

All schemas have been updated to incorporate the CCRS 2012/213 clinical requirements into the existing record structures.

The changes are limited to the IdentInfo section of the records and the optional RecordType attribute allowable value for each record type.

#### **Record Level Changes**

- Removed ReEntry Record
- Updated Admission Record to handle combined Admission/ReEntry requirements
- Updated FullAssessment Record
- Updated Quarterly Assessment Record
- Updated Discharge Assessment Record

## 3.2 Admission Record Changes – Version 1.2

Legend +Added, -Deleted, ~Changed, \*Deprecated

```
<Admission ~RecordType="AD">
  <IdentInfo>
    <ReasonForAssessment>01</ReasonForAssessment>
    <UniqRegistID>String</UniqRegistID>
    <Sex>M</Sex>
    <BirthDate>1967-08-13</BirthDate>
    <EstBirthdate>true</EstBirthdate>
    ~<TreatyBand>String</TreatyBand>
    <HealthCardNum>String</HealthCardNum>
    <ProvIssHlthCrd>AB</ProvIssHlthCrd>
    <HealthRecNum>String</HealthRecNum>
    <HealthRegNum>String</HealthRegNum>
    <FacilityNum>String</FacilityNum>
    <ResidentName>String</ResidentName>
    <MaritalStatus>1</MaritalStatus>
    +<AboriginalIdentity>
      <FirstNations>0</FirstNations>
      <Metis>0</Metis>
      <Inuit>0</Inuit>
    </AboriginalIdentity>
    <RoomNum>
    +<ResponsibilityForPayment>
      <ProvGovPlan>true</ProvGovPlan>
      <OthProvTerr>true</OthProvTerr>
      <FedGovVACa>true</FedGovVACa>
      <FedGovFNIHB>true</FedGovFNIHB>
      <FedGovOth>true</FedGovOth>
      <WorkCompBoard>true</WorkCompBoard>
      <CadResPrivIns>true</CadResPrivIns>
      <CadResPubTrPay>true</CadResPubTrPay>
      <CadResSelfPay>true</CadResSelfPay>
      <OthCounSelfPay>true</OthCounSelfPay>
      <RespPayUnkUnav>true</RespPayUnkUnav>
    </ResponsibilityForPayment>
    +<AdmissionType>01</AdmissionType>
  </IdentInfo>
  <DemographicInfo>
  <CustomaryRoutine>
  <AdminInfo>
    <PrivPayResFlag>0</PrivPayResFlag>
    <BedType>LSCL</BedType>
    <UnitMISFuncCtr>0</UnitMISFuncCtr>
    +<MISFuncCentre>0</MISFuncCentre>
    +<ProgramType>String</ProgramType>
  </AdminInfo>
</Admission>
```

### 3.3 Full Assessment Record Changes – Version 1.2

Legend +Added, -Deleted, ~Changed, \*Deprecated

```
~<FullAssessment RecordType="FA">
  <IdentInfo>
    <ReasonForAssessment>01</ReasonForAssessment>
    <UniqRegistID>String</UniqRegistID>
    <Sex>F</Sex>
    <BirthDate>1967-08-13</BirthDate>
    <EstBirthdate>true</EstBirthdate>
    ~<TreatyBand>String</TreatyBand>
    <HealthCardNum>String</HealthCardNum>
    <ProvIssHlthCrd>BC</ProvIssHlthCrd>
    <HealthRecNum>String</HealthRecNum>
    <HealthRegNum>String</HealthRegNum>
    <FacilityNum>String</FacilityNum>
    <ResidentName>String</ResidentName>
    <MaritalStatus>2</MaritalStatus>
    +<AboriginalIdentity>
      <FirstNations>1</FirstNations>
      <Metis>1</Metis>
      <Inuit>1</Inuit>
    </AboriginalIdentity>
    <RoomNum>
    <AssessRefDate>1967-08-13</AssessRefDate>
    *<LegalGuardian>
    *<AdvancedDirectives>
    +<ResponsibilityForPayment>
      <ProvGovPlan>true</ProvGovPlan>
      <OthProvTerr>true</OthProvTerr>
      <FedGovVACa>true</FedGovVACa>
      <FedGovFNIHB>true</FedGovFNIHB>
      <FedGovOth>true</FedGovOth>
      <WorkCompBoard>true</WorkCompBoard>
      <CadResPrivIns>true</CadResPrivIns>
      <CadResPubTrPay>true</CadResPubTrPay>
      <CadResSelfPay>true</CadResSelfPay>
      <OthCounSelfPay>true</OthCounSelfPay>
      <RespPayUnkUnav>true</RespPayUnkUnav>
    </ResponsibilityForPayment>
    +<DecisionMaker>
      <PersonalCare>0</PersonalCare>
      <Property>0</Property>
    </DecisionMaker>
    +<AdvanceDirectives>
      <NotResuscitating>0</NotResuscitating>
      <NotHospitalize>0</NotHospitalize>
    </AdvanceDirectives>
  </IdentInfo>
```

