SNAPshot Version 3.8

User Manual

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August 2007

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Introduction

This manual describes the main features of SNAPshot 3.8.

SNAPshot is generally referred to simply as 'Snap' within this manual.

INSTALLATION

Introduction

Installation follows the normal Windows Setup procedure.

32 bit Windows – 95, 98, NT4, ME, 2000 – is required. SNAPshot 3.8 will not run under Windows 3.x.

The CD for version 3.8 of SnapShot contains separate Setup procedures for SnapShot and SnapRep.

First time installation of SnapShot

If you are installing SnapShot for the first time (or you have uninstalled a previous version of SnapShot) you should install SnapShot first and then install SnapRep – see below.

Upgrading from an earlier version of SnapShot

If you are upgrading from an earlier version of SnapShot, you should use the SnapRep Setup procedure as described below.

Installing SnapRep

SnapRep uses Crystal Reports (CR) to generate reports and CR requires components of the Microsoft Internet Explorer to run.

If your PC has Windows 95 or Windows NT 4.0 installed, you should ensure that Internet Explorer (preferably version 4 or later) is installed before running SnapRep Setup.

If you have Windows 98, ME or 2000 installed, you can run the SnapRep Setup process directly without any problems since the necessary components will have already been installed.

If Internet Explorer is installed, you can then run SnapRep Setup.

If Internet Explorer is not installed, when you run SnapRep Setup, you may see a message saying that Craxdrt.dll or CRViewer.dll (the Crystal Report programs) could not be registered. If this occurs, you will be able to generate the report data tables into the RepDB.mdb file but you will not be able to display/print the report.

RUNNING SNAPSHOT

To start the system, press Start:Programs on the task bar and select 'SNAPshot'.

Upgrading to New Versions

IMPORTANT NOTES REGARDING MODIFICATIONS TO SNAPSHOT TABLES

SNAPshot Tables and LUTs

The Snap.mdb Access database is accessible outside of the Snap system to allow users to generate reports and make modifications to user-defined tables and LUTs (look up tables whose names commence with ‘x’). You should **not** attempt to modify other Snap tables or LUTs since this can cause database integrity or system inoperability problems.

Whilst modifications may appear to work for a particular version of Snap, when upgrades are released your changes may be undone and it is possible that the system will crash.

SNAPshot QueryDefs

In some situations Snap will delete all query definitions with a name commencing with the letter Q or q and later re-generate them. If you place your own QueryDefs in the Snap database you should, firstly, begin the name with a letter other than Q or q and, secondly, keep a copy of the QueryDefs in another Access database.

STEPS TO UPGRADE FROM SNAPSHOT VERSION 3.7 TO 3.8

1. Make sure that no users are logged onto Snap since you must logon as the Administrator with exclusive database access to upgrade to 3.8.

2. Back up your current database file(s) – **this is the most important step.**

3. Run the Setup program for the version 3.8 upgrade and select your existing program folder – normally c:\snapshot. Note that Setup will overwrite the existing SnapOrig.mdb and SnapTest.mdb files so if you wish to keep the older copies you should move them to another folder. You will need to run Setup from the SnapShot folder on the CD (this updates the SNAPshot program) and once this has successfully completed, run Setup from the SnapRep directory (this updates the reports).

4. When you click on the SNAPshot icon to start the system, make sure that you hold down the Shift key before clicking – this will take you to the empty startup screen without trying to open the database. (Note that Snap may only appear minimised as a button on the Taskbar – click on it to maximise or use Alt-Tab). If you forget to hold down the Shift key, you will receive an error message but you can then log on as Administrator with exclusive access.

5. Use the Administrator Options Dialog to logon to your database file with the Administrator password and set database mode to exclusive. Then select the File:Open Main Screen menu option.

6. SNAPshot will automatically upgrade your 3.7 database to 3.8.

7. After a few moments, you should see a message saying that the upgrade has been completed.

CHANGES MADE IN VERSION 3.8:

Patient Screen

- The 'occupation of person' item has been moved to the patient screen.
- A new item called 'Country of residence' has been added to the patient screen.
- The item 'Indigenous status' has been amended to include a separate codeset for New Zealand facilities.

Episode Screen

- Two new items called 'Support provided prior to admission' and 'Support provided at episode end' have been added to the episode screen.
- The item 'interruption days' has been re-named to 'suspension (interruption) days'.
- The item 'type of usual accommodation prior to admission' has been amended to include a separate codeset for New Zealand facilities.
- The item 'accommodation post discharge' has been amended to include a separate codeset for New Zealand facilities.
- The item 'Funding source for hospital patient' has been amended to include a separate codeset for New Zealand facilities.
- The 'Episode type' item has been amended to allow overnight admitted patients in designated and non-designated sub/non-acute units to be separately identified.
- The items 'Usual living arrangements – episode beginning' and 'Usual living arrangements – episode end' have been moved to the Episode screen.

Rehab/GEM Screen

- A new function has been added that allows non-palliative care episodes to be reviewed and new clinical scores to be recorded without ending the episode. To do this, enter relevant 'end' clinical scores for the current review period and click on the 'add' button. The end clinical scores of the earlier period are copied to become the begin clinical scores for the new period. Enter the 'review date' for the patient in order to save the record. When the episode is grouped, the clinical items associated with the first period of care will be used to assign the AN-SNAP class. Enter the 'review date' for the patient in order to save the record. Note that this function can also be used in the Maint/RUG and MH screens.

- The list of Impairment codes has been updated to incorporate the results of a recent review of this codeset.
- A new item called 'Outpatient (O/P) care plan established 7 days prior discharge' has been added to the Rehab/GEM screen to assist with Australian Health Care Agreement reporting requirements.
- A new item called Community/Outreach (Com.OR) plan established 7 days prior discharge' has been added to the Rehab/GEM screen to assist with Australian Health Care Agreement reporting requirements.

Australasian Rehabilitation Outcomes Centre (AROC) Screen

- It is compulsory to create an AROC dataset record before ending overnight (episode type 1) rehabilitation (case type 2) episodes. This is done by clicking on 'add' and 'save' in the 'AROC Dataset' screen.
- A new item called 'Date of relevant acute admission' has been added to the AROC Dataset screen.

- Four new items called ‘Complication interfering with rehabilitation’ have been added to the AROC Dataset screen.
- A new item called ‘Time since onset’ replaces the previous item ‘Date of onset of impairment’.
- The codeset for the ‘employment status’ item has been amended.
- A new item called ‘Was impairment the result of trauma?’ has been added to the AROC Dataset screen.
- The ASIA impairment scale has been moved to the clinical screen.
- The list of health funds/other payers has been updated.
- A new item called ‘Number of occurrences – treatment suspensions’ has been added to the AROC Dataset screen.
- The item ‘Reason for program interruption’ has been re-named to ‘Was suspension unplanned’.
- The list of comorbidities has been updated.

Pall Care Screen

- A new clinical tool called ‘Symptom Assessment Scale’ has been added to the Palliative Care screen.
- The capacity to record the Karnovsky Rating Scale and the Palliative Care Severity Scale scores has been added.

Palliative Care Outcomes Collaboration (PCOC) Screen

- It is compulsory to create an PCOC dataset record before ending overnight (episode type 1) palliative care (case type 1) episodes. This is done by clicking on ’add’ and ‘save’ in the ‘PCOC Dataset’ screen

- A new screen called ‘PCOC’ has been added to allow the capture of the following PCOC dataset items not included in other screens:

    - Referral date;
    - Source of referral;
    - Date of first assessment;
    - Proposed model of care – episode start;
    - Reason for consultative service;
    - Location of consultative service;
    - Mode of consultative service;
    - PCOC diagnosis;
    - Place of death;
    - Main language spoken at home.

SNAP Class Screen

- The SNAP grouping functions have been upgraded to allow episodes to be grouped to either AN-SNAP Version 1 or AN-SNAP Version 2. Refer to Section titled ‘The SNAPshot Grouper’ on Page 44 for details of this set of changes.

Reports/Extracts

- The default destination for SNAP extracts has been changed to c:\SnapExtract.
- A new report called ‘Missing AROC Fields Report’ (report #27) has been created that lists any AROC dataset items that have not been entered for episodes with an end date in the last 12 months.
- A new extract called PCOC Extract (#59) has been added.

The Startup Screen

When Snap starts it displays an empty screen. It will then look for a database and, if it finds one, will display the main input screen (see 'The Main Screen' below).

Sometimes, you will need to return to the Startup screen to perform certain utility functions or to select a different database. Unlike previous versions of Snap, version 3.2 (and later) allows you to have any number of Snap databases located on your computer or on other 'server' computers.

SELECTING A DATABASE

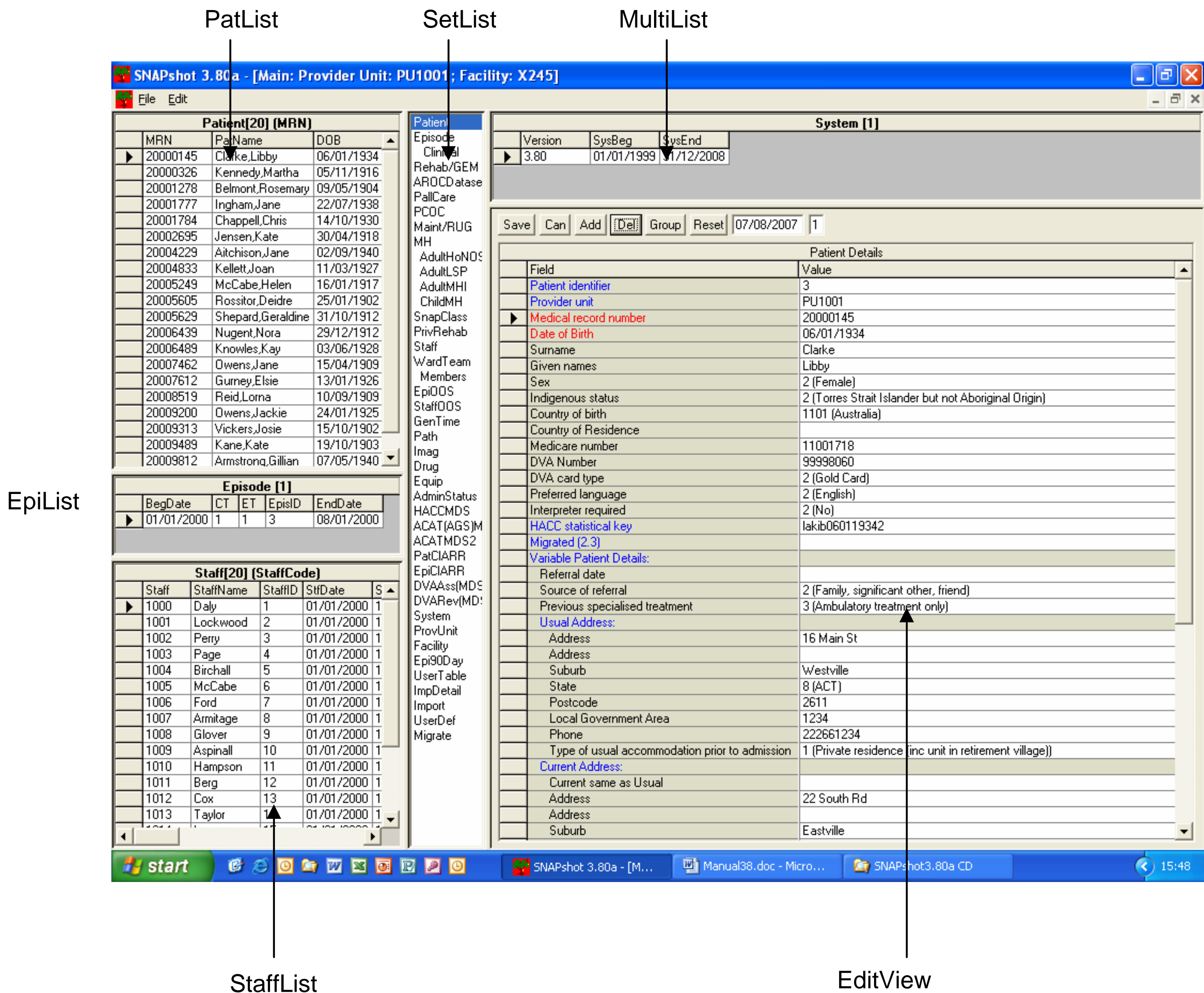
If the Main screen is open close it by clicking on the lower of the two 'X' buttons in the top right hand corner of the screen. Don't choose the top 'X' button or you will close Snap.

You will then see the startup screen and you should choose the File:Select Database option on the menu bar. You can then use the file dialog box to select the database that you require – this must be an Access 97 database with a file extension of '.mdb'.

Having selected a database you must now use the File:Main menu option to open it.

The next time that you run Snap, the latest database that you selected will be used.

The Main Input Screen



Most data capture for Snap 3.8 is performed from a single window which contains 6 segments or ‘panes’:

- *PatList* – which is the patient list for the currently selected provider unit.
- *EpiList* – which is the list of episodes for the patient currently selected in PatList but note that this is only for the currently selected facility.
- *StaffList* – which is a list of staff members for the currently selected facility.
- *SetList* – which lists the various data sets which can be edited in EditView.
- *MultiList* – which contains various lists depending on the data set which is currently selected.
- *EditView* – which is the segment where all insert, delete and update transactions are performed.

Screen sizing

The Main screen is flexible. When it is first displayed it will fill the entire screen and this is normally the way that you will want to use it but it can be resized if you wish to view other applications concurrently.

Various monitors can be used – such as VGA, Super VGA or XGA – but a minimum of Super VGA is recommended (800 x 600 pixels). The higher the resolution, the better.

Within the Main screen each of the segments listed above can be re-sized to suit the operation you are currently undertaking by dragging the bars which separate them. For example, if you are entering staff time data you will need the StaffList but if you are entering episodic data you can squeeze out the StaffList, and so on.

Note: if you are editing data in EditView you will receive the message "Save or cancel changes" if you try to select another segment. You should complete the changes to the current data set and then press Save (or Cancel). If you try to resize a segment whilst editing a data set the message will appear but, as the second part of the message indicates, you should press the Esc key, resize the segment by dragging the bar to the required position, press the left mouse button, clear the message and continue editing.

Entering transactions

The most important point to understand is that all editing is performed in the EditView segment in the bottom right hand corner. All other segments are used for the purpose of selection. The normal procedure is to select a data set from the SetList and then select relevant rows from the other lists. For example, if you wish to add a new episode record, you will select the EpiAdmin option from the SetList to display the episode administration details in the EditView and then select the first patient in PatList. When you click on the Add button, an empty record will be created but certain key fields will be pre-set – for example, for a patient record the Provider Unit field is pre-set.

Many of the data sets which are displayed in EditView have a single data column. Others have multiple columns – for example, the FIM data set has begin and end values.

The field names are displayed in different colours. Blue indicates that the field is read-only and cannot be changed. Red means that the field is compulsory and a value must be entered. Black means that the field is optional. However, some optional fields may become compulsory when values for other fields are set. For example, if case type is set to 3, Mental Health Service becomes compulsory and you will receive an error message if a value is not provided when you try to save the record.

The Process Key – F7

For certain segments and certain data sets in the EditView, special options can be invoked by pressing the F7 key. For example, if the cursor is on the PatList and you press F7 you can sort the patient list or search for particular patients. In the Staff lists, F7 will sort by Staff code or Staff name. If you have selected a Facility and the cursor is in the EditView and you press F7 you can enter a password.

PASSWORDS

Microsoft Access Passwords

If the database administrator has specified a password for the Snap Access database then the user will be prompted to enter this password prior to being prompted for the Facility password. If a password has not been specified for the Snap Access database, then the prompt will not appear.

Very Important: the Access password must be assigned using Access – Snap will simply ask for it to enable it to open the Snap database. If you forget an Access password, **you will not be able to open the database**. Access passwords are maintained using Access not Snap.

Logging on Using a Facility Password

Most users will logon to Snap using one or more Facility passwords. Before this can occur, the Administrator must define one or more Facility records and specify passwords for them.

When you start Snap the Main screen will appear and the list of Facilities will appear in MultiList with the Facility used in the previous session selected. If this is the Facility that you wish to process press F7 and enter the password. The remaining data sets will then appear and you can enter transactions.

Note that the cursor must be in the EditView when you press F7.

If you wish to process data for a different Facility it is not necessary to logoff, simply select the Facility data set, select the required Facility, and then press F7 to enter the password.

Within a session, you only need to enter the password for a Facility once.

See the section 'Administrator Functions' for information regarding the Administrator password.

90 DAY REVIEW

When you enter the Main screen Snap will display a message advising you of the name of the database that you are opening and the number of records which require review.

After you have logged on, you can see a list of the episodes by selecting the Epi90Day data set.

This list is updated on demand – press F7 to update the list.

General Operations

The SetList segment lists all of the data sets that you can edit. When you click on a data set name – such as Patient or Staff – the fields for the data set are displayed in the EditView segment.

For some data sets – such as Facility – when you make the selection a list will appear in the MultiList segment and the currently selected facility record will appear in the EditView.

TRANSACTIONS

As described above, all database transactions are performed in the EditView segment and include:

- *Add* – which is used to insert a new record of the type currently displayed in EditView.
- *Del* – which is used to delete the record currently displayed in EditView.
- *Save* – which is used to save the record currently displayed in EditView.
- *Cancel* – which is used to discard changes you have made to the record currently displayed in EditView.
- *Reset* – which is used to re-select all lists when you change provider unit or facility but which can also be used to refresh the data currently being displayed to reflect any changes made by other users.

When you are editing a data set the SetList will disappear and the message ***Edit*** will appear.

Normally, you will create a new record by clicking on the Add button. For some data sets, however, a blank EditView will appear but the Add button will be disabled since the data set is part of existing record. For example, to create a new Snap episode you must select EpiAdmin in SetList, select the relevant patient in PatList and then press the Add button to create an empty EditView. When you subsequently select data sets such as EpiClinical or Behaviour, the Add button will be disabled. For these data sets, simply enter the required field values and press the Save button.

GENERAL EDITING CONTROLS

To edit an existing record in EditView, simply click on the relevant field and enter data. If you are moving from field to field, F2 can be used to put you into field edit mode. If there are multiple columns you can use Tab or Shift-Tab to move right and left or you can use the left and right arrow keys. To move up and down use the up/down arrow keys. Before you can press the Save button to save changes you must complete field editing for the last field by moving off that field or by pressing the Enter key otherwise you will receive a prompt.

Date formats are flexible – for example 01 Jan 2000 can be entered as 1/1/00 but it will be displayed as 01/01/2000. Note that separator character such as slashes or spaces must be entered. The current year will be assumed – eg '1 1' will convert to 01/01/2000.

Control Keys

Key	Action
Arrows	Move left, right, up or down.
Enter or Tab	Save field changes (if any) and move to the next field to the right or down.
Shift+Tab	Save field changes (if any) and move to the previous field to the left or up.
Alt+down arrow	For coded fields – open the drop down list.
Ctrl+A	Add a new record.
Ctrl+S	Save the current changes.
Esc	If field in edit mode cancel field changes. In record edit mode, cancel record changes. If you are positioned in the EditView but are not currently editing, pressing the Esc key will move the cursor to the Date field and you can move forward to the Shift field by pressing the Tab key or back to the control buttons using Shift-Tab. Pressing the Tab key on the Shift field will move you to the EditView. If you press the Esc key on the Date field, you will jump to the SetList and you can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys.
Shift+Up/Down (on SetList)	You can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys. When you are positioned on the required set, release the Shift key and the set will be selected.
F6	The F6 key will move you forwards from segment to segment. Shift-F6 will move backwards.
F7	F7 is the 'Process' key and, for certain segments/data sets, provides additional processing options.

For coded fields such as sex or marital status, you may either enter the value directly or press the button to reveal a drop down list. The button is displayed for the currently selected field if it has an associated lookup table.

For all of the sets described below, you must select the appropriate data set from SetList before attempting a transaction. For example, if you wish to edit a patient record, you must select the patient in PatList **and** click on Patient in SetList.

Creating a SNAPshot Database

You can have any number of SNAPshot databases on your system and you can use the File:Select Database menu option on the empty screen to select the database you wish to process. The first step, however, is creating an empty database.