### 3.4 Quarterly Assessment Record Changes – Version 1.2

Legend +Added, -Deleted, ~Changed, \*Deprecated

```
~<QuarterlyAssessment RecordType="QA">
  <IdentInfo>
    <ReasonForAssessment>05</ReasonForAssessment>
    <UniqRegistID>String</UniqRegistID>
    <Sex>0</Sex>
    <BirthDate>1967-08-13</BirthDate>
    <EstBirthdate>true</EstBirthdate>
    ~<TreatyBand>String</TreatyBand>
    <HealthCardNum>String</HealthCardNum>
    <ProvIssHlthCrd>MB</ProvIssHlthCrd>
    <HealthRecNum>String</HealthRecNum>
    <HealthRegNum>String</HealthRegNum>
    <FacilityNum>String</FacilityNum>
    <ResidentName>String</ResidentName>
    <MaritalStatus>3</MaritalStatus>
    +<AboriginalIdentity>
      <FirstNations>9</FirstNations>
      <Metis>9</Metis>
      <Inuit>9</Inuit>
    </AboriginalIdentity>
    <RoomNum>
    <AssessRefDate>1967-08-13</AssessRefDate>
    *<LegalGuardian>
    *<AdvancedDirectives>
    +<DecisionMaker>
      <PersonalCare>1</PersonalCare>
      <Property>1</Property>
    </DecisionMaker>
    +<AdvanceDirectives>
      <NotResuscitating>1</NotResuscitating>
      <NotHospitalize>1</NotHospitalize>
    </AdvanceDirectives>
  </IdentInfo>
```

### 3.5 Discharge Tracking Record Changes – Version 1.2

**Legend** +Added, -Deleted, ~Changed, \*Depreciated

```
~<DischargeTrackingForm RecordType="DC">
  <IdentInfo>
    <ReasonForAssessment>06</ReasonForAssessment>
    <UniqRegistID>String</UniqRegistID>
    <Sex>M</Sex>
    <BirthDate>1967-08-13</BirthDate>
    <EstBirthdate>>true</EstBirthdate>
    ~<TreatyBand>String</TreatyBand>
    <HealthCardNum>String</HealthCardNum>
    <ProvIssHlthCrd>NB</ProvIssHlthCrd>
    <HealthRecNum>String</HealthRecNum>
    <HealthRegNum>String</HealthRegNum>
    <FacilityNum>String</FacilityNum>
    <ResidentName>String</ResidentName>
  </IdentInfo>
```

## **3.6 Summary of Changes by Schema – Version 1.2**

### **Schema IAR\_CCRS\_Submission\_1.2.xsd**

Version 1.2 - Update to add 2012/2013 CCRS and Clinical value changes

#### **1. Removed Re-entry Record**

- removed GroupReEntry group

#### **2. CCRSSubmissionElement**

- Changes attribute @specversion from 2008-2011 to 2012
- Changed attribute version from 1.1 to 1.2

#### **3. Admission Record**

- Admission@RecordType - changed from fixed value 10 to AD.
- Admission.IdentInfo - changed TreatyBand data type through update of GroupIDInfoAA
- Admission.IdentInfo - added through GroupIDInfoASSup - AboriginalIdentity AA4
- Admission.IdentInfo - added through GroupIDInfoAa - ResponsibilityForPayment - A7
- Admission.IdentInfo - added AdmissionType - AA7Type
- Admission.AdminInfo - added through GroupADAdminInfo - added MISFuncCentre (AD3), ProgramType (AD4)
- GroupAdmission redefined to allow for AD - Re-Entry form: fields previously optional/not required in re-entry form become optional in admission record. These elements are mandatory:
  - AA8 Reason For Assessment
  - AA1 Unique Registration Identifier
  - AA6 Facility Identifier
  - A6a Health Record Number
  - AA7 Admission Type
  - AB1 Admission/Re-entry Date
  - AB2a Admission/Re-entry From Facility/Level of Care

#### **3. FullAssessment Record**

- FullAssessment@RecordType - changed from fixed value 10 to FA.
- FullAssessment.IdentInfo - changed TreatyBand data type through update of GroupIDInfoAA
- FullAssessment.IdentInfo - added through GroupIDInfoASSup - AboriginalIdentity AA4
- FullAssessment.IdentInfo - added through GroupIDInfoAa - ResponsibilityForPayment - A7
- FullAssessment.IdentInfo - made optional through GroupIDInfoAb - LegalGuardian(A9), AdvancedDirectives(A10)
- FullAssessment.IdentInfo - added through GroupIDInfoFullQtrly - DecisionMaker(A11), AdvanceDirectives(A12)

#### **4. Quarterly Assessment Record**

- QuarterlyAssessment@RecordType - changed from fixed value 13 to QA.