To create a database you must copy an empty 'template' database called 'SnapOrig.mdb' but to do this you must be logged on as the Administrator and you must have Exclusive access to the database.

Select SnapOrig.mdb

When you start Snap for the first time you will receive an error message saying that Snap cannot locate the database called 'c:\SnapShot\snap.mdb'.

From the empty screen use the File:Select Database menu option to open the File Dialog and select the \SnapShot\SnapOrig.mdb database.

When you click on the OK button you will receive a message warning you that you will not be allowed to open this database since it is provided only for the purposes of copying.

Logon as Administrator

Note that each time you select a different database you will have to enter the Administrator password for that particular database unless you wish to logon as a normal user.

Use the File:Administrator Options menu item to open the Administrator dialog.

Enter the password – by default 'admink' – and click the exclusive mode tick box. Then press the 'Logon as Administrator' button and press Exit.

Copy SnapOrig.mdb

From the empty screen use the File:Database Utilities menu option to open the Utilities dialog. Press the 'Copy Database' button and enter the name of the database – for example 'Snap.mdb'.

Press Exit to quit the Utilities dialog.

Select the new database

From the empty screen use the File:Select Database menu option to open the File Dialog and select the new database. This operation will log you off as Administrator since each database has its own passwords.

Open the Main screen

Use the File:Open Main Screen menu option to open the main processing screen. When it opens you will have access to only one data set – the Facility set. Since this is a new database there are no Facilities defined and so you will have to logon as Administrator because only the Administrator can define passwords. You can do this from the Main screen but note that you cannot set the Exclusive access flag from this screen – you must use Administrator Options to set the flag.

To logon as Administrator, with the EditView selected (the cursor is positioned on it) hold down the Shift key and press F7. The Password dialog will appear and you can enter the Administrator password (default 'admink').

Add a Facility record

Click on the Add button to add a new record and enter the Facility details. As a minimum you must enter the four character code and a name but you may also enter default values for fields such as CaseType.

Press the Save button to save the record and then define the user password for this facility by pressing F7 (without the Shift key).

You will have to enter the password twice. If you forget a user password you, as Administrator, can create a new one at any time. If you forget the Administrator password see the chapter on Administrator Functions.

After you have added a user password you will see the encrypted value in the read-only field called 'Key'.

You can repeat this process for as many facilities as you wish to define.

Add a ProvUnit (Provider Unit) record

Before you can add patient records to the database you must define at least one provider unit.

Select the ProvUnit data set, press the Add button and add a ProvUnit record.

Select a ProvUnit/Facility

When you have finished defining ProvUnit and Facility records you must select one of each for processing. To do this select the ProvUnit data set, select the required ProvUnit in MultiList and then press the Reset key. Then repeat the process for the Facility dataset.

Now look at the main Snap title bar and you should see the codes for the selected ProvUnit and Facility. This is important, whenever you start a Snap session you should check that the correct ProvUnit/Facility codes appear at the top of the Snap window.

Processing Patient Records

Patient records are defined in respect of a ProvUnit which may relate to one or more Facilities as long as all facilities use the same patient identifiers – ProvUnit code, MRN (Medical Record Number) and DOB (Date of Birth).

When you select a ProvUnit/Facility combination you will see a list of all patients for the provider units, all episodes in the currently selected Facility for the patient currently selected in PatList and all Staff members for the currently selected Facility in StaffList.

The first thing you should do when opening the Main processing screen is check that the ProvUnit/Facility codes displayed in the Snap title bar at the top of the Snap Window are the correct ones. If not, use the ProvUnit and Facility data sets and the Reset button to select the required combination.

To add a new Patient record, select the Patient data set and press the Add button. An empty record will appear in EditView except that the ProvUnit field will display the currently selected ProvUnit. Since ProvUnit is a read-only field (the description is in blue) you cannot change this field. You can only enter patient data for the currently select ProvUnit. If you want to enter patient details for a different ProvUnit you must select the relevant ProvUnit and press the Reset button.

Once the empty patient record appears, enter field values using the procedures described in the General Operations chapter.

Patient record ordering

By default, patients are listed in MRN order but you can switch between MRN and Surname ordering by clicking on PatList and press the F7 key. The current ordering is displayed in the caption bar at the top of the list.

Patient Name is an optional field but if you leave it blank during editing, when you save the record Snap will place the MRN into the Name field since it is used for ordering purposes. You can, at any time, overwrite the code with a name (except, of course, by entering a blank name).

Searching for patients on MRN, Name or HACC Statistical Linkage Key

If you click on the PatList (or press the F6 key to move the cursor to it) you can enter characters to search the list on. If MRN is displayed in the caption bar for PatList the list is in MRN order and, normally, you would enter numeric digits. If 'Name' is displayed you would normally enter alpha characters. You can enter up to 12 characters and these are displayed in the caption bar as you enter them. Similarly, if HACCKey is the current sort order, you can enter the first characters of the Statistical Linkage Key. Use the destructive backspace key to erase characters from the right.

If there are no search characters entered, when you press F7 you can select one of the three sort orders.

If you are looking for the patient 'Smith Jack', you would use F7 to select Name order and then you would enter, say, 'smi' (without the quotes) and then press F7. Snap will locate to the first record beginning with 'smi' (the search is not case-sensitive – smi is the same as SMI). For this type of search you would select the option [First name commencing with 'smi'] after pressing F7.

If you cannot locate the patient you can use a different kind of search by selecting the option [Find first name containing 'smi'] and Snap will search to find the first record which contains 'smi' anywhere in the patient name – for example JSmith. If the first record selected is not the required patient you can find the next one by pressing F7 and selecting the option [Find next name containing 'smi'].

To avoid having the dialog box appear every time you press F7, if you hold the Shift key down whilst pressing F7, Snap will automatically search for the next patient containing 'smi'. Note, however, that pressing Shift-F7 locates to the next record irrespective of where you are currently positioned in the patient list so for the first search you should select the [Find first name containing 'smi'].

Variable Patient Fields

Variable patient fields are normally recorded in the Episode record but, initially, they can be recorded in the Patient record. When you create the first Episode record the details will be copied from the Patient record. Thereafter, the details will be copied from episode to episode.

Processing Snap Episode Records

If you want to process any episodic data for a patient you must first create a Snap Episode record. You cannot, for example, create a RehabMDS record without first creating a Snap Episode record.

The first (important) step is to select the relevant patient in PatList. You can move the cursor to PatList either by using the mouse to click on the appropriate row in PatList or you can press the F6 key to cycle through the different Main screen segments until the cursor lands on PatList and you can then use the arrow and/or PageUp/PageDown keys to move through the list of patients.

Copying Episodic Data

The Snap Episode record and several MDS (minimum data set) records contain fields which are automatically copied when creating new records. For example, in the Episode record variable patient details such as address and next-of-kin information are copied from the currently selected record. This last point is important since normally you will want to copy data from the latest episode and you should make sure that the record indicator in EpiList is pointing to the episode from which you require the fields to be copied. If the latest episode is not selected, you will receive a warning message which you can override since it is possible that you wish to create a new episode record which pre-dates the latest episode.

Note that as from version 3.6, Variable Patient Details are always copied from the Patient record to newly created Episode records. Previously, these details were copied from Episode to Episode after the first Episode record had been created for a patient. The address details that are copied are the Usual Address rather than the Current Address details.

DELETING A SNAP EPISODE

If you delete a Snap Episode record all associated OOS (staff time) and MDS data will also be deleted.

CLOSING A SNAP EPISODE

There are certain checks which can only occur when an episode is closed – ie when you enter the Episode End Date. This includes cross checks with related OOS and MDS data and you will not be able to save the entered End Date until all errors have been resolved. It is normally good practice to enter and save all fields other than the End Date and only enter the End Date when you feel that all related data fields have been entered. If you receive cross check error messages you can simply cancel the Episode save operation, fix the problem and then enter and save the Episode End Date.

THE CLINICAL DATA SET

Below the Episode data set in SetList and slightly indented you will see the Clinical data set. The indentation implies that the Clinical data set is part of the Episode record. To create a new Episode data set you must add a new Episode record but the Add operation is not necessary for the Clinical data set since its fields are actually stored in the Episode record. This means that you cannot process Clinical data set fields until you have created an Episode record. The MH (Mental Health) record similarly has subordinate data sets which appear as indented names in SetList.

The PallCare Data Set

Palliative care records can only be added for Episodes with CaseType 1.

A list of all of the existing PallCare records for the currently selected episode appear in MultiList and you can view or edit the details in EditView by selecting the required record.

The Staff Data Set

Staff records are defined in relation to a Facility – each Facility has its own staff list.

The Cost Centre and Designation fields are optional and, if you do not use them, there will be only one Staff record for each staff member. If you record either of the fields and update them as changes occur you should be careful to select the appropriate staff record when adding OOS/Staff Time data.

STAFF ORDERING

By default, staff are listed in Staff code order but you can switch between Staff code and name ordering by clicking on StaffList and press the F7 key. The current ordering is displayed in the caption bar at the top of the list.

Staff name is an optional field but if you leave it blank during editing, when you save the record Snap will place the staff code into the name field since it is used for ordering purposes. You can, at any time, overwrite the code with a name (except, of course, a blank name).

Occasion of Service (OOS) Data Sets

Staff/patient contact can be entered in two ways – by patient episode (EpiOOS) or by staff member (StaffOOS).

The EpiOOS data set

Next to the transaction controls – Save, Cancel, Add, etc. – you will see two fields which are used to contain a date and shift. By default, the current date and shift '1' appear but you can reset these fields as required. For EpiOOS, the fields are simply used as default values when you add new OOS records and you can replace the values in EditView as required.

EpiOOS displays all staff time records for the currently selected episode.

To add a new time record, select the relevant episode in EpiList, select the relevant staff member in StaffList and click on the Add button.

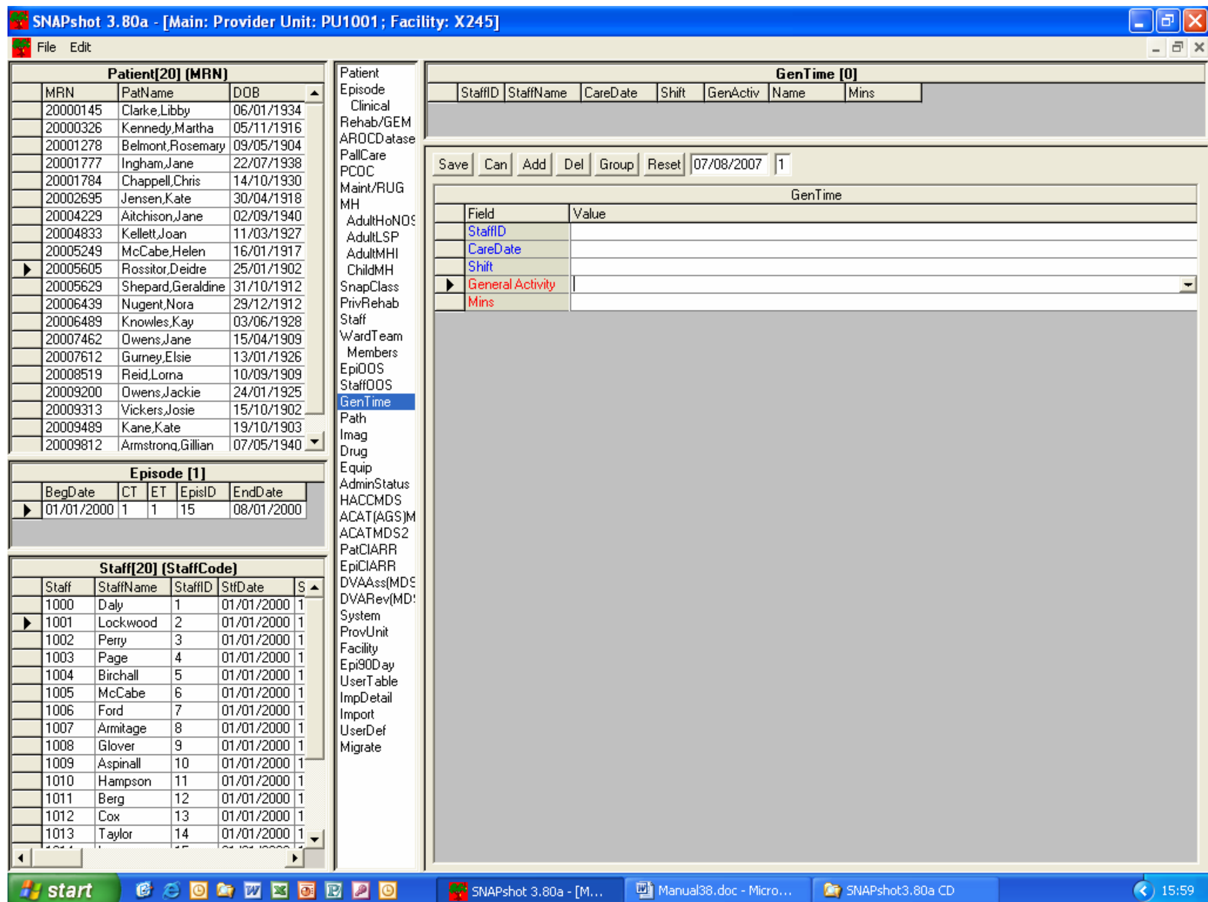
To edit an existing time record, select the record in MultiList, modify relevant field values and press Save.

The StaffOOS data set

For the StaffOOS data set, the date and shift fields play a more important role since they restrict the list of time records in MultiList to only those with the selected date/time. Update transactions work in the same way as for EpiOOS.

If you change the date/shift fields the data set will disappear for the EditView. When you have completed the changes, simply reselect the required data set in SetList and the EditView will reappear.

The GenTime data set



The GenTime data set can be used to record staff time which is not patient-specific from the following list:

General Activities	
Code	**Name**
1	General clinical
2	Clinical travel
3	Teaching
4	Research
5	Health promotion
6	Other Travel
7	Quality improvement
8	Administration
9	Other
A	On Duty

Any combination may be selected for a specified date/shift but note that the OnDuty activity represents the total number of minutes for the shift – for example, 480 for an eight hour shift.

Ward/Team and Member Records

Prior to Snap 3.6 a field ward provided in the Episode record called Team/Ward which allowed up to 20 characters of text to be entered. This field is retained (with the description 'Team/Ward (old)') and a new field has been added below it called 'Ward/Team' which allows a four character code to be selected.

The WardTeam data set

Two data sets are included in the SetList called WardTeam and Members. The process for defining WardTeam records and the Staff Members that WardTeams comprise is as follows:

1. Select the WardTeam set and create new WardTeam record(s) using the Add button.
2. Select a WardTeam record. The latest WardTeam record selected will be used when adding new members to the team.
3. Click on the Members set.
4. Select a staff member and press the Add button to add the staff member to the selected WardTeam.
5. Repeat step 3 above for all staff members that belong to the WardTeam.
6. Go to step 2 above to select the next WardTeam.

The Members record

SNAPshot 3.80a - [Main: Provider Unit: PU1001; Facility: X245]

File Edit

Patient[20] (MRN)

MRN	PatName	DOB
20000145	Clarke,Libby	06/01/1934
20000326	Kennedy,Martha	05/11/1916
20001278	Belmont,Rosemary	09/05/1904
20001777	Ingham,Jane	22/07/1938
20001784	Chappell,Chris	14/10/1930
20002695	Jensen,Kate	30/04/1918
20004229	Aitchison,Jane	02/09/1940
20004833	Kellett,Joan	11/03/1927
20005249	McCabe,Helen	16/01/1917
20005605	Rossitor,Deidre	25/01/1902
20005629	Shepard,Geraldine	31/10/1912
20006439	Nugent,Nora	29/12/1912
20006489	Knowles,Kay	03/06/1928
20007462	Owens,Jane	15/04/1909
20007612	Gurney,Elsie	13/01/1926
20008519	Reid,Lorna	10/09/1909
20009200	Owens,Jackie	24/01/1925
20009313	Vickers,Josie	15/10/1902
20009489	Kane,Kate	19/10/1903
20009812	Armstrong,Gillian	07/05/1940

Episode [1]

BegDate	CT	ET	EpisID	EndDate
01/01/2000	1	1	15	08/01/2000

Staff[20] (StaffCode)

Staff	StaffName	StaffID	StfDate	S
1000	Daly	1	01/01/2000	1
1001	Lockwood	2	01/01/2000	1
1002	Perry	3	01/01/2000	1
1003	Page	4	01/01/2000	1
1004	Birchall	5	01/01/2000	1
1005	McCabe	6	01/01/2000	1
1006	Ford	7	01/01/2000	1
1007	Armitage	8	01/01/2000	1
1008	Glover	9	01/01/2000	1
1009	Aspinall	10	01/01/2000	1
1010	Hampson	11	01/01/2000	1
1011	Berg	12	01/01/2000	1
1012	Cox	13	01/01/2000	1
1013	Taylor	14	01/01/2000	1

Patient
Episode
Clinical
Rehab/GEM
AROCDatase
PallCare
PCOC
Maint/RUG
MH
AdultHoNOS
AdultLSP
AdultMHI
ChildMH
SnapClass
PrivRehab
Staff
WardTeam
Members
EpiOOS
StaffOOS
GenTime
Path
Imag
Drug
Equip
AdminStatus
HACCMDS
ACAT(AGS)M
ACATMDS2
PatCIARR
EpiCIARR
DVAAss(MDS
DVARev(MDS
System
ProvUnit
Facility
Epi90Day
UserTable
ImpDetail
Import
UserDef
Migrate

Members [2]

War	Code	Name	StaffID	Staff	StaffName
1	Tm1	Team 1	6	1005	McCabe
1	Tm1	Team 1	15	1014	Lyons

Save Can Add Del Group Reset 07/08/2007 1

Ward Team Members

Field	Value
WardTeamID	1
StaffID	6

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The System Data Set

The System Data Set can only be changed by the Administrator and there can be only one System record for each Snap database.

The Data Collection Begin/End dates are useful for checking that dates which are episode related are within a reasonable timeframe. The range that you specify must be between 01/01/1990 and 31/12/2019 but you will probably want to define a tighter timeframe – the Administrator can change the range at any time. When SNAPshot is installed, the default episode end date is 31/12/2007.

The Background Colour flag can be used if your computer does not have high resolution colour. If you set the flag to Yes, a gray background will be used.

Note that these settings apply to one of possibly a number of Snap databases.

The ProvUnit (Provider Unit) Data Set

You must define at least one ProvUnit before you can enter Patient records and you must define Patient records before you can enter episodic data.

The Facility Data Set

Episode records are created in relation to a selected Facility. Similarly, Staff records relate to a selected Facility.

To process the data for a Facility, users must know the Facility password assigned by the Administrator. The Administrator can access any data.

You can define default values for each Facility for the following fields: CaseType, EpisType, CareModel, MHServ (Mental Health Service) and Assessment Type. Default Funding Source refers to the ‘Funding source for hospital patient’ on the Patient screen. When you add new Episode records, these fields will be preset but you can override the default values in the Episode record if required.

The Epi90Day Data Set

When you enter the Main processing screen you will receive a message telling you the total number of episodes which commence more than 90 days previously but do not have an Episode End Date.

You can view the core fields for each of these episode by selecting the Epi90Day data set. You cannot change the data directly but, if you are logged onto the required Facility, you can select the Episode data set and edit the relevant record(s).

Administrator Functions

A Snap database must be managed by an Administrator and there are certain functions which can only be accessed by the Administrator.

STARTING SNAP

Normally when Snap is started the Main processing screen appears which is convenient for most users. The facilities which are provided by the startup (empty) screen – such as selecting a different Snap database – can usually be accessed simply by closing the Main screen and selecting the appropriate menu item.

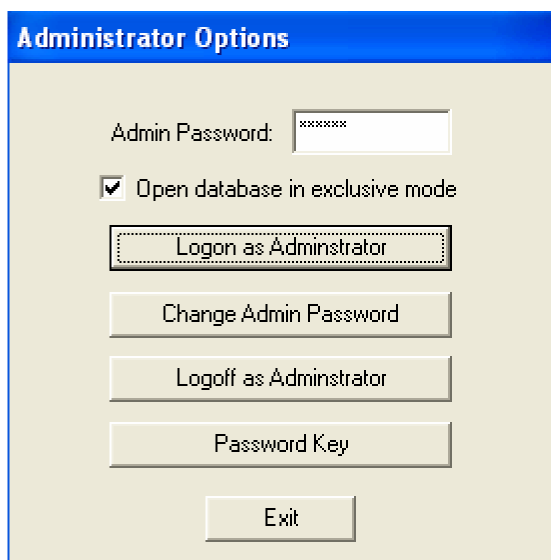
However, if the database becomes damaged it is possible that Snap will try to open the database to display the Main screen but a system failure may occur which will prevent access to the startup screen.

If you start the system by holding down the Shift key whilst clicking on the Snap icon, the Main screen will not be opened. Note that the Snap startup screen might not be displayed but there will be a button on the task bar at the bottom of the screen which you can click or you can use Alt-Tab to switch to Snap.

Warning: if you start Snap from the Windows Explorer rather than from the icon, you cannot hold down the Shift key and double click with the mouse. Instead, click once on Snap.exe and then hold down the Shift key and press the Enter key.

ADMINISTRATOR OPTIONS DIALOG

You can logon/off as the Administrator on the Main screen (if you know the password) but for some operations – such as the Database Utilities options and creating new UDTs (User-Defined Tables) – you must logon to the database in Exclusive mode. To obtain Exclusive mode, no other user can be logged onto Snap and, once you have Exclusive access, no user can logon until you logoff.



To logon as Administrator enter the 6 character password and, if you require exclusive access, click the check box. Then click on the 'Logon as Administrator' button. The default password is 'ADMINK' but you should change this when you create a new Snap database using the 'Change Admin Password' button.

To change the password, click on the button and then enter the new password twice for confirmation.

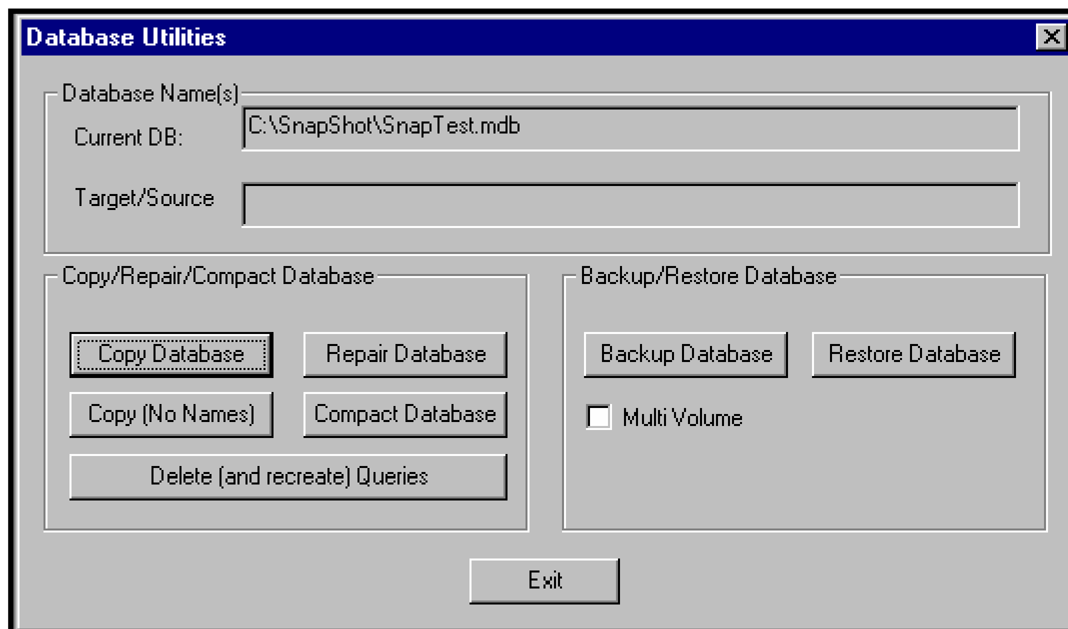
If you want to logoff as Administrator, click on the 'Logoff as Administrator' button.

If you lose the Admin password, click on 'Password Key' and contact CHSD on (02) 4221 4411 who will decrypt the key for you.

Note that if you select a different database, you will have to enter the Admin password for that database.

DATABASE UTILITIES

The File:Database Utilities menu option is only accessible for the currently selected database if you are logged on as the Administrator with exclusive access.



The Copy Database Button

You can use this button to make a copy of the current database as displayed in the top panel. You may wish to do this simply to make a backup of the database on, for example, the network server disk but the Backup Database option is normally more efficient since it will compress the database before copying to the target drive.

The most important use for this option is creating a new 'empty' Snap database. To do this, you should use File:Select Database to choose the 'SnapOrig.mdb' file and then use Copy Database to copy it to, say, Snap.mdb. Note that you will not be able to open the Main screen with SnapOrig.mdb as the selected database since it is provided as a template to create new empty Snap database files.

The Copy (No Names) Button

Use this option to copy the current database to a new database with patient names removed.

If you use either of the Copy buttons, Snap will Compact the target database.

The Repair Database Button

If the database becomes damaged you may be able to recover it by pressing this button. See also the Delete Queries button.

The Compact Database Button

There are two operations which the Administrator should perform regularly – Backup and Compact. Database transactions cause wasted space to build up within the database. Before you take your regular backup, Compact the database to reduce its size and make access more efficient.

The Delete Queries Button

You should not normally need to use this option but if your database is damaged it is probably a good idea to press this button after you have used the Repair option. It will remove all of the stored query definitions which will be recreated when you open the Main screen.

The Backup Database Button

This option will compress the current database as it copies it to the file that you nominate.

You should not rely on backup files stored on the same system as the Snap database but rather backup to removable storage such as Tape, Zip, Jaz, LS120 or floppy drives or to the network storage. If you store your backup file on the same drive as the current database and there is a disk crash you could lose both the database and backup.

If you are backing up to floppy drive (1.44MB) you may need to click on the Multi Volume check box because more than one floppy may be required. Selecting Multi Volume will cause a 'spanned' volume to be created if one floppy is not enough.

The Restore Database Button

Use the Restore button to restore a file previously created using the Backup options described above. You can select the target folder to be the same as the current database or different.

PASSWORDS

There are two types of password – the Administrator password and Facilities passwords. Passwords must be precisely 6 characters in length and must contain only alphanumeric characters. They are not case-sensitive – for example, 'passwd' is the same as 'PASSWD'. When you enter passwords, the characters are not displayed – just the placeholder character '*'.

Administrator Password

Only the Administrator can set passwords and when a new database is created (see Copy Database above) the Administrator should first change the Administrator password from ADMINK to something different (see Administrator Options Dialog above) and then define at least one Facility and assign a password to the facility.

User (Facility) Passwords

For normal users, the logon procedure is performed in the Main screen. Snap will display only a list of Facilities and the user must select the required Facility and enter the required password. Note that if there is no value in the 'Key' value this means that the Administrator

has not yet allocated a password and processing cannot proceed until a password is assigned.

By default, Snap will position to the Facility that was in use in the previous session and, if this is the required Facility, the user can logon by pressing the process key (F7) and then entering the password. If the password is correct, all user data sets will become accessible. If a user needs to switch from Facility to Facility, the password for each facility only needs to be entered once during the same session – until the user logs off.

Admin Logon from the Main Screen
It is often convenient to be able to logon as the Administrator directly from the Main screen rather than from the Administrator Options dialog. However, if exclusive access is required, this can only be achieved using the dialog.

To logon as the Administrator, with any Facility record selected and the cursor on the EditView, hold down the Shift key and press the F7 key – the password dialog will have the caption 'Enter Administrator Password'.

To logoff as Administrator but still stay in the Main screen, repeat the process by holding down the Shift key and pressing F7. You will then have user access to the currently selected Facility but will not be able to access other Facilities for which the password has not been entered.

Setting/Changing Facility Passwords
To set or change a Facility password you must logon as Administrator, select a Facility and then press F7 (without the Shift key). You will then see the 'Change Facility Password' dialog and you should enter the new password and repeat the entry in the Confirm box. If the codes match, the new Facility password will be assigned.

LOST PASSWORDS

If you forget a Facility password, the simplest solution is for the Administrator to assign a new one – it is not necessary for the Administrator to enter the old Facility password before assigning a new one.

If you lose the Administrator password you should press the 'Password Key' button in the Administrator Options dialog, record the number that is displayed and contact the Centre for Health Service Development on (02) 421 4411 who will decrypt the key for you.

FACILITY DEFAULT VALUES

The Administrator can set up default values in the Facility data set for the following Episode fields:

Case Type
Episode Type
Model of Care
Mental Health Service
Assessment Type
HACC Eligible
Service Delivery Setting
Funding Source refers to the 'Funding source for hospital patient' on the Patient screen
AN-SNAP Version.

When a new Episode (or Patient) record is added, the values for the fields above will be set with the default values.

User-Defined Table (UDT)

INTRODUCTION

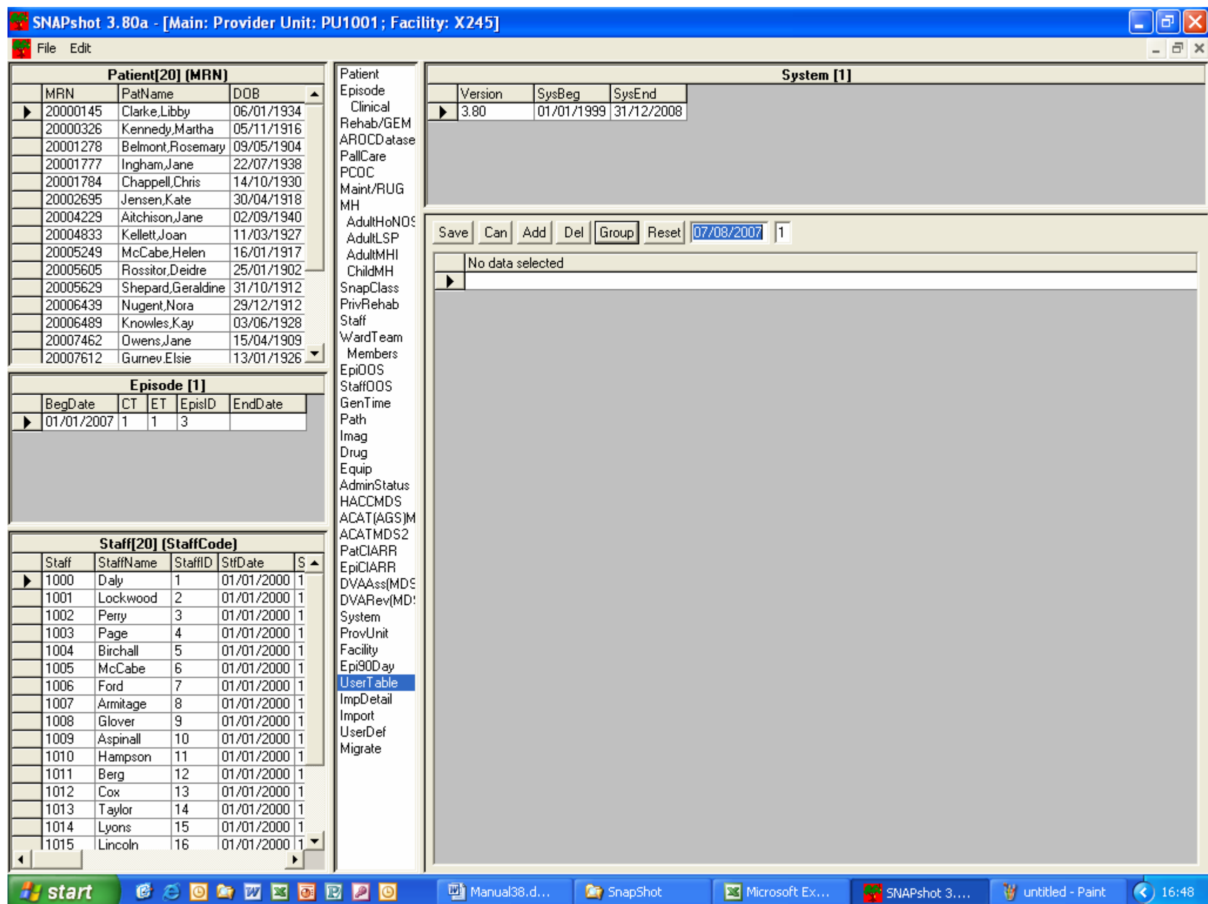
You may create, for each Facility, a table which contains fields which you define. The table is linked to the Snap Episode table and so it can contain a mixture of variable patient level and episode level data.

Each user-defined table can contain up to 20 fields which may be of the following MS Access types: Text (1 to 250 characters), Date, Byte, Short, Long, Single or Double. Snap will only accept dates in Date fields, not date/time values.

You should design the table carefully since you cannot change it using Snap once Snap has created it. If you have a copy of Access 97 and know how to manipulate table definitions then you can make changes but you should read the section below on changing UDT definitions.

Note that as from version 3.40 you can use the ‘Delete on backup (No Names)’ attribute to cause the values of selected fields to be removed when you create copies of the database.

In the example above, five fields have been defined. When the UserTable for this facility is selected, the data will appear as follows:



DEFINING THE FIELDS

To define and create a UDT you must enter the Admin password to provide access to the ‘UserDef’ data set. If you do not enter the Admin password, this set name will not appear in the SetList.

To add field definitions select the UserDef set and add a record for each field. You can manipulate the UserDef field list at any time but when you want to create the table you should be the only user on the network logged onto Snap since you must have exclusive access.

EpisID

The first field that you define must be called ‘EpisID’ and must be of type ‘Long’. The order of fields is determined by the Seq field and you should number your fields with an interval, of say 1000, so that you can reorder the fields (as they will appear in the EditView when UserTab is selected) if necessary – but, remember, EpisID must always appear first by having the lowest Seq number.

Other fields

The other fields may have names which you assign but Snap imposes the following restrictions:

1. The field names must be 15 characters or less in length, contain only alphanumeric characters or the underscore character and commence with an alpha character.

2. Field names may not be duplicated and are not case-sensitive – eg BeginDate is the same as BEGINDATE.

3. You should avoid field names which Access specifically recognises as keywords such as Date, Table, Long, etc.

4. The field type must be one of the types listed above (see drop down list for Field Type).

5. If you define a look-up-table (LUT), the field type should not be Date, Single or Double and you will have to use the Import facility to import the values for the LUT.

6. Look-up-tables (used in drop down lists) must also conform the field naming conventions above and, if you wish to create your own LUTs, must commence with a small 'x' to distinguish them from Snap-defined LUTs.

7. LUT names must be unique across Facilities – eg if Facility N222 defines a LUT called xRefSource then it is accessible to all Facilities but N765 cannot define a different LUT with the same name.

CREATING THE UDT

Once you have defined the set of fields for a Facility, select any of the fields in UserDef and select the EditView. Press the process key F7 on the keyboard and you will receive a prompt asking if you wish to create a new table for the Facility. The table will have the name XXXXUserTab where XXXX is the code for the Facility.

Snap will then create the table, a primary key on the EpisID field and a relationship between the Episode table and XXXXUserTab.

Important

When you create a new UDT you must be the only user on the network since Snap requires exclusive access to the Episode table

ACCESSING THE UDT

Once the UDT has been created, users can access it the same way as they access other data sets by selecting a Facility and then clicking on the UserTab set name in the SetList.

One new UDT record can be added for each Snap Episode record. If you delete the Snap Episode record, the corresponding UDT record is deleted. If you delete a patient record, all UDT records for all Facilities for the patient will be deleted.

CHANGING THE DEFINITION OF A UDT

You cannot change the definition of fields in a UDT once the Access table has been created. If you need to add new fields, delete existing fields or change the attributes of an existing field you must, firstly, use Access to change the table and, secondly, use the UserDef set to change the field definitions in Snap to be consistent with the new table definition. If the Snap definition and the Access table definition are not consistent, you will receive an error message when you try to select the UserTab set.

The constraints which are listed above for UDTs above apply to any changes that you make in Access since you have to make corresponding changes to UserDef records. For example, if you add a field with a name of more than 15 characters in Access, when you try to define the field in Snap, you will receive an error message.

If you have little experience in using Access, you should try to find some one who is more expert to help you – particularly if you plan to change the definitions of existing fields since this could lead to loss of data.

USER-DEFINED LOOK-UP-TABLES (LUTS)

If you specify a coded field in the UDT you can link it to an existing LUT by specifying the name or create a new LUT and import it using the Import option.

If you create your own LUT you must prefix its name with a small 'x' to distinguish it from Snap LUTs and you should be careful not to overwrite a LUT which has been set up by another Facility. You can make this check during Import since you will receive a prompt telling you that the LUT already exists.

You can link either numeric or text codes (1 to 15 chars) to the LUT but if your codes have leading zeros you should define them as Text fields not numeric fields. If you define a coded field as numeric and enter, for example 01 or 0023, the leading zeros will be dropped and the resulting codes will not match the LUT (or will match it incorrectly).

Importing Data

IMPORT DATA SETS

The Import option may be used for the following data sets:

Patient details
Staff details
Staff time
Pathology tests
Imaging
Pharmacy
Equipment
Look-up-tables (LUTs) for equipment, pathology, imaging and pharmacy
Look-up-tables (LUTs) for user defined fields.

The import data must be provided in a comma-separated value (CSV) file.

If you are importing patient data – make sure that DOB has four character years – 22/10/03 will be interpreted as 22/10/2003 not 22/10/1903. (Any year less than 30 assumes 2000).

THE IMPDETAIL DATA SET

The following details are required for each type of import:

1. The name of the import data set – patient, staff, etc.
2. For LUTs, the name of the look-up-table.
3. The name of the CSV (comma-separated value) file including the full path – for example c:\snap\path.txt

These details are stored in the ImpDetail data set and you can change the values if required and add new entries for user-defined LUTs.

TargSet	ImpLUT	ImpFile
Drug	None	c:\Snap\Drug.txt
EpiOOS	None	c:\Snap\OOS.txt
Equip	None	c:\Snap\Equip.txt
Imag	None	c:\Snap\Imag.txt
LUT	DrugLUT	c:\Snap\DrugLUT.txt
LUT	EquipLUT	c:\Snap\EquipLUT.txt
LUT	ImagLUT	c:\Snap\ImagLUT.txt
LUT	PathLUT	c:\Snap\PathLUT.txt
Path	None	c:\Snap\Path.txt
Patient	None	c:\Snap\Patient.txt
Staff	None	c:\Snap\Staff.txt

Before you can use the Import data set you must select a record in the ImpDetail set. For example, if you wanted to import Patient data you would:

- select the ImpDetail data set;
- click on the row containing the Patient target set;
- select the Import data set; and
- press the Process key (F7) in the EditView to choose the import option.

THE IMPORT DATA SET

Before you can import data you must use the ImpDetail data set to select the set you wish to import. When you then select the Import data set, you see either an empty MultiList if the previous import did not have any errors or a list of records which could not be imported if errors occurred. Each error record contains a description of the condition which causes it to be rejected.

Correcting errors in the import data

If there are any records which cannot be imported, these will be listed in MultiList and you can select them, edit them and retry the import on the rejected/corrected records. Alternatively, you can fix up the problem in the source system and create an import file (for only the rejected records) and run Import on the new file.

If you choose to edit the rejected records in Snap it is important to note that the fields in the import transactions are all text fields so if, for example, you are entering a date, you should enter all characters in the form dd/mm/yyyy. For a coded field you can use the drop down list to select a value.

When you have finished amending the rejected records, select the EditView, press F7 and choose the 'Re-process records above' option. If some of these records are rejected you can repeat the process.

THE SCHEMA.INI FILE

When you install SNAPshot a file which defines the format of the import CSV files will be placed in the SnapShot folder. If you store databases in other folders and want to import data into them then you must copy the schema.ini file into the database folder. The Access database engine expects to find this file when it imports the data.

In the import CSV file all fields are defined as type 'text' and the widths are defined as being considerably longer than the actual database fields. This allows, for example, a date field in the import file with a value of 'Sometime in late June' to be imported into the 'staging' table without losing the data. (It will, of course, not be accepted as a legal date).