- QuarterlyAssessment.IdentInfo - changed TreatyBand data type through update of GroupIDInfoAA
- QuarterlyAssessment.IdentInfo - added through GroupIDInfoASSup - AboriginalIdentity AA4
- QuarterlyAssessment.IdentInfo - made optional through GroupIDInfoAb - LegalGuardian(A9), AdvancedDirectives(A10)
- QuarterlyAssessment.IdentInfo - added through GroupIDInfoFullQtrly - DecisionMaker(A11), AdvanceDirectives(A12)
- GroupQuarterlyAssessment: added DemographicInfo/AdmissionDate (AB1)

## 5. Discharge Assessment Record

- DischargeTrackingForm@RecordType - changed from fixed value 16 to DC.
- DischargeTrackingForm.IdentInfo - changed TreatyBand data type through update of GroupIDInfoAA
- GroupDischarge: added DemographicInfo/AdmissionDate (AB1)
- GroupDischarge - removed fields from section AA to be compatible with CIHI spec. These fields remain:
  - AA1 Unique Registration Identifier
  - AA6 Facility Identifier
  - A6a Health Record Number

## 6. Special Project Record

- GroupSpecialProject:
  - SpecProjCode element assigned SP1Type
  - SpecProjData element assigned SP2Type
  - IdentInfo element: added child element HealthRecNum (A6a)
  - AssessmentType/SpecialProject attribute RecordType changed fixed value from 18 to SP
  - added DemographicInfo/AdmissionDate (AB1)

## 7. Update Record

- AssessmentType/UpdateRecord attribute RecordType changed fixed value from 17 to UP
- Field ProgramType added to GroupUpdateRecord
- GroupUpdateRecord: added DemographicInfo/AdmissionDate (AB1)

## 8. Demographic Change Form

- removed Demographic Change assessment type and group

# Schema IAR\_CCRS\_SectionTypes\_1.2.xsd

## 1. GroupIDInfoAA

- Changed TreatyBand from AA4aType(xs:string) to basic xs:string type to maintain backwards compatibility
- AA4aType has been redefined in CCRS 2012 specifications

## 2. GroupIDInfoAASup

- Add AboriginalIdentity (AA4) element.

#### 4. GroupIDInfoAb

- Deprecated (made optional) LegalGuardian(A9), AdvancedDirectives(A10)

#### 5. AddGroupADAdminInfo

- Add MISFuncCentre (AD3Type), ProgramType (AD4Type).

#### 6. Add Group GroupIDInfoFullQtrly

- Add DecisionMaker (A11)
- Add AdvanceDirectives (A12)

#### 7. In GroupMSkinConditionA change type:

- for SkinTearCut element to M4fType
- for SurgicalWounds to M4gType

#### 8. In GroupUMedicationList:

- attribute RecordType changed fixed value from 14 to MD
- removed field U1 - MedNameDose

#### 9. GroupAFFacilityProfile (not used in IAR) - removed

#### 10. GroupKOralNutritionalStatusQtrly and GroupKOralNutritionalStatusFull:

- element ParenteralEnterallIntake and its child elements made optional

### Schema IAR\_CCRS\_SimpleTypes\_1.2.xsd

- Change AA4aType type to First Nations (integer) from Treaty Band (string)
- Add AA4bType - Metis
- Add AA4cType - Inuit
- Add AD4Type - Program Type - Used by Admission/Re-Entry Form
- Add AA7Type - Admission Type - Used by Admission/Re-Entry Form
- Add A11Type - Decision Maker for Personal Care and Property
- Add A11aType - Personal Care
- Add A11bType – Property
- Add A12aType - Not Resuscitating
- Add A12bType - Not Hospitalizing
- Removed leading zeroes in enumeration values for AB2aType, U2Type, R3aType, AA8AllType, AA8AdminType, AA8FullType, AA8QtrlyType, AA8DischargeType
- removed all type definitions for AF (facility profile) element
- O1Type, P5Type, P6Type, U5Type: removed pattern, added restriction 0 to 99