The file definitions in the schema.ini file have been specified with the extension '.txt' rather than '.csv'. The reason for this is that if you import a CSV file into Excel it does nasty things like automatically stripping off leading zeros which can cause problems with fields such as MRNs. With '.txt' files, Excel provides an import dialog which lets you define fields such as MRN as being text and then you don't lose the leading zeros. However, you can change the schema.ini file names to, for example, Patient.csv if you choose but remember to change the names in the ImpDetail data set in the Main Snap screen if you do.

The actual database field lengths are shown in square brackets after the field definitions – they must not appear in an actual schema.ini file.

```
[Patient.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM

Col1=ProvUnit      text width 30     [    6]
Col2=MRN           text width 30     [   12]
Col3=DOB           text width 30     [ Date]
Col4=SurName       text width 50     [   20]
Col5=GivName       text width 50     [   20]
Col6=Sex           text width 30     [    1]
Col7=IndStat       text width 30     [    1]
Col8=Country       text width 30     [ Byte]
Col9=Medicare      text width 30     [   12]
Col10=DVANum       text width 30     [   12]
Col11=PrefLang     text width 30     [ Byte]
Col12=Interpret    text width 30     [    1]
Col13=PatRefDate   text width 30     [ Date]
Col14=PrevTreat    text width 30     [    1]
Col15=uAddress1    text width 80     [   27]
Col16=uAddress2    text width 80     [   27]
Col17=uSuburb      text width 80     [   27]
Col18=uState       text width 30     [    1]
Col19=uPostCode    text width 30     [    4]
Col20=uPhone       text width 30     [   10]
Col21=uAccom       text width 30     [    1]
Col22=Address1     text width 80     [   27]
Col23=Address2     text width 80     [   27]
Col24=Suburb       text width 80     [   27]
Col25=State        text width 30     [    1]
Col26=PostCode     text width 30     [    4]
Col27=Phone        text width 30     [   10]
Col28=Accom        text width 30     [    1]
Col29=MarStat      text width 20     [    1]
Col30=MajIncSrc    text width 30     [ Byte]
Col31=HealthFund   text width 50     [Short]
Col32=FundMemNum   text width 50     [   15]
Col33=PatComment   text width 200    [   50]
Col34=KinName      text width 80     [   27]
Col35=KinAddr      text width 80     [   27]
Col36=KinPostCd    text width 30     [   10]
Col37=KinSuburb    text width 80     [   27]
Col38=KinPhone     text width 30     [    4]
Col39=KinRel       text width 30     [ Byte]

[Staff.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Facility      text width 30     [    4]
Col2=Staff         text width 30     [   10]
Col3=StfDate       text width 30     [ Date]

Col4=SessType      text width 30     [    1]
Col5=StaffName     text width 50     [   20]
Col6=CC            text width 30     [   20]
```

```
Col7=Desig          text width 30     [     3]
```

[Path.txt]

```
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=ProvUnit       text width 30     [     6]
Col2=MRN            text width 30     [    12]
Col3=DOB            text width 30     [  Date]
Col4=Facility       text width 30     [     4]
Col5=CaseType       text width 30     [     1]
Col6=EpisType       text width 30     [     1]
Col7=CareDate       text width 30     [  Date]
Col8=Item           text width 50     [    12]
Col9=Num            text width 30     [Short]
Col10=Cost          text width 30     [Double]
```

[Imag.txt]

```
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=ProvUnit       text width 30     [     6]
Col2=MRN            text width 30     [    12]
Col3=DOB            text width 30     [  Date]
Col4=Facility       text width 30     [     4]
Col5=CaseType       text width 30     [     1]
Col6=EpisType       text width 30     [     1]
Col7=CareDate       text width 30     [  Date]
Col8=Item           text width 50     [    12]
Col9=Num            text width 30     [Short]
Col10=Cost          text width 30     [Double]
```

[Drug.txt]

```
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=ProvUnit       text width 30     [     6]
Col2=MRN            text width 30     [    12]
Col3=DOB            text width 30     [  Date]
Col4=Facility       text width 30     [     4]
Col5=CaseType       text width 30     [     1]
Col6=EpisType       text width 30     [     1]
Col7=CareDate       text width 30     [  Date]
Col8=Item           text width 50     [    12]
Col9=Num            text width 30     [Short]
Col10=Cost          text width 30     [Double]
```

[Equip.txt]

```
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=ProvUnit       text width 30     [     6]
Col2=MRN            text width 30     [    12]
Col3=DOB            text width 30     [  Date]
Col4=Facility       text width 30     [     4]
Col5=CaseType       text width 30     [     1]
Col6=EpisType       text width 30     [     1]
```

```
Col7=CareDate      text width 30     [ Date]
Col8=Item          text width 50     [   12]
Col9=Cost          text width 30     [Double]

[OOS.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=ProvUnit      text width 30     [    6]
Col2=MRN           text width 30     [   12]
Col3=DOB           text width 30     [ Date]
Col4=Facility      text width 30     [    4]
Col5=CaseType      text width 30     [    1]
Col6=EpisType      text width 30     [    1]
Col7=Staff         text width 30     [   10]
Col8=CareDate      text width 30     [ Date]
Col9=Shift         text width 30     [    1]
Col10=Mins         text width 30     [ Long]
Col11=IV1          text width 30     [ Byte]
Col12=IV2          text width 30     [ Byte]
Col13=IV3          text width 30     [ Byte]
Col14=IV4          text width 30     [ Byte]
Col15=ServSetting  text width 30     [    1]

Col16=GEAssist     text width 30     [ Byte]
Col17=GEAssist2    text width 30     [ Byte]
Col18=Meals        text width 30     [ Byte]
Col19=Linen        text width 30     [ Byte]
Col20=Transport    text width 30     [ Byte]
Col21=HomeMod      text width 30     [ Long]

[DrugLUT.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Code          text width 30     [   15]
Col2=Name          text width 200    [   60]
Col3=Seq           text width 30     [ Long]
Col4=Cost          text width 30     [Double]
Col5=Heading       text width 30     [    1]

[EquipLUT.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Code          text width 30     [   15]
Col2=Name          text width 200    [   60]
Col3=Seq           text width 30     [ Long]
Col4=Cost          text width 30     [Double]
Col5=Heading       text width 30     [    1]

[ImagLUT.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Code          text width 30     [   15]
Col2=Name          text width 200    [   60]
```

```
Col3=Seq          text width 30     [ Long]
Col4=Cost         text width 30     [Double]
Col5=Heading      text width 30     [     1]
```

```
[PathLUT.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Code         text width 30     [    15]
Col2=Name         text width 200    [    60]
Col3=Seq          text width 30     [ Long]
Col4=Cost         text width 30     [Double]
Col5=Heading      text width 30     [     1]
```

INCOMPLETE IMPORT FILES

Snap will try to match the records in the import file with records in the database even if not all key fields are specified. For example, to guarantee a match on OOS/Staff Time data you should provide all of the key field values for ProvUnit, MRN, DOB, Facility, CaseType, EpisType, Staff, CareDate and Shift. However, it is quite probable that the source system does not have all of these details. For example, a staff time recording system might record MRN, Staff, CareDate and number of minutes. Snap will try to process such a file by trying to supply the missing details as follows:

- MRN, Staff and CareDate are compulsory fields.
- ProvUnit and Facility will be assumed to be the currently selected values in the Main screen.
- DOB will be derived from the Patient table as long as there is only one patient in the nominated ProvUnit with the specified MRN. Otherwise DOB will be requested in the error list.
- CaseType and EpisType will be derived from the Episode table unless there are concurrent episodes in which case you will have to provide additional detail.
- Shift will be assumed to be 1.

If you use the OOS.txt format described above for the schema.ini file, you must have all of the fields present in the import data file although columns such as ProvUnit can be left blank. You can add new definitions to the schema.ini file which omit these fields. For example, if you have only one ProvUnit and one Facility, MRNs are always unique, concurrent episodes are extremely rare and you don't enter intervention codes or HACC OOS data, you could provide import files which conform to the following specification:

```
[OOS2.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=MRN          text width 30     [    12]
Col2=Staff        text width 30     [    10]
Col3=CareDate     text width 30     [ Date]
Col4=Mins         text width 30     [ Long]
```

Changes to the schema.ini file are probably best performed by a technical person who is familiar with Access if this is possible.

The AdminStatus Data Set

This data set allows you to record administrative events or actions such as Application for Nursing Home Placement or Respite Care Approval using the following fields: Episode Identifier, Date, Type of action, Status of action and comments (50 characters or less).

The codes for the Type and Status field codes may be up to 15 characters in length and you must provide look-up-tables (LUTs) for them for each facility for which AdminStatus records are to be created – see the 'Import' section above for details on importing LUTs.

The LUTs must be imported as CSV (comma separated value) files which can be created using tools such as Excel. The codes may be numeric or alpha but you are strongly advised not to use leading zeros in numeric codes – such as 00211 – since systems such as Excel have a tendency to remove them. If you are designing a new LUT and wish to use numeric codes, the best approach is to determine how many digits you need and then ensure that all codes will have significant digits in the total range. For example, if you need a five digit code, start numbering at 10000.

For each code in the LUT (15 or less characters) the LUT description must be 60 characters or less.

An example is shown below for Facility X245 – note the naming convention for the LUT names which must commence with a small x and end with 'StatType' and 'AdmStatus'.

StatType and AdmStatus LUTs

xX245StatType					
LutSet	**Code**	**Name**	**Seq**	**Cost**	**Heading**
xX245StatType	1000	Application for form	1		
xX245StatType	2624	App for nursing home placement	2		
xX245StatType	3612	Respite care approval	3		

xX245AdmStatus					
LutSet	**Code**	**Name**	**Seq**	**Cost**	**Heading**
xX245AdmStatus	Canc	Cancelled	3		
xX245AdmStatus	Pend	Pending	1		
xX245AdmStatus	Proc	Processed	2		

Import Details

In the ImpDet set you need to create 2 records to define the Import sets as follows:

Target set	Look up table code	CSV file name
GenLUT	xX245AdmStatus	C:\SnapShot\UserLUT.txt
GenLUT	xX245StatType	C:\SnapShot\UserLUT.txt

When you have created the LUT for Status Type, place the list as a CSV file called GenLUT in the SNAPshot folder and follow the Import procedure. Then repeat the process for Admin Status.

Alternatively, you could use more specific names for the CSV file name field above but you would have to modify the schema.ini file to include descriptions for the file names supplied as shown in the example below:

Target set	Look up table code	CSV file name
GenLUT	xX245AdmStatus	C:\SnapShot\X245Type.txt
GenLUT	xX245StatType	C:\SnapShot\X245Stat.txt

The schema.ini file would be modified by copying the UserLUT definition:

```
[UserLUT.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Code          text width 30     [     15]
Col2=Name          text width 200    [     60]
Col3=Seq           text width 30     [   Long]
Col4=Cost          text width 30     [Double]
Col5=Heading       text width 30     [      1]

[X245Type.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Code          text width 30     [     15]
Col2=Name          text width 200    [     60]
Col3=Seq           text width 30     [   Long]
Col4=Cost          text width 30     [Double]
Col5=Heading       text width 30     [      1]

[X245Stat.txt]
ColNameHeader=False
Format=CSVDelimited
MaxScanRows=0
CharacterSet=OEM
Col1=Code          text width 30     [     15]
Col2=Name          text width 200    [     60]
Col3=Seq           text width 30     [   Long]
Col4=Cost          text width 30     [Double]
Col5=Heading       text width 30     [      1]
```

Note: if your CSV file contains column header names, you should change the schema.ini file definition above by specifying:

```
ColNameHeader=True
```

Deleting or Changing Codes in the LUT

You should be careful not to remove codes from the LUTs which exist in the AdminStatus records or to change the meaning of codes. In general, you should only add new codes.

The SNAPshot Grouper

The SNAPshot Grouper incorporates the grouping logic for the AN-SNAP 1, AN-SNAP 2 and MH-CASC classifications.

GROUPING OPTIONS

The Group button on the main Snap screen may be used to group an individual record, 'bulk' group all of the records for the currently selected Facility, bulk group all records in the database, or 'batch' group a file of records in a text file.

Note that if you are *regrouping* data and the data have been migrated from Snap 2.3 to Snapshot, the grouper will only overwrite Class codes if the Status code is 100 (OK). If an error status is returned, the new status code is stored but the old Class code remains. This is to allow historical data migrated from Snap 2.3 to retain the Class codes assigned when the grouping rules were different. If there is no Class code prior to grouping, 999 will be assigned to ungroupable records.

If a MH-CASC class is assigned, the Snap class will be 901.

To group the current episode or phase simply press the Group button. To bulk or batch group you will need to hold down the Shift key whilst you press the Group button – then a list of options will appear.

SELECTING THE VERSION OF AN-SNAP

Episodes or phases are grouped to the version of AN-Snap selected in the AN-Snap Version field in the Episode or Phase record. If you are Bulk or Batch grouping, as described below, you will be prompted to select the required version. For Bulk grouping, the selected version will be set in all relevant records prior to grouping – either for the currently selected Facility or for all records in the database.

Records migrated from Snap 2.3 that are ungroupable (class returned is 999) will retain their old class code as described above and the AN-Snap Version field will be set to 1.

GROUPING INDIVIDUAL RECORDS

You must select one of two data sets to group individual records:

- For palliative care episodes, select the relevant phase record and press the Group button.

- For all other case types, select the relevant episode record and then choose the SnapClass data set.

In either case, all of the fields required for grouping will be displayed either as part of the data set or in the read-only section under 'Grouping fields'.

The Class and Status fields will be updated and the new values displayed on screen.

BULK GROUPING

To select Bulk Grouping hold down the Shift key whilst you press the Group button.

There are two options for bulk grouping records in the current database:

- Group all episode / phase records in the currently selected Facility. You will need to log on to the relevant Facility for this option.

- Group all episode / phase records in the database. This option requires that you log on as the Administrator.

BATCH GROUPING

To select Batch Grouping hold down the Shift key whilst you press the Group button.

If you select this option a text file called GroupDat.txt will be grouped and the output written to a text file called GroupOut.txt. These files must be in the database folder (c:\SnapShot by default).

The file can have one of two formats as shown below. The first format is the normal one where the output fields appear immediately following the input fields.

	Field	Offset	Length	MinVal	MaxVal
Input fields					
1	CaseType	1	1	1	6
2	EpisType	2	1	1	4
3	Assess	3	1	1	2
4	Age	4	3	0	124
5	LOS	7	4	1	9999
6	ProvType	11	1	1	5
7	Phase	12	1	1	5
8	SevTot	13	2	0	12
9	RugAdmTot	15	2	4	18
10	ImpairInt	17	2	1	16
11	FimAdmMot	19	2	13	91
12	FimAdmCog	21	2	5	35
13	HonTot	23	2	0	48
14	HonActive	25	1	0	4
15	HonADL	26	1	0	4
16	MaintType	27	1	1	5
17	CareFocus	28	1	1	4
18	SolePract	29	1	1	2
19	MHServ	30	1	0	3
20	Diag1	31	6	0	0
21	HoNOS5	37	2	0	20
22	HoNOS10	39	2	0	40
23	LSP13	41	2	13	52
24	CGASBeg	43	3	1	100
25	MHLS	46	1	1	2
26	CABehav	47	1	0	4
27	CASchool	48	1	0	4
28	HonCABeg	49	2	0	70
29	FAHSTotal	51	1	0	4
30	Impairment	52	7	0	0
31	Complete*	59	1	0	1
Output fields					
	Class	60	4	100	9999
	Status	64	3	100	999
	MHClass	67	8	Text	
	Episode Cost Weight	75	10		
	Inlier Cost Weight	85	10		
	Outlier Cost Weight	95	10		

* Complete is a flag set from Episode EndDate: 0 = no date, 1 = date present.

Each record in the text file must have a block of columns which contains the input fields. If the record length is less than the end position of the last field (59 above) the record is padded with blank characters before being passed to the grouper.

The Offset column shows the relative position of the field within the grouper fields block. For example, you may want to include MRN and Episode BeginDate in the file at the beginning of each record. If MRN is 12 characters and the date takes 10 characters (dd/mm/yyyy), then CaseType would begin in column 23.

Each record must be terminated by a carriage return / line feed pair.

You may also include fields at the end of the record – in the example they would start in column 146 (22 + 104). The grouper will add the output fields to the string record and return it with the appropriate Class, Status and MHClass values inserted.

Use the System data set to specify the start character position of the grouper field block (23 in the example above), and the format that you are using (1 above or 2 below).

The maximum record size is 2000 characters.

The second format can be used for testing the grouper and it contains the expected values of the output fields followed by the fields output by the grouper.

	Field	Offset	Length	MinVal	MaxVal
Input fields					
1	CaseType	1	1	1	6
	…				
31	Complete	59	1	0	1
	ExpClass	60	4	100	9999
	ExpStatus	64	3	100	999
	ExpMHClass	67	8	Text	
	Exp Episode CW	75	10		
	Exp Inlier CW	85	10		
	Exp Outlier CW	95	10		
	Flag	105	1		
Output fields					
	Class	106	4	100	9999
	Status	110	3	100	999
	MHClass	113	8	Text	
	Episode Cost Weight	121	10		
	Inlier Cost Weight	131	10		
	Outlier Cost Weight	141	10		

The grouper will compare the expected Class, Status and MHClass values with those derived by the grouping logic and, if there is a discrepancy, it will place a hash sign (#) in the Flag field of the output file (GroupOut.txt). The MHClass field must be left justified and blank filled.

An example of a batch file in format 2 is shown below.

Grouper field values

The table for format 1 above shows the range of values allowed for each field in the grouper fields block. The grouper is selective about which fields it examines but if it needs to use a field a value must be specified otherwise the Status field will be returned with a value other than 100 – typically 300 plus the field number – see first column in tables above. If a field is not required for grouping – for example Phase for a non-Palliative Care patient – it may be left blank.

In most cases, you cannot leave fields which the grouper references blank. MHServ is an exception where blank is converted to zero. The Diag1 and Impairment fields should be left-justified, blank-filled. In all other cases, a blank in a field will cause a field error. Input fields which are to be used for grouping should be right justified, zero-filled.

Example of Format 2 grouper batch file

```
*ase Type 1-6
*Episode Type 0-4
*|Assessment Only 1-2
*||Age
*|||  Los
*|||  |   ProvType 1-5
*|||  |   |Phase 1-5
*|||  |   ||Severity 0-12
*|||  |   ||| Rug 4-18
*|||  |   ||| | ImpairInt
*|||  |   ||| | | FIM Motor 13-91
*|||  |   ||| | | | FIM Cognit 5-35
*|||  |   ||| | | | | HONOS 0-60
*|||  |   ||| | | | | | HONOS Overactive 1-5
*|||  |   ||| | | | | | |HONOS ADL 1-5
*|||  |   ||| | | | | | ||Maint Type 1-5
*|||  |   ||| | | | | | |||CareFocus (Psych Phase) 1-4
*|||  |   ||| | | | | | ||||SolePract
*|||  |   ||| | | | | | |||||MHServ
*|||  |   ||| | | | | | ||||||Diag01
*|||  |   ||| | | | | | |||||||     Honos5
*|||  |   ||| | | | | | |||||||     | Honos10
*|||  |   ||| | | | | | |||||||     | | LSP13
*|||  |   ||| | | | | | |||||||     | | | CGASBeg
*|||  |   ||| | | | | | |||||||     | | | |  MHLS
*|||  |   ||| | | | | | |||||||     | | | |  |CABehav
*|||  |   ||| | | | | | |||||||     | | | |  ||CASchool
*|||  |   ||| | | | | | |||||||     | | | |  |||HonCABeg
*|||  |   ||| | | | | | |||||||     | | | |  |||| FAHSTotal
*|||  |   ||| | | | | | |||||||     | | | |  |||| |Impair
*|||  |   ||| | | | | | |||||||     | | | |  |||| |       Complete Epi (enddate)
*|||  |   ||| | | | | | |||||||     | | | |  |||| |       |Cls ErrMHClass
*|||  |   ||| | | | | | |||||||     | | | |  |||| |       ||   |  |       CWgts...
*|||  |  1||| | | |2| | |||||3|     | |4| |  ||||5|       |6   |  |  7    |    8
*2345678901234567890123456789012345678901234567890123456789012345678901234567890012
*EAaaallllPPssrriimmcchhoaMCPMDiag1.H5H0LSCGAMCSHBFiiiiiiiEcccceeeMMMMMMMM
* PallCare
111000000500000000000000000000      000000000000000       12101100
112000001001000400000000000000      000000000000000       12102100
* Rehab
211000000500000000000000000000      000000000000000       12201100
212000001500000008910500000000      0000000000000008.111  12227100
* Psychogeriatric
311000002000000000000000000003      000000000000000       12301100
312000001000000000000000400003      000000000000000       12302100
* GEM
411000000500000000000000000000      000000000000000       12401100
412000001000000000431500000000      000000000000000       12402100
* Maintenance
511000002000000000000000000000      000000000000000       12501100
512000009000001800000000002000      000000000000000       12502100
```

Note that the lines commencing with an asterisk are treated as comments.

In the example above, the expected values are included in the GroupDat.txt file. The Snap class code starts in column 60, the Status code in column 64, the MH-CASC class code starts in column 67, and the costweight values start in columns 75, 85 and 95. The grouper will append the calculated codes starting in column 106 and will indicate in column 105 with a # sign if there is a discrepancy between the expected and returned grouper values.

Resolving Grouping Errors

When you attempt to assign a SNAPclass to a record, either by performing a bulk group operation, or by selecting SNAPclass in the setlist and hitting the group button for individual records, SNAPshot will assign a status code to the record. These status codes can be viewed, by record, in the SNAPclass screen, and a summary of all the ungroupable records (that is, those records with a status code other than 100) can be found in the Database Summary, report number 20.

Refer to the table below to determine how best to correct the problem.

SNAPclass status codes and suggested resolutions to field errors

Status Code	Description	Suggested resolution
100	Grouping OK	No action required
301	Field error: CaseType	Check Case Type, refer to the AN-SNAP clinical training handbook for business rules
302	Field error: EpisType	Check Episode Type, refer to the AN-SNAP clinical training handbook for business rules
303	Field error: Assessment Only	Currently, it is only possible to assign a SNAP class to Assessment Only for a Rehabilitation Episode
304	Field error: Age	Check date of birth (rules now prevent non-sensical DOBs but previous versions didn't apply any checks)
305	Field error: LOS	Episode End Date needs to completed (along with all supporting episode end data)
306	Field error: ProvType	Check Provider Type, refer to the AN-SNAP clinical training handbook for business rules
307	Field error: Phase	Check PallCare Phase, refer to the AN-SNAP clinical training handbook for business rules
308	Field error: Severity Total	For Ambulatory pallcare clients - check valid values for Pain, Symptom, Pysch/Spiritual,Family/carer scores within PallCare dataset
309	Field error: RUG Admission Total	Ensure that the RUG scores have been entered in the Maint/RUG screen
310	Field error: Impairment Integer	Ensure that the Impairment Code has been entered in the Rehab/GEM screen
311	Field error: FIM Admission Motor Score	Ensure that the FIM motor scores have been entered in the Rehab/GEM screen
312	Field error: FIM Admission Cognition Score	Ensure that the FIM cognition scores have been entered in the Rehab/GEM screen
313	Field error: HoNOS Total	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
314	Field error: HoNOS Overactive Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
315	Field error: HoNOS ADL Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
316	Field error: Maintenance Type	Ensure that the Maintenance Type has been entered in the Maint/RUG screen
317	Field error: Focus of Care	Ensure that the MH data items have been entered for mental health episodes
318	Field error: Sole Practitioner	Ensure that the data item Sole Practitioner in the Episode Screen has been completed
319	Field error: MH Service	Ensure that the Mental Health Service data item in the Episode screen has been completed for mental health episodes
320	Field error: Diagnosis 1	Enter primary diagnosis (diagnosis 1) in Clinical screen for mental health episodes
321	Field error: HoNOS 5 Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes

Status Code	Description	Suggested resolution
322	Field error: HoNOS 10 Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
323	Field error: LSP 13 Score	Ensure that the AdultLSP data items have been entered for adult mental health episodes
324	Field error: CGAS Begin Score	Enter CGA begin (and end) scores in ChildMH screen for child mental health episodes
325	Field error: MHLS	Ensure that the MH data items have been entered for mental health episodes
326	Field error: HONOSCA Behaviour Score	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
327	Field error: HONOSCA School Score	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
328	Field error: HONOSCA Total Begin Score	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
329	Field error: Factors Affecting Health Status Total	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
330	Field error: Impairment code.	Enter UDS Impairment code
331	Field error: Complete (End Date)	Enter Episode end date and supporting episode end data
999	Can't assign class	Refer to status code above and suggested resolution

Reporting

Three levels of reporting can be identified for the SNAPshot database:

1. Unit record level reporting from the Main Snap screen to print from any of the 6 data segments – available from version 3.3.

2. The generation of standard summary reports.

3. User-defined reports using report generation tools such as Access and Crystal Reports – not provided as part of the SNAPshot package.

REPORTING FROM THE MAIN SNAPSHOT SCREEN

Function key F8 has been reserved to invoke report options from any segment on the Main screen. After pressing F8, you will have the following options:

Print Preview

If you select this option the rows/records in the currently selected segment will be displayed in the print preview screen and you can choose to print all pages by pressing the printer icon, a range of pages or the current page. If no rows are marked, all rows will be displayed but you can choose which rows to display by marking them.

You can mark rows in a list by clicking on the record indicator (the grey box at the left of each row of data). To mark a contiguous block, click on the first row, hold down the Shift key and click on the last row. To mark/unmark individual rows selectively, hold down the Ctrl key and click on the relevant record indicators.

Before choosing to produce hardcopy, you should check the number of pages displayed at the top of the print preview screen since there are some options which may optimise the printed output. For example, you can use the Page Setup option (see below) to reduce the margins or to select landscape orientation.

You should also note that less space is required in the printed output to display data values than on screen, so you may be able to reduce column widths to fit all of the data on one page. You can also reduce the row height of the grid temporarily if, for example, the displayed output is slightly longer than one page.

Caution: if you want to exit the print preview window without printing, use the File:Exit menu option (or press Alt-F4) to quit the window rather than pressing the 'X' in the top right hand corner. On some versions of Windows, pressing the 'X' can cause Snap to lock up. If the system locks under Windows 95/98, you will need to press Ctrl-Alt-Del, select SNAPshot, and then press the End Task button to quit Snap.

Write to Report.html

If you have Internet Explorer on your computer you can build more customised reports by writing to an HTML file. This option will write selected rows, or all rows if none are marked, to a file identified using the option below (Specify HTML file).

By default, the file name will be c:\SnapShot\Report.html. To view the HTML file(s), go to Windows Explorer and open this file.

You can create as many HTML files as required and locate them wherever is convenient. You should avoid using a shared file on your file server since your report output may then be overwritten by another user. You should create your own file, preferably on your local c: drive. You can use the same file repeatedly by creating report output, printing the HTML file and then reusing it or you can create several different files and print them later.

Note that any report output previously written to this file will be overwritten using this option – if you want to add data to the selected HTML file, use the next option.

Append to Report.html

This option will append selected rows, or all rows if none are marked, to the selected HTML file. You can build a report from selected data sets and selected rows from any of the Main screen lists by using this option. To view the appended records in the HTML file(s), go to Windows Explorer and open the HTML file.

An example is shown below with data from Patient, Episode and Maint/RUG Detaila screen.

Patient Details	
Field	Value
Medical record number	20000145
Date of Birth	06/01/1934
Surname	Clarke
Given names	Libby
Sex	2 (Female)

Episode Admin Details	
Field	Value
Episode begin date	01/01/2007
Case type	1 (Palliative Care)
Episode type	1 (Overnight admitted patient:designated sub/non-acute unit)
Episode identifier	3
Assessment only	2 (No)
Assessment type	1 (Medical, with diagnostic pathology and/or imaging)
Mode of episode start	1 (Admitted from usual accommodation)

Maint/RUG Details		
Field	Begin	End
Review date	01/01/2000	

Specify HTML file

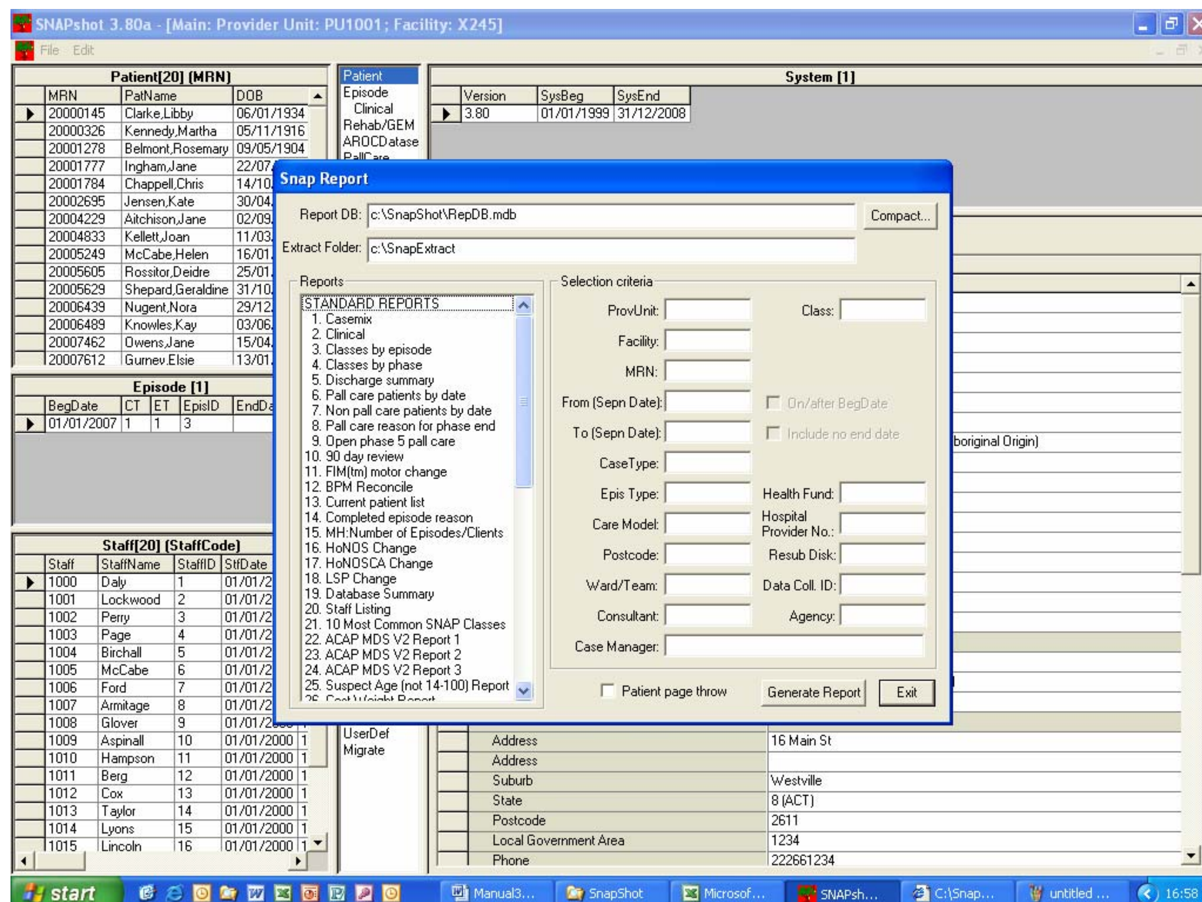
Use this option to specify the HTML file – for example, you might want to create a folder called SnapTemp on your c: drive and store your HTML file(s) there.

Page/Printer setup

This option will display the Page Setup dialog and you can set page options such as margins and can press the ‘Printer…’ button to set printer options.

Standard Summary Reports

THE MAIN SNAP REPORT SCREEN (SHIFT-F8)



To display the Snap Report dialog screen, press Shift-F8 whilst positioned on any of the data lists.

The Snap Report dialog screen provides the following controls:

1. The name of the report database.

2. A list of reports – click on the report you wish to generate.

3. Selection criteria – enter the values you wish to use to select particular subsets of the database.

4. A page throw option which is enabled for some reports to allow you to specify that the data for each patient is to commence on a new page.

5. Operation buttons – Generate and Exit.

The Report Database

When you generate a report the data are written into an Access database which is different from main database. Each user (PC) should have a separate report database – preferably on the local hard disk drive. If the report database has to be stored on a server computer, each user should have a different file.

When you change the report database name, Snap will either select an existing file or, if it does not exist, will create it for you.

The Report Database Folder

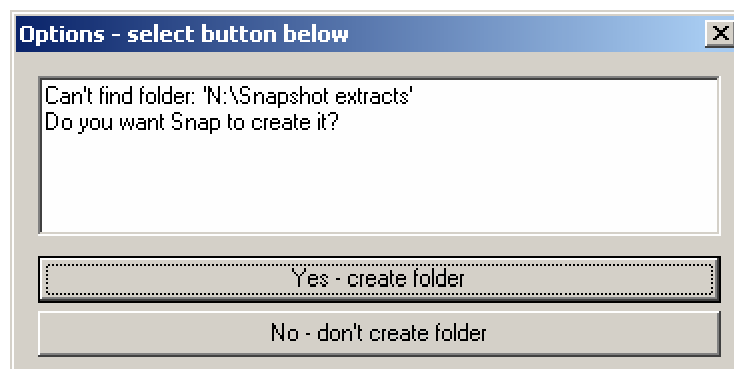
You can create as many report databases as you like – for example you might want to keep the tables which are generated during a session for analysis using another system. In this situation it is normally preferable to keep the report databases in the same folder. However, if you wish to use multiple folders you will have to copy the **.rpt** files into each folder where you store report databases.

The reporting facility inside Snap uses Crystal Reports version 8 and the .rpt files are the report definition files. You should **not** change the .rpt files if you have a copy of the Crystal Reports system installed.

Extract Folder

You need to specify the folder in which to write the data extract files. This folder can be different to SNAPshot installation directory. It can even be on a different computer, on a server for instance.

If the folder does not exist, you will be asked if you want it to be created.



Selection criteria

If you do not enter any values in the criteria edit boxes, all relevant records will be included. Alternatively, you may choose any combination of values to select data subsets. Note that all selection fields relate to episode records. If you only have one facility code in the database, it is not necessary to specify a value for the Facility criterion.

If you specify more than one field value, then all of the conditions must be met. For example, if you specify Case Type and Consultant, then only those records meeting both specifications will be included in the report.

Values for alpha fields such as Ward/Team or Consultant are not case-sensitive so ‘smith’ is the same as ‘smith’.

The reports by date are based on care date. Both From and To dates must be entered. Records are listed if the patients were in care between the From and To dates. For example, to list patients in care on 23/10/00, specify From 23/10/00 To 23/10/00. You could choose intervals longer than one day – such as a week - but only those patients in care for the entire period would be listed.

The Generate button

If you press the Generate button, you can see how the report will appear when it is printed and how many pages will be required. Examples of report output are shown below using the Preview screen. For example, the ‘Casemix’ report appears below.

There are a number of controls at the top of the Preview screen. The first button (*printer*) allows you to send the report, or selected pages, to the printer. The *envelop* button provides options for exporting the data to various file types such as comma separated value, Excel and Word files. The *lightning* button refreshes the data but you should not normally need to press it. The *drop down list* contains a zoom option which you can change by selecting from the list. The next four buttons let you *navigate* through the report – to the *first* page, the *next* page, the *previous* page and the *last* page respectively.

The *binoculars* button let you search for text in the report.

To exit from the Preview screen, press the *close* button (‘X’) in the top right of the screen.

1. The Casemix Report

Report:

100% 1 of 1

Casemix Report

Class	Episode Type	Class Description	Number of Cases	Average LOS	1996 Study LOS	Diff
206	O/n Rehab	Strk & Brns,Mot 47-62	1	3.00	26.95	23.95
999	All	Ungroupable	1		n/a	
Total			**2**			

This report lists all AN-SNAP classes for the selected criteria. It shows the number of episodes in each class and the average length of stay for each class. The length of stay for non-overnight episodes (i.e. the number of days that the person is seen) is calculated by counting contact dates for the episode or phase as shown on the Dates Seen screen. If no activity data are entered, the length of stay is shown as 0.

The Casemix Report also includes comparative data on length of stay from the 1996 National SNAP study. It displays the average length of stay reported in the 1996 study. It also shows the difference between the 1996 national results and your facility results.

Note that the Casemix report excludes episodes/phases without an end date.

2. The Clinical Report

Report:

100% 1 of 1+

Clinical Report

Selection Criteria:

Patient: ProvUnit: PU1001 MRN: 20000145 DOB: 22/10/1901 IndStat 2 Sex: 2 Age: 99
SurName: Clarke Given Name: Libby Interpret: 2

Episode: Facility: X245 From: 08/02/01 To: 15/03/01 LOS: 35 CareModel: 2.2
CaseType 3 EpisType: 1 Assess: 2 AssType 1
BegReason: 2 EndReason: 2 Leave: IntDays:
Team: 84 Consult: ReversJ ReferDate:
Diag1: bad hair day Diag2: 23456
Diag3: 34567 Diag4: 45678
MiniScale: 8 MaintType: 1 ProvType: SolePract: 2
SolePract: 2 FirstEpis: CompStat: MHServ: 3
EpisNum:
Class: 303 O/n PsychoGer HoNOS Overactive behaviour 1,2, ADL 0-3
Status: 100 Grouping OK AvLOS: 21.1
National: 7182 DayCost: 340 EpiCW: 2.41 DayCW: 1.42

RUG: Begin: Eat: 2 Bed: 1 Toilet: 1 Transfer: 4 Total: 8
End: 2 3 4 3 12

Behaviour: Physical Aggression: B Verbal Disruption: C Behaviour: A Total: 0

FIM: Begin: Eat: 3 Groom: 4 Bath: 3 Upper: 4 Lower: 5 Toil: 3
End: 2 1 3 2 2 2
Begin: Blad: 4 Bowel: 3 Xfer: 4 XferToil: 5 Tub: 3 Walk: 4
End: 1 3 2 2 2 1
Begin: Stair: 3 Comp: 4 Exp: 5 Social: 3 Prob: 4 Mem: 3
End: 3 2 2 2 1 3
Begin: Total: 67 Motor: 48 Cognit: 19 Date: 01/01/00
End: 36 26 10 01/01/00
Begin: BarScore: 25 BarMax: 100 Impairment 01.2
End: 20 100

Mental Health: MHServ: 3 Carefocus: 2 ModeSep: 1 SourceRefer: 1 CGASBegin: 5
MHLS: 2 EmpStat: 1 MHITotal: 22 CGASEnd: 4

Honos Begin: Overactive: 2 Injury: 2 Drink: 0 Cognit: 1 Disab: 3 Halluc: 2
End: 1 3 2 2 0 1

This report is designed for use in case conference. It displays most of the episode (and for palliative care patients, the phase) fields including derived fields such as score totals. Several patient record fields are also reported. Only active data are shown – for example, if there is no RUG data then the RUG section will not appear. For a given patient, there may be multiple episodes and phases.

It includes a set of fields called 'National'. These include comparative data from the 1996 National SNAP Study. The fields include the national average cost per episode for the class to which the episode/phase is assigned; the national average cost per day; the episode cost weight (EpiCW); the day cost weight (DayCW); and the national average length of stay. For ambulatory episodes (same day, outpatient and community) this is the average number of days in which the patient is seen over a period of 90 days. For overnight episodes, this is the average length of hospital stay. For ongoing episodes (length of hospital stay greater than 90 days), this is the average cost and length of stay over a 90 day period. Leave days are excluded.

3. Classes by Episode

Classes by Episode

Selection Criteria:

ProvUnit	MRN	Episodes	LOS	Start	End	Ep	Class	Ep	Class	Ep	Class	Ep	Class
PU1001	20000145	1	5	01/01/00	08/01/00	1							
	20000326	1	3	01/01/00	04/01/00	1	206						
	20001278	1	4	01/01/00	05/01/00	1	206						
	20001777	1	16	01/01/00	17/01/00	1	206						
	20001784	1	11	01/01/00	12/01/00	1	206						
	20002695	1	7	01/01/00	08/01/00	1	206						
	20004229	1	9	01/01/00	10/01/00	1	206						
	20004833	1	5	01/01/00	06/01/00	1	206						
	20005249	1	15	01/01/00	16/01/00	1	206						
	20005605	1	5	01/01/00	08/01/00	1							
	20005629	1	5	01/01/00	04/01/00	1							
	20006439	1	13	01/01/00	14/01/00	1	206						
	20006489	1	16	01/01/00	17/01/00	1	206						
	20007462	1	4	01/01/00	05/01/00	1	206						
	20007612	1	5	01/01/00	20/01/00	1							
	20008519	1	5	01/01/00	06/01/00	1	206						
	20009200	1	3	01/01/00	04/01/00	1	206						
	20009313	1	17	01/01/00	18/01/00	1	206						
	20009489	1	11	01/01/00	12/01/00	1	206						
	20009812	1	19	01/01/00	20/01/00	1	206						

This report shows the grouping results for all episodes for each patient. The Start date shows the start date for the first episode. The end date shows the end date for the last episode.

For example, if a patient has two episodes (such as an overnight episode followed by a community episode), the number of episodes will be recorded as 2. The first episode will be listed as Episode 1 with the class number shown in the next column. The second episode will be listed as Episode 2 and the class number for the second episode will also be listed.

The Class values appear in columns and will wrap around to subsequent rows in multiples of four if necessary.

Patients in care for a whole 12 month period will typically have 4 episodes (each of 90 days). See subsequent section on the 90 day review report.

4. Classes by Phase

Report:

100% 1 of 1

Classes by Phase

ProvUnit	MRN	Phases	Start	End	Ph	Class	Ph	Class	Ph	Class	Ph	Class
PU1001	20002625	1	01/01/00		1	102						
	20002702	1	01/01/00		1	102						
	20003169	1	01/01/00		1	102						
	20004688	1	01/01/00		1	102						
	20005760	1	01/01/00		1	102						
	20008526	1	01/01/00		1	102						
	20008875	1	01/01/00		1	102						

This report is similar to the previous report but shows group classes for each phase in multiples of four per line. As with the previous report, it is designed to allow for an analysis of the patterns of care for each patient.

5. Discharge Summary Report

Report:

100% | 1 of 1+

Discharge Summary

Selection Criteria:

Patient:	Name:	Libby		Clarke	MRN:	20000145		DOB:	22/10/1901	
	Address:	16 Main St			Suburb:	Westville				
					Postcode:	2611				
	Phone:	222661234			State:	ACT				
Episode:	From:	08/02/01	To:	15/03/01	Case Type:	Mental Health, including Psychogeriatric				
	Assess Only:	No			Epis Type:	overnight admitted patient				
	Begin Reason:	Admitted from other than usual accommodation								
	Prior Accom.:	Private residence (inc unit in retirement village)								
	End Reason:	Discharged to interim accommodation								
	Post Accom.:	Private residence (inc unit in retirement village)								
	Consultant:	ReversJ			Team:	84				
	Diag1:	bad hair day			Diag2:	23456				
	Diag3:	34567			Diag4:	45678				
	Class:	HoNOS Overactive behaviour 1,2, ADL 0-3								
FIM™:	Admission	67	Discharge	36	Change:	-31	Impairment:	01.2		
RUG:	Admission:	8	Discharge:	12	Change:	4				
Mental	HoNOS Beg	22	HoNOS End:	21	LSP Beg:	40	LSP End:	40	MHI total:	22
Health:	HonCA Beg:	21	HonCA End:	21	CGAS Beg:	5	CGAS End:	4	FAHS total:	3

Patient:	Name:	Martha		Kennedy	MRN:	20000326	DOB:	05/11/1916
	Address:	16 Main St			Suburb:	Westville		
					Postcode:	2611		
	Phone:	222661234			State:	ACT		
Episode:	From:	01/01/00	To:	04/01/00	Case Type:	Rehabilitation		
	Assess Only:	No			Epis Type:	overnight admitted patient		
	Begin Reason:	Admitted from usual accommodation						
	Prior Accom.:	Private residence (inc unit in retirement village)						
	End Reason:	Discharged to usual accommodation						
	Post Accom.:	Private residence (inc unit in retirement village)						
	Consultant:	ReversJ			Team:	84		
	Diag1:	12345			Diag2:	23456		
	Diag3:	34567			Diag4:	45678		

This report shows patient details plus summary episode and phase data. It is designed for use in the preparation of discharge summaries at the conclusion of each episode.

6. The Palliative Care Patients by Date Report

Report:

100% | 1 of 1

Palliative Care Patients by Date

Patients in care from: 01/01/2000 To: 31/01/2000

Provider Unit	EpisBegin	EpisEnd	MRN	Phase	PhaseBegin	Class
PU1001	01/01/00		20002625	1	01/01/00	102
	01/01/00		20002702	1	01/01/00	102
	01/01/00		20003169	1	01/01/00	102
	01/01/00		20004688	1	01/01/00	102
	01/01/00		20005760	1	01/01/00	102
	01/01/00		20008526	1	01/01/00	102
	01/01/00		20008875	1	01/01/00	102

This report will allow you to print out a list of all patients in care on a specified date/s. It is designed for local clinical management purposes.

7. The Non Palliative Care Patients by Date Report

Report:

100% | 1 of 1

Non Palliative Care Patients by Date

Patients in care from: 01/01/2000 To: 31/01/2000

Provider Unit	EpisBegin	EpisEnd	MRN	Class
PU1001	01/01/00		20001185	206
	01/01/00		20001659	206
	01/01/00		20001926	206
	01/01/00		20002303	206
	01/01/00		20002483	206
	01/01/00		20002625	
	01/01/00		20002702	
	01/01/00		20003169	
	01/01/00		20003261	206
	01/01/00		20004688	
	01/01/00		20005760	
	01/01/00		20006139	206
	01/01/00		20006641	206
	01/01/00		20008526	
	01/01/00		20008588	206
	01/01/00		20008703	206
	01/01/00		20008875	
	01/01/00		20009264	206
	01/01/00		20009374	206

As with the previous report, this report will allow you to print out a list of all patients in care on a specified date/s. It is designed for local clinical management purposes.

8. The Palliative Care Reason for Phase End Summary Report

Report:

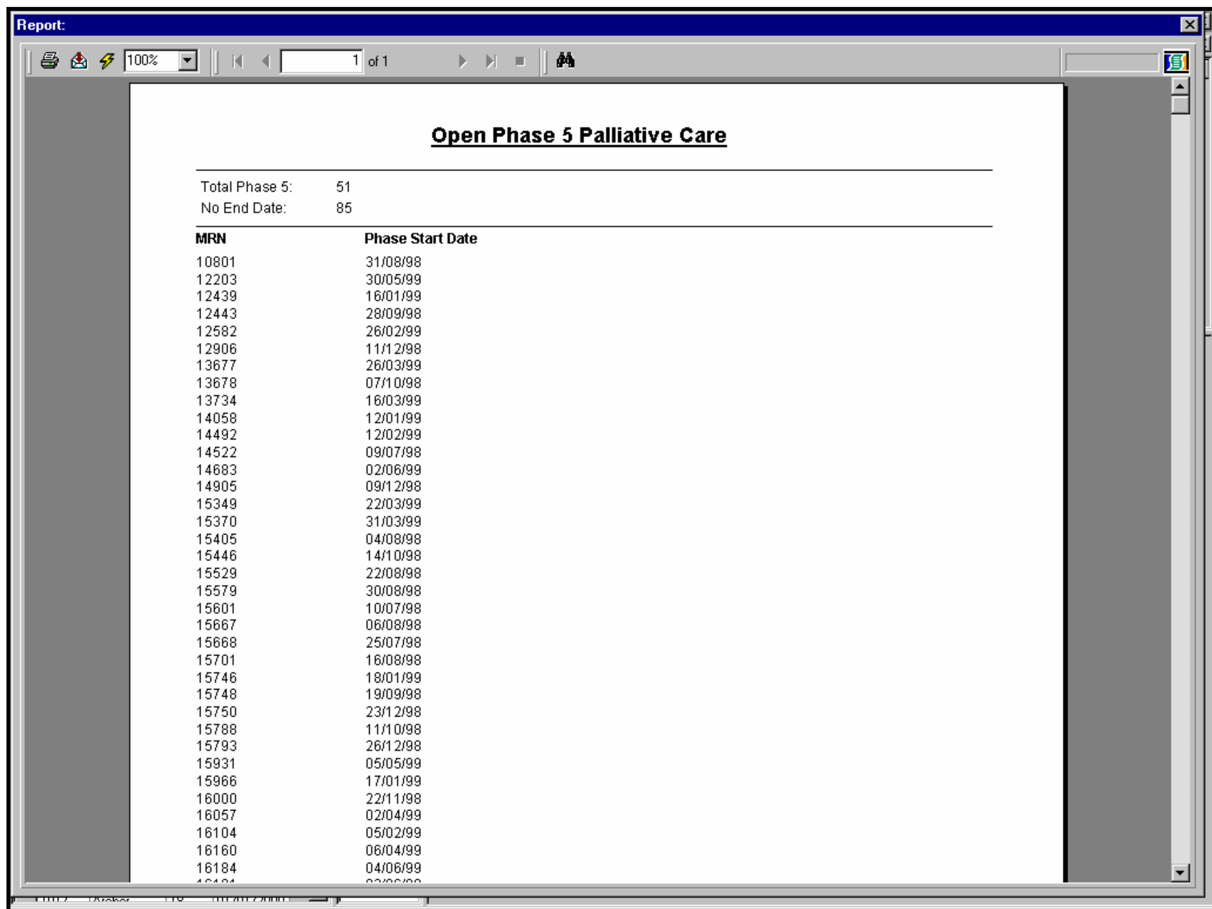
100% | 1 of 1

Palliative Care Reason for Phase End Summary

Reason for phase end	Number	Percent
No phase end reason recorded	1,597	99.56 %
Phase change	7	0.44 %
	1,604	

This report provides summary data on the reasons for the end of each palliative care phase. It shows the number and percentage for each reason.

9. The Open Phase 5 Palliative Care Report



Open Phase 5 Palliative Care

Total Phase 5: 51
No End Date: 85

MRN	Phase Start Date
10801	31/08/98
12203	30/05/99
12439	16/01/99
12443	28/09/98
12582	26/02/99
12906	11/12/98
13677	26/03/99
13678	07/10/98
13734	16/03/99
14058	12/01/99
14492	12/02/99
14522	09/07/98
14683	02/06/99
14905	09/12/98
15349	22/03/99
15370	31/03/99
15405	04/08/98
15446	14/10/98
15529	22/08/98
15579	30/08/98
15601	10/07/98
15667	06/08/98
15668	25/07/98
15701	16/08/98
15746	18/01/99
15748	19/09/98
15750	23/12/98
15788	11/10/98
15793	26/12/98
15931	05/05/99
15966	17/01/99
16000	22/11/98
16057	02/04/99
16104	05/02/99
16160	06/04/99
16184	04/06/99

This report lists all bereavement cases for which no end date has been recorded. It is designed for local clinical management purposes and, in particular, to allow for the review of local discharge policies.

10. The 90 Day Review Report

Report:

100% | 1 of 1

90 Day Review Report

Episodes commencing befor 01/01/2001

Provider Unit: PU1001
Facility: X245

MRN	Surname	Given Name	Begin Date	Case Type	Episode Type	Case Manager
20000116	Cox	Rosemary	01/01/00	2	1	Tommy Quango
20001188	Remington	Alice	01/01/00	2	1	Tommy Quango
20002168	Dunn	Beryl	01/01/00	2	1	Tommy Quango
20002317	Clements	Sandra	01/01/00	2	1	Tommy Quango
20002993	Chappell	Gillian	01/01/00	2	1	Tommy Quango
20003401	Freeman	Chris	01/01/00	1	1	Tommy Quango
20003584	Anderson	Deidre	01/01/00	2	1	Tommy Quango
20003931	Jackson	Florence	01/01/00	2	1	Tommy Quango
20004488	Handley	Joan	01/01/00	2	1	Tommy Quango
20005556	Collins	Martha	01/01/00	1	1	Tommy Quango
20007595	Vickers	Margaret	01/01/00	2	1	Tommy Quango
20007949	Rossitor	Lena	01/01/00	2	1	Tommy Quango
20007958	Armitage	Margaret	01/01/00	2	1	Tommy Quango
20008115	Davies	Melinda	01/01/00	2	1	Tommy Quango
20008492	Connor	Gerry	01/01/00	1	1	Tommy Quango
20008703	Barker	Melinda	01/01/00	2	1	Tommy Quango
20009152	Armitage	Jane	01/01/00	1	1	Tommy Quango
20009292	Soul	Rosalind	01/01/00	1	1	Tommy Quango

SNAP allows both complete and ongoing episodes to be assigned to an AN-SNAP class. For Palliative Care episodes, this requires an epsidoe to be ended and a new episode opened. To do this, end the episode, and record the 'mode of episode end' as '90 day' review'. Open a new episode and record the Reason for Episode Start as '90 Day Review'. New episode start data will then need to be entered. The episode will then be assigned to the previous class or to a new one if their condition has changed. The pattern of episodes for Ongoing cases is reported in the Classes by Episode Report.

For rehabilitation, GEM, psychogeriatric and maintenance episodes, a patient can be reviewed and have an AN-SNAP class assigned without ending the episode. To do this, select the relevant clinical screen ('rehab/GEM', 'MH' or 'Maint/RUG'), click on the 'add' button, and enter a 'review date' for the patient. Relevant clinical data (such as FIM scores) can then be entered against the currently selected episode.

The 90 Day Review Report lists all open episodes which started before or on the From date. The To date must not be specified. The purpose of the 90 Day Review Report is to provide the facility with a list of all open episodes of more than 90 days. If the From date is empty when the report is selected, the date will be calculated by SnapRep using the current date. If a date is present, however, it will not be overwritten so you may need to clear the From date before clicking on the 90 Day Review Report.

11. The FIM™ Motor Change Report

Report:

100% | 1 of 1

FIM™ Motor Change

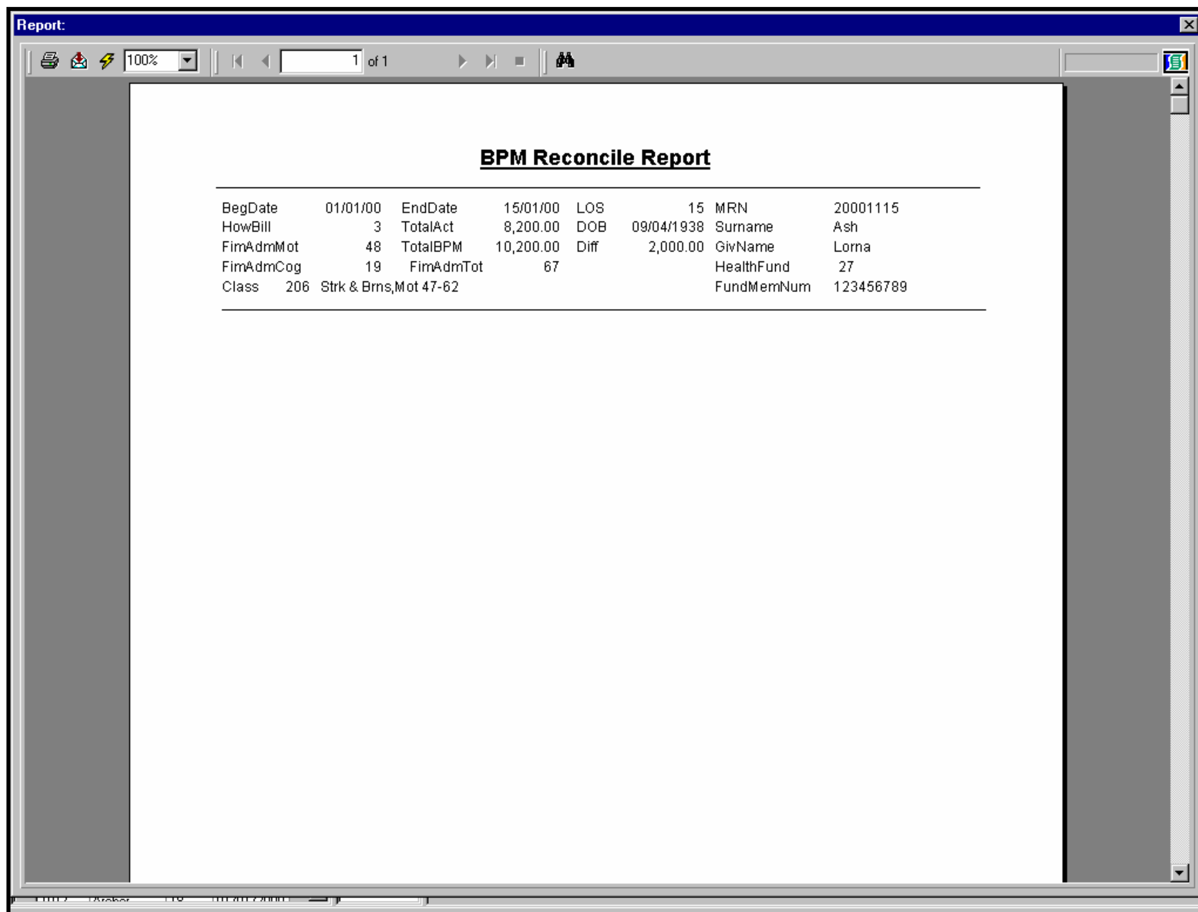
Class	Episode Type	Class Description	Number of Cases	Average Change	National Change	Diff
255	OP/Com Rehab	Assess,Mult	13	1.31	n/a	0.00
256	OP/Com Rehab	Treat,Medical Only	1	0.00	2.64	-2.64
257	OP/Com Rehab	Amp	1	0.00	2.09	-2.09
258	OP/Com Rehab	Brain Injury & MMT	3	-0.67	0.99	-1.66
259	OP/Com Rehab	Spnl Injury	MotorChg.DescAbb (String)	.00	0.95	-0.95
260	OP/Com Rehab	Strk & DD,Sole Practitioner	3	0.00	1.25	-1.25
261	OP/Com Rehab	Strk & DD,Mult,FIM Mot <=80	5	0.40	3.93	-3.53
262	OP/Com Rehab	Strk & DD,Mult,FIM Mot >=81	2	0.00	1.32	-1.32
263	OP/Com Rehab	Oth Impairs,Sole Practitioner	94	0.56	1.06	-0.50
264	OP/Com Rehab	Oth Impairs,Mult,FIM Mot <=80	40	0.90	4.98	-4.08
265	OP/Com Rehab	Oth Impairs,Mult,FIM Mot >=81	16	0.06	0.71	-0.65
453	OP/Com GEM	Assess,Mult	15	0.27	n/a	0.00
455	OP/Com GEM	FIM Mot <=40	25	1.56	-0.14	1.70
456	OP/Com GEM	FIM Mot 41-56	26	0.46	0.22	0.24
457	OP/Com GEM	FIM Mot>=57,Sole Practitioner	150	-0.45	-0.22	-0.23
458	OP/Com GEM	FIM Mot>=57,Mult	164	-1.05	-1.26	0.21
Total			**560**			

This report is similar to the Casemix Report. It shows information on the change in FIMTM Motor Sub-scale score from the beginning to the end of the episode.

This report includes only those episodes classified as Case Types 2 and 4 (Rehabilitation and GEM) and who are seen for other than 'Assessment Only'. It includes only episodes with a FIM Motor score (excluding those episodes with a Barthel score) and includes only episodes with both a Start score and an End score.

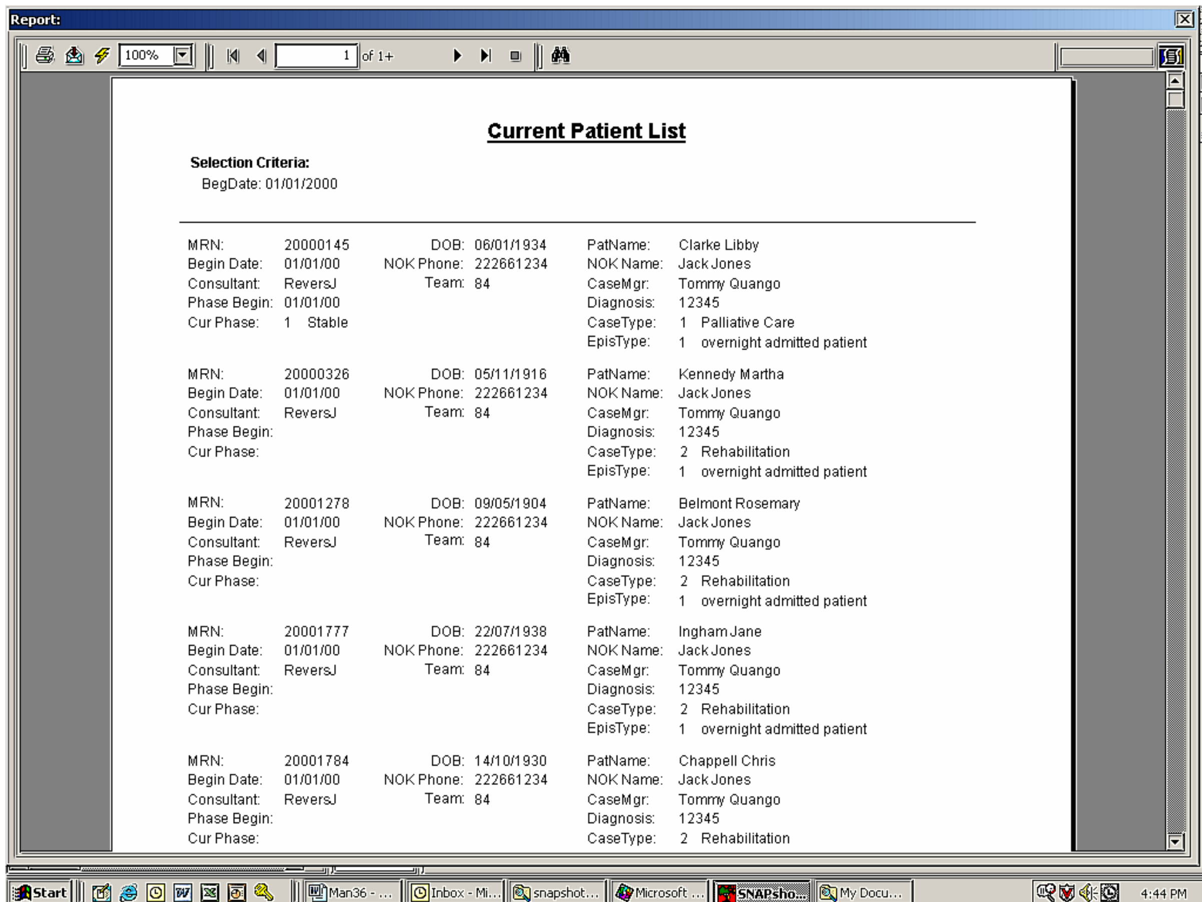
The FIMTM Motor Change Report also includes comparative data on FIMTM Motor change from the 1996 National SNAP study. It displays the average FIMTM Motor change reported in the 1996 study. It also shows the difference between the 1996 national results and your facility results.

12. BPM Reconcile Report



This report shows fields from the PrivRehab data set.

13. Current Patient List Report



Report:

Current Patient List

Selection Criteria:
BegDate: 01/01/2000

MRN: 20000145 DOB: 06/01/1934 PatName: Clarke Libby
Begin Date: 01/01/00 NOK Phone: 222661234 NOK Name: Jack Jones
Consultant: ReversJ Team: 84 CaseMgr: Tommy Quango
Phase Begin: 01/01/00 Diagnosis: 12345
Cur Phase: 1 Stable CaseType: 1 Palliative Care
EpisType: 1 overnight admitted patient

MRN: 20000326 DOB: 05/11/1916 PatName: Kennedy Martha
Begin Date: 01/01/00 NOK Phone: 222661234 NOK Name: Jack Jones
Consultant: ReversJ Team: 84 CaseMgr: Tommy Quango
Phase Begin: Diagnosis: 12345
Cur Phase: CaseType: 2 Rehabilitation
EpisType: 1 overnight admitted patient

MRN: 20001278 DOB: 09/05/1904 PatName: Belmont Rosemary
Begin Date: 01/01/00 NOK Phone: 222661234 NOK Name: Jack Jones
Consultant: ReversJ Team: 84 CaseMgr: Tommy Quango
Phase Begin: Diagnosis: 12345
Cur Phase: CaseType: 2 Rehabilitation
EpisType: 1 overnight admitted patient

MRN: 20001777 DOB: 22/07/1938 PatName: Ingham Jane
Begin Date: 01/01/00 NOK Phone: 222661234 NOK Name: Jack Jones
Consultant: ReversJ Team: 84 CaseMgr: Tommy Quango
Phase Begin: Diagnosis: 12345
Cur Phase: CaseType: 2 Rehabilitation
EpisType: 1 overnight admitted patient

MRN: 20001784 DOB: 14/10/1930 PatName: Chappell Chris
Begin Date: 01/01/00 NOK Phone: 222661234 NOK Name: Jack Jones
Consultant: ReversJ Team: 84 CaseMgr: Tommy Quango
Phase Begin: Diagnosis: 12345
Cur Phase: CaseType: 2 Rehabilitation

This report lists all episodes for patients that were receiving care according to the specified dates. For example, if the Begin Date is 01/01/2001, then all episodes commencing on or before this date will be listed. If an end date of 05/01/2001 is also specified, episodes which concluded on 01-04/01/2001 will not be listed since the patient was not in care during the whole specified period of 1st to the 5th.

It is now possible to list those patients receiving care on or after a specified date by entering the From [Care Date] and checking the On/After BegDate check box.

14. Completed Episode Reason Report

Report:

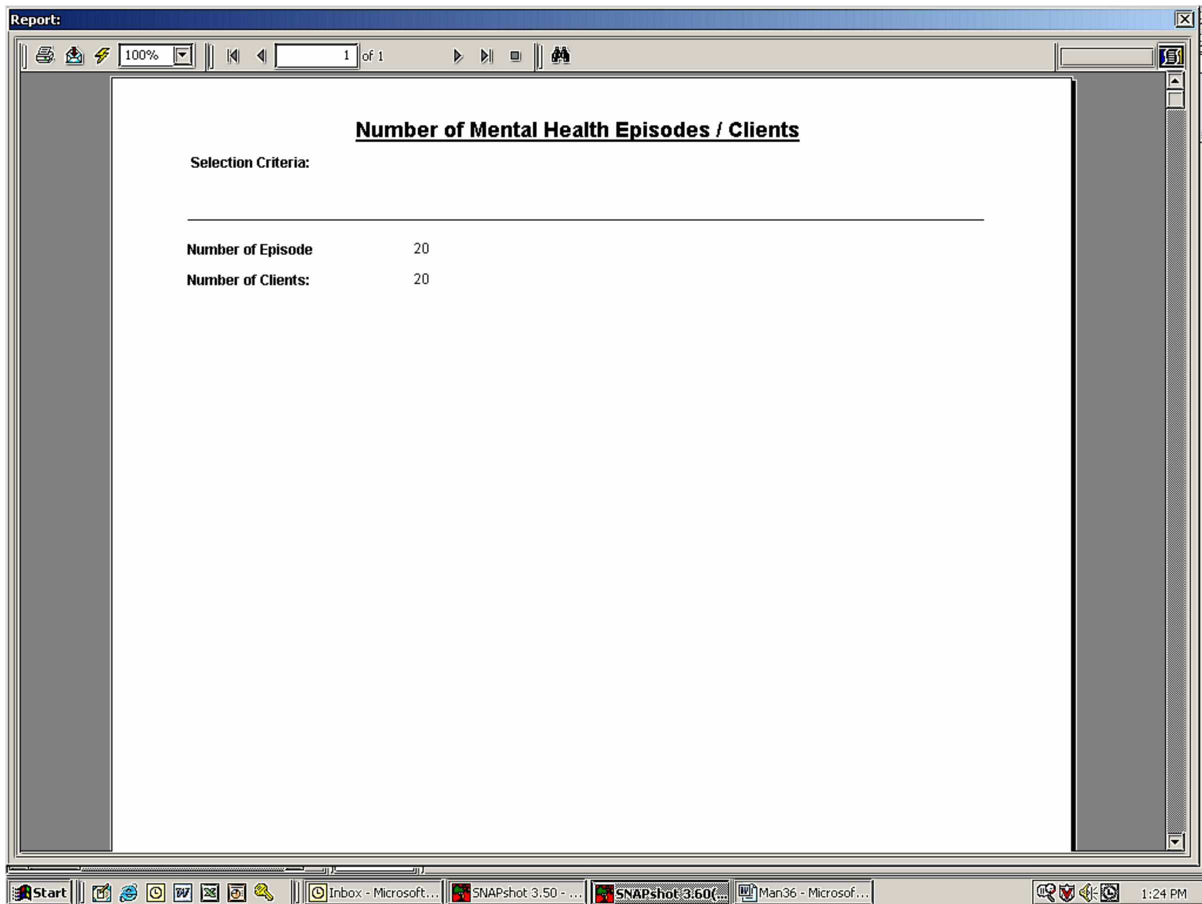
Completed Episode Reason Report

Selection Criteria:

MRN	Patient Name	Begin Date	End Date	Reason for episode end
20000145	Clarke Libby	08/02/01	15/03/01	2 Discharged to interim accommodation
20000326	Kennedy Martha	01/01/00	04/01/00	1 Discharged to usual accommodation
20001278	Belmont Rosemary	01/01/00	05/01/00	1 Discharged to usual accommodation
20001777	Ingham Jane	01/01/00	17/01/00	1 Discharged to usual accommodation
20001784	Chappell Chris	01/01/00	12/01/00	1 Discharged to usual accommodation
20002695	Jensen Kate	01/01/00	08/01/00	1 Discharged to usual accommodation
20004229	Aitchison Jane	01/01/00	10/01/00	1 Discharged to usual accommodation
20004833	Kellett Joan	01/01/00	06/01/00	1 Discharged to usual accommodation
20005249	McCabe Helen	01/01/00	16/01/00	1 Discharged to usual accommodation
20005605	Rossitor Deidre	01/01/00	08/01/00	1 Discharged to usual accommodation
20005629	Shepard Geraldine	01/01/00	04/01/00	1 Discharged to usual accommodation
20006439	Nugent Nora	01/01/00	14/01/00	1 Discharged to usual accommodation
20006489	Knowles Kay	01/01/00	17/01/00	1 Discharged to usual accommodation
20007462	Owens Jane	01/01/00	05/01/00	1 Discharged to usual accommodation
20007612	Gurney Elsie	01/01/00	20/01/00	1 Discharged to usual accommodation
20008519	Reid Lorna	01/01/00	06/01/00	1 Discharged to usual accommodation
20009200	Owens Jackie	01/01/00	04/01/00	1 Discharged to usual accommodation
20009313	Vickers Josie	01/01/00	18/01/00	1 Discharged to usual accommodation
20009489	Kane Kate	01/01/00	12/01/00	1 Discharged to usual accommodation
20009812	Armstrong Gillian	01/01/00	20/01/00	1 Discharged to usual accommodation
334455	Ester Polly	23/09/04	24/10/04	8 Discharge at own risk
55664433	Nylon Dry	13/01/03	02/03/03	2 Discharged to interim accommodation
		12/09/03	29/09/03	1 Discharged to usual accommodation
77886655	Notsure Eym	12/09/04	11/10/04	2 Discharged to interim accommodation

This reports lists all patient episodes meeting the specified criteria for which the episode end date has been recorded.

15. MH:Number of Episodes/Clients Report



This report shows the total number of episodes and clients for mental health patients.

16. HoNOS Change Report

Report:

100% | 1 of 1

Change in HoNOS Score by Episode

MRN	Episode Begin	Patient Name	Change
20008703	01/01/00	Barker Melinda	1
20009264	01/01/00	Yabsley Camille	1
20001115	23/12/99	Ash Lorna	8
20008588	01/01/00	Townsend Josie	1
20009374	01/01/00	Birchall Melinda	1
20002702	01/01/00	Osmond Melinda	1
20008875	01/01/00	Foster Rosemary	1
20004688	01/01/00	Agnew Verona	1
20006139	01/01/00	Sargent Rosalind	1
20001185	14/12/99	Beasley Martha	27
20001659	29/12/99	Sanders Veronica	48
20002625	01/01/00	Eggleton Barbara	1
20005760	01/01/00	Chivers Sandra	1
20001926	01/01/00	Whelan Jackie	1
20003261	01/01/00	Shipton Josie	1
20002303	01/01/00	Lake Vera	1
20008526	01/01/00	Becker Irene	1
20002483	01/01/00	Beggs Melinda	1
20006641	01/01/00	Parr Martha	1
20003169	01/01/00	Jago Jackie	1

This report shows the change in the HoNOS begin and end scores by episode.

17. HoNOSCA Change Report

Report:

100% 1 of 1

Change in HoNOSCA Score by Episode

MRN	Episode Begin	Patient Name	Change
20008703	01/01/00	Barker Melinda	0
20009264	01/01/00	Yabsley Camille	0
20001115	23/12/99	Ash Lorna	0
20008588	01/01/00	Townsend Josie	0
20009374	01/01/00	Birchall Melinda	0
20002702	01/01/00	Osmond Melinda	0
20008875	01/01/00	Foster Rosemary	0
20004688	01/01/00	Agnew Verona	0
20006139	01/01/00	Sargent Rosalind	0
20001185	14/12/99	Beasley Martha	0
20001659	29/12/99	Sanders Veronica	11
20002625	01/01/00	Eggleton Barbara	0
20005760	01/01/00	Chivers Sandra	0
20001926	01/01/00	Whelan Jackie	0
20003261	01/01/00	Shipton Josie	0
20002303	01/01/00	Lake Vera	0
20008526	01/01/00	Becker Irene	0
20002483	01/01/00	Beggs Melinda	0
20006641	01/01/00	Parr Martha	0
20003169	01/01/00	Jago Jackie	56

This report shows the change in the HoNOSCA begin and end scores by episode.

18. LSP Change Report

Report:

Change in LSP Score by Episode

MRN	Episode Begin	Patient Name	Change
20008703	01/01/00	Barker Melinda	0
20009264	01/01/00	Yabsley Camille	0
20001115	23/12/99	Ash Lorna	0
20008588	01/01/00	Townsend Josie	0
20009374	01/01/00	Birchall Melinda	0
20002702	01/01/00	Osmond Melinda	0
20008875	01/01/00	Foster Rosemary	0
20004688	01/01/00	Agnew Verona	0
20006139	01/01/00	Sargent Rosalind	0
20001185	14/12/99	Beasley Martha	0
20001659	29/12/99	Sanders Veronica	48
20002625	01/01/00	Eggleton Barbara	0
20005760	01/01/00	Chivers Sandra	0
20001926	01/01/00	Whelan Jackie	0
20003261	01/01/00	Shipton Josie	0
20002303	01/01/00	Lake Vera	-48
20008526	01/01/00	Becker Irene	12
20002483	01/01/00	Beggs Melinda	0
20006641	01/01/00	Parr Martha	0
20003169	01/01/00	Jago Jackie	3

This report shows the change in the LSP begin and end scores by episode.

19. Database Summary Report

Report:

100% | 1 of 1

Database Summary Report

Item	Number of Records: Total	No End Date	Ungroupable	> 90 Days
CASE TYPE COUNTS:				
1 Palliative Care	5	5		5
2 Rehabilitation	15	14		14
PHASE COUNTS:				
Phase Records	5	5		5
RECORD COUNTS (ALL):				
ACAT	20			
ClassDsc	177			
Drug	20			
DVAAss	20			
DVARev	60			
EpiCIARR	20			
EpiFIM	20			
EpiHACC	20			
Episode	20			
Equip	20			
Facility	9			
GenLUT	3,650			
GenTime	20			
Imag	20			
ImpDet	12			
MHIS	20			
Migrate	7			
Path	20			
Patient	20			
Phase	5			
ProvUnit	9			
PrvRehab	20			
Rehab	20			
Staff	20			
StafTime	101			
SysTab	1			
UserDef	5			

Section 1 shows number of episodes, episodes with no end date and ungroupable episodes by case type.
Section 2 shows number of phases, phases with no end date and ungroupable phases for palliative care records.
Section 3 shows record counts for all record types.
Section 4 shows MRNs for Episodes > 90 Days or No End Date.
Section 5 shows MRNs for Patients without Episodes.
Section 6 shows MRNs for Episodes without occasions of service for Episode Types 2 (LOS >1), 3 and 4.
Section 7 shows DOBs/MRNs for patients with the same date of birth.
Section 8 shows MRNs/DOBs for patients with the same MRN but different DOB.
Section 9 shows Ungroupable records

20. Staff Listing

Report:

Staff Listing

Selection Criteria:

StaffID	Facility	Staff	SessType	StaffName	CC	Desig	HaccAgency
1	X245	1000	1	Daly	3A	RN	12345
2	X245	1001	1	Lockwood	3A	RN	12345
3	X245	1002	1	Perry	3A	RN	12345
4	X245	1003	1	Page	3A	RN	12345
5	X245	1004	1	Birchall	3A	RN	12345
6	X245	1005	1	McCabe	3A	RN	12345
7	X245	1006	1	Ford	3A	RN	12345
8	X245	1007	1	Armitage	3A	RN	12345
9	X245	1008	1	Glover	3A	RN	12345
10	X245	1009	1	Aspinall	3A	RN	12345
11	X245	1010	1	Hampson	3A	RN	12345
12	X245	1011	1	Berg	3A	RN	12345
13	X245	1012	1	Cox	3A	RN	12345
14	X245	1013	1	Taylor	3A	RN	12345
15	X245	1014	1	Lyons	3A	RN	12345
16	X245	1015	1	Lincoln	3A	RN	12345
17	X245	1016	1	Lindsay	3A	RN	12345
18	X245	1017	1	Parr	3A	RN	12345
19	X245	1018	1	Barrett	3A	RN	12345
20	X245	1019	1	Shipton	3A	RN	12345

This report shows the details of staff, including their Cost Centre (CC), Designation and HACC Agency identifier (if any). For an occasion of service to be deemed eligible for inclusion in the HACC extract staff must have a valid HACC agency code and designation.

21. 10 Most Common SNAP Classes

Report:

100% | 1 of 1

10 Most Common SNAP Classes

Selection Criteria:

Class	Description	Number of Episodes	%	Days	ALOS
558	Maintenance & Support, Nursing, age>=37, RUG 4	943	26	15,801	16.76
563	Maintenance & Support, Multidisc., age>=27, RUG 4-11	571	16	10,492	18.37
453	Assess, Multidisciplinary	170	5	279	1.64
552	Assess, Nursing	142	4	190	1.34
999	Ungroupable - see status code	116	3	1,391	11.99
452	Assess, Medical Only	93	3	93	1.00
226	Orthopaedic conditions, motor 14-51	78	2	3,198	41.00
405	Cognition 16-35, motor 51-77	61	2	1,537	25.20
224	Orthopaedic conditions, motor 58-73	58	2	1,396	24.07
404	Cognition 16-35, motor 13-50	56	2	1,621	28.95
	Total	**2,288**	**100**	**35,998**	**15.73**

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22. ACAP MDS V2 Summary Report (1)

Report:

100% | 1 of 1

ACAP MDS V2 Summary Report (1)

Selection Criteria:

BegDate: 01/01/2000 EndDate: 01/01/2000

Patient ID	MRN	Surname	Given Name	Sex	Stat Link Key	Referral Date	Prio-rity	Assessment End Date	Reason
1	20004833	Kellett	Joan	2	eleoa110319272	01/01/00	1	01/01/00	1
2	20005249	McCabe	Helen	2	cCbel160119172	01/01/00	1	01/01/00	1
3	20000145	Clarke	Libby	2	lakib060119342	01/01/00	1	01/01/00	1
4	20006439	Nugent	Nora	2	ugnor291219122	01/01/00	1	01/01/00	1
5	20002695	Jensen	Kate	2	eneat300419182	01/01/00	1	01/01/00	1
6	20000326	Kennedy	Martha	2	enear051119162	01/01/00	1	01/01/00	1
7	20004229	Aitchison	Jane	2	ithan020919402	01/01/00	1	01/01/00	1
8	20009313	Vickers	Josie	2	iceos151019022	01/01/00	1	01/01/00	1
9	20008519	Reid	Lorna	2	ei2or100919092	01/01/00	1	01/01/00	1
10	20009812	Armstrong	Gillian	2	rmtil070519402	01/01/00	1	01/01/00	1
11	20009200	Owens	Jackie	2	wesac240119252	01/01/00	1	01/01/00	1
12	20005629	Shepard	Geraldine	2	heaer311019122	01/01/00	1	01/01/00	1
13	20007462	Owens	Jane	2	wesan15041909	01/01/00	1	01/01/00	1
14	20001278	Belmont	Rosemary	2	eloos090519042	01/01/00	1	01/01/00	1
15	20005605	Rossitor	Deidre	2	osiei250119022	01/01/00	1	01/01/00	1
16	20007612	Gurney	Elsie	2	urels130119262	01/01/00	1	01/01/00	1
17	20009489	Kane	Kate	2	an2at191019032	01/01/00	1	01/01/00	1
18	20006489	Knowles	Kay	2	nolay030619282	01/01/00	1	01/01/00	1
19	20001784	Chappell	Chris	2	haphr141019302	01/01/00	1	01/01/00	1
20	20001777	Ingham	Jane	2	ngaan220719382	01/01/00	1	01/01/00	1

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This report provides a summary of the records eligible to be selected for inclusion in the ACAP MDS V2 extract.

It allows ACATs to check that all expected records will be extracted, you should run both of the two exception reports to identify client records that won’t be successfully extracted because there is incorrect or missing data.

23. ACAP MDS V2 Exception Report (2)

Report:

ACAP MDS V2 Exception Report (2)

Selection Criteria:

BegDate: 01/06/1999 EndDate: 01/06/2000

Patient ID	MRN	Surname	Given Name	Sex	Stat Link Key	DOB	Referral Date	Prio-rity	Inc	Assessmt Date	End Reason
21	4000302	mouse	minnie	2	ouein120119452	12/01/1945	02/01/00	1	2	03/01/00	
23	990088	duck	donald	1	uc2on010119971	01/01/1997			1	04/01/00	

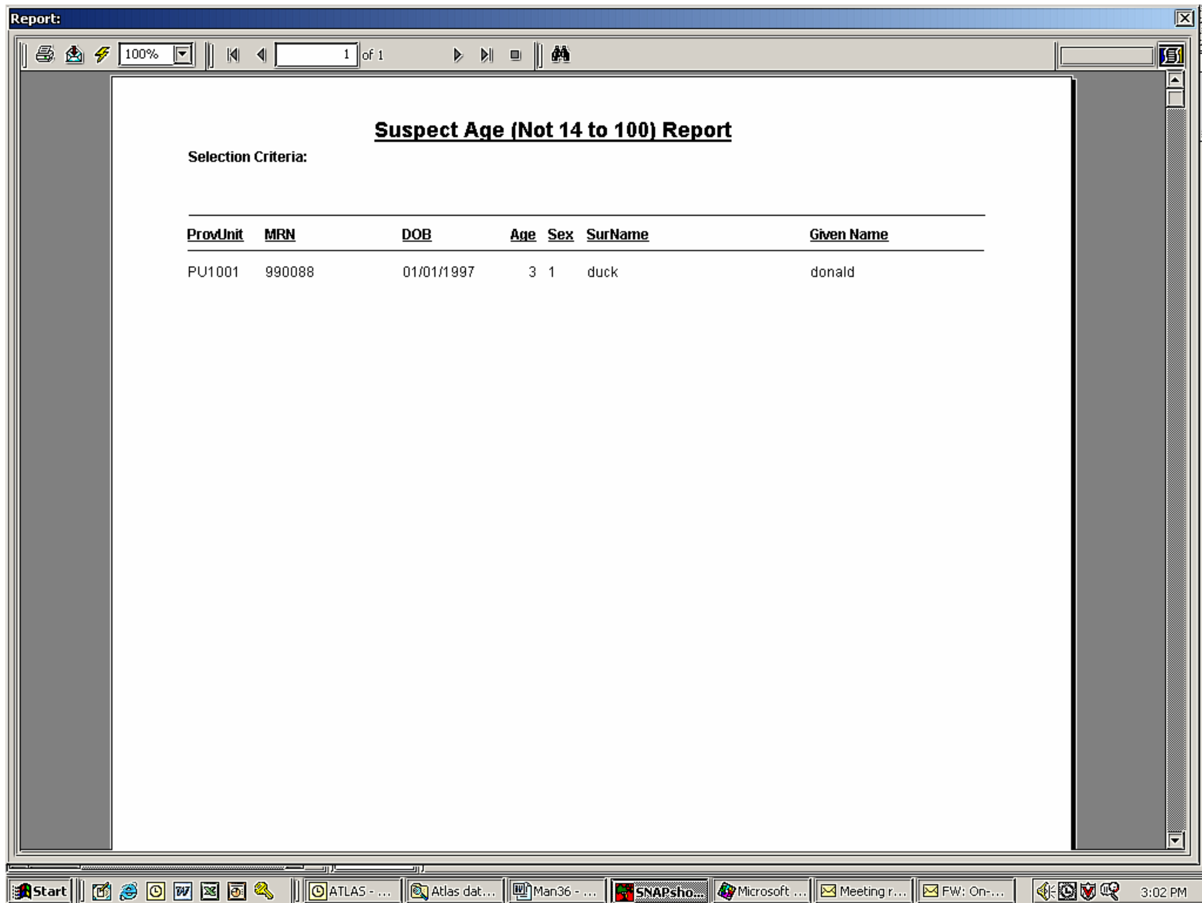
This exception report provides a summary of the records ineligible to be selected for inclusion in the ACAP MDS V2 extract. Whilst there is a valid Assessment End Date there is either incorrect or missing mandatory data items, or the ‘Include in ACAP MDS’ value in the Episode table has not been set to 1 (Yes).

It allows ACATs to check incorrect records and to correct them so that they will be extracted, you should run both of the two exception reports to identify client records that won’t be successfully extracted because there is incorrect or missing data.

24. ACAP MDS V2 Exception Report (3)

An example of this report has not been provided.

25. Suspect Age (not 14-100) Report



Suspect Age (Not 14 to 100) Report

Selection Criteria:

ProvUnit	MRN	DOB	Age	Sex	SurName	Given Name
PU1001	990088	01/01/1997	3	1	duck	donald

This report shows clients with ages which don't fall in the expected age range, whilst these may be correct it could indicate that an incorrect DOB has been entered, 2001 rather than 1901 for instance.

26. Cost Weight Report

Summary of cost weights (available for information)

Selection Criteria:
FromDate: 01/07/2004 (EndDate>=)   ToDate: 30/06/2005 (EndDate<=)

Class	Description	CaseType	EpisType	Cases	Epis Wgt	Inlier PD	Outlier PD	Total CW
	Case Type	1						
101	Stb,R 4	1	1	28	2.11	5.51	5.45	13.07
102	Stb,R 5-17	1	1	18	3.69	7.34	1.71	12.74
104	UnStb,R 4-17	1	1	159	36.17	49.31	23.79	109.27
105	UnStb,R 18	1	1	21	4.86	3.52	7.48	15.86
106	Deter,R 4-17	1	1	67	16.22	9.84	6.21	32.27
107	Deter,R 18,A <=71	1	1	12	3.52	1.57	0.00	5.08
108	Deter,R 18,A >=72	1	1	32	6.19	2.97	0.00	9.16
109	Term,R 4-16	1	1	13	2.68	1.70	2.31	6.68
110	Term,R 17-18	1	1	65	10.97	4.83	0.54	16.34
111	Bereav	1	1	34	2.71	1.27	0.00	3.98
161	UnStb,Nurs,R<=14,A>=60	1	2	1	0.00	0.00	0.00	0.00
163	UnStb,Nurs,R>=15	1	2	1	0.00	0.00	0.00	0.00
164	Deter,Mult,S <=10	1	2	1	0.00	0.00	0.00	0.00
169	Term,Mult	1	2	1	0.00	0.00	0.00	0.00
999	Ungroupable	1	1	1	0.00	0.00	0.00	0.00
				454				224.44
	Case Type	2						
204	Strk/Brns,Mot 63-91,Cog 20-35	2	1	5	1.28	3.43	0.55	5.27
205	Strk & Brns,Mot 63-91,Cog 5-19	2	1	5	2.78	3.94	2.76	9.48
206	Strk & Brns,Mot 47-62	2	1	6	2.52	6.91	0.06	9.49
207	Strk & Brns,Mot 14-46,A>=75	2	1	13	6.86	16.92	8.31	32.09
208	Strk & Brns,Mot 14-46,A<=74	2	1	6	3.77	7.29	1.50	12.56
209	Brain Dysfnc,Mot 71-91	2	1	1	0.32	0.47	0.00	0.79
210	Brain Dysfnc,Mot 29-70,A>=55	2	1	3	0.73	2.29	1.87	4.89
211	Brain Dysfnc,Mot 29-70,A<=54	2	1	1	0.00	0.00	0.20	0.20
213	Neurological,Mot 74-91	2	1	1	0.15	0.34	0.00	0.49
214	Neurological,Mot 41-73	2	1	5	1.84	3.86	0.00	5.70
215	Neurological,Mot 14-40	2	1	4	2.70	5.55	1.95	10.20
217	Spnl Cord Dysfnc,Mot 47-80	2	1	2	0.55	1.14	0.77	2.46
219	Amp of limb,Mot 66-91	2	1	5	0.63	5.51	3.46	9.60
220	Amp of limb,Mot 47-65	2	1	3	1.54	5.43	5.32	12.29
221	Amp of limb,Mot 14-46	2	1	4	1.46	2.97	1.75	6.18
222	Pain Syndromes, motor>=14	2	1	7	1.11	4.92	0.00	6.02
223	Orthpaed Conds,Mot 74-91	2	1	7	0.43	2.12	0.29	2.84
224	Orthpaed Conds,Mot 58-73	2	1	23	3.94	14.46	0.42	18.82
225	Orthpaed Conds,Mot 52-57	2	1	15	3.84	12.42	1.78	18.05
226	Orthpaed Conds,Mot 14-51	2	1	29	10.62	28.07	10.18	48.87
227	Cardiac, motor>=14	2	1	3	0.83	2.59	0.06	3.47
228	Major Mult Trauma, motor>=14	2	1	3	0.64	0.81	1.15	2.59
229	Oth Impairs,Mot 67-91	2	1	8	0.70	3.14	0.52	4.35
230	Oth Impairs,Mot 53-66	2	1	21	5.67	16.24	0.98	22.89
231	Oth Impairs,Mot 25-52	2	1	20	7.41	18.61	3.95	29.97
232	Oth Impairs,Mot 14-24	2	1	2	0.50	1.53	0.79	2.81
				202				282.38
	Case Type	5						

This report shows cost weights by case type.

27. Missing AROC Fields Report

Report:

Missing AROC Fields Report

Selection Criteria:

Facility	MRN	End Date	Missing Fields	Field List
X245	123	01/26/2008	23	Sex, uAccom, PriorSupport, FundSource, HealthFund, EmpStat, AdmitClass, ImpairTrauma, RelAcuteDate, OnsetTime, DischargeTo, EndSupport, Impair, ExistComorb, Comorb1, AdmEat, AdmComp, DisEat, DisComp, DateEntBeg, DateEntEnd, DateRehabPlan, DateDischPl

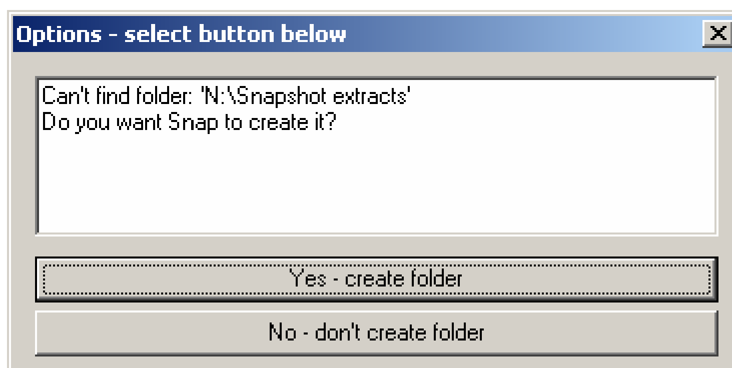
This report shows a list of missing AROC dataset items for episodes with an end date within the last 12 months.

Extracts

Extract Folder

You need to specify the folder in which to write the data extract files. This folder can be different to the SNAPshot installation directory. It can even be on a different computer, on a server for instance.

If the folder does not exist, you will be asked if you want it to be created.



51. VRP Episode/Patient (Extract)

This option writes two tables into the currently selected report database which by default is c:\SnapShot\RepDB.mdb, typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.

It is also used for the Private Rehabilitation Study and cannot be displayed in the Preview screen as is the case for other reports.

52. ACAT:AGS MDS (Extract)

This 'report' produces a comma-separated value file according to the ACAT specification.

The file ACATMDS.TXT is written to the folder which contains the RepDB.mdb file – typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.

This extract has been replaced by MDS 2 and should only be produced on request by the Evaluation Unit.

53. ACAT:AGS MDS 2 (Extract)

This 'report' produces a comma-separated value file according to the ACAT specification.

The file ACATMDS.TXT is written to the folder which contains the RepDB.mdb file – typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.

54. FIM Listing (Extract)

This ‘report’ produces a comma-separated value file containing the following fields:

Field	Description	Example Values
FundName	Health Fund Name	Federation Health
FacName	Facility Name	St Luke's
MRN	Medical Record No.	20000116
BegDate	Admission Date	01/01/2000
EndDate	Discharge Date	02/01/2000
GivName	Given Name	Rosemary
SurName	Surname	Cox
DOB	Date of Birth	14/07/1921
Sex	Sex	2
AdmEat	Adm: Eating	1
AdmGroom	Adm: Grooming	2
AdmBath	Adm: Bathing	3
AdmUpper	Adm: Dressing upper body	4
AdmLower	Adm: Dressing lower body	5
AdmToilet	Adm: Toileting	6
AdmBladder	Adm: Bladder management	7
AdmBowel	Adm: Bowel management	1
AdmXfer	Adm: Transfer - bed/chair	2
AdmXfrToil	Adm: Transfer - Toilet	3
AdmTub	Adm: Transfer - Tub	4
AdmWalk	Adm: Walk/wheel chair	5
AdmStair	Adm: Stairs	6
AdmComp	Adm: Comprehension	7
AdmExp	Adm: Expression	1
AdmSocial	Adm: Social interaction	2
AdmProb	Adm: Problem solving	3
AdmMemory	Adm: Memory	4
DisEat	Dis: Eating	7
DisGroom	Dis: Grooming	6
DisBath	Dis: Bathing	5
DisUpper	Dis: Dressing upper body	4
DisLower	Dis: Dressing lower body	3
DisToilet	Dis: Toileting	2
DisBladder	Dis: Bladder management	1
DisBowel	Dis: Bowel management	7
DisXfer	Dis: Transfer - bed/chair	6
DisXfrToil	Dis: Transfer - Toilet	5
DisTub	Dis: Transfer - Tub	4
DisWalk	Dis: Walk/wheel chair	3
DisStair	Dis: Stairs	2
DisComp	Dis: Comprehension	1
DisExp	Dis: Expression	7
DisSocial	Dis: Social interaction	6
DisProb	Dis: Problem solving	5
DisMemory	Dis: Memory	4

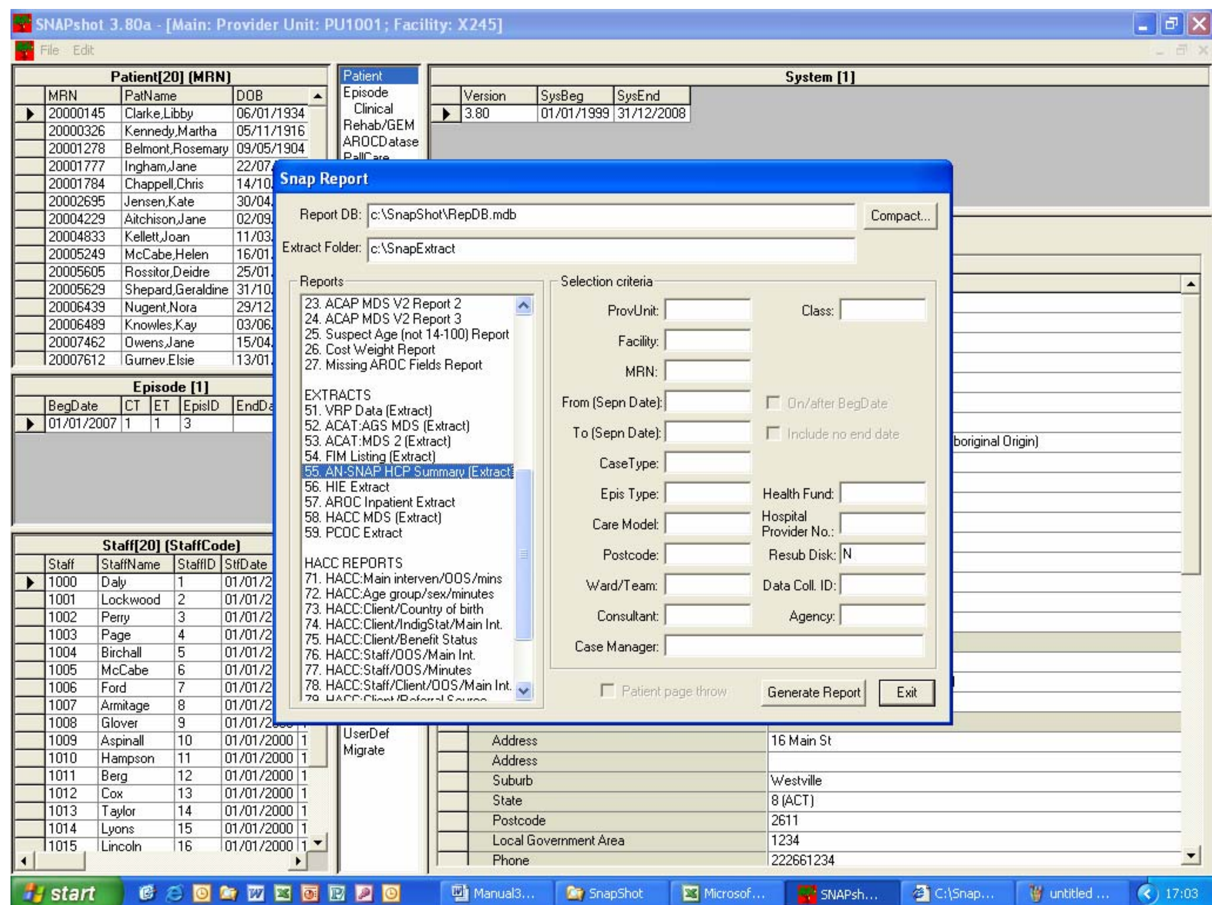
The file FIMExt.TXT is written to the folder which contains the RepDB.mdb file – typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.

55. AN-SNAP HCP Summary (Extract)

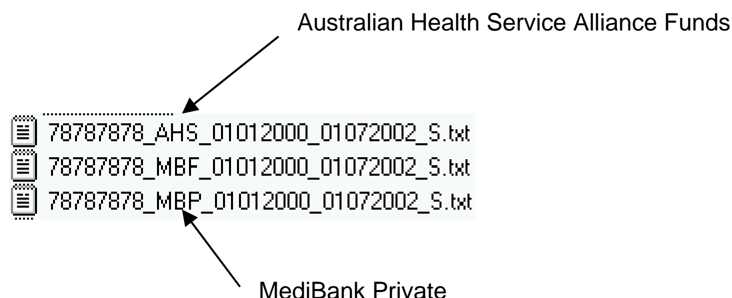
<u>For private facilities</u>

This report produces a comma-separated value file that comprises the AN-SNAP items to be reported under the Hospital Casemix Protocol.

To display the HCP extract dialog screen, press Shift-F8 whilst positioned on any of the data lists. Select item 55. AN-SNAP HCP Summary (Extract) and enter the value for the Hospital Provider No. and appropriate 'from' and 'to' dates (typically a calendar month), then press Generate Report. This produces a set of text files, one extract for each non Australian Health Service Alliance fund, and one extract for all Australian Health Service Alliance funds. The files are written to the folder which contains the RepDB.mdb file – typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.



The naming convention for the HCP extracts is as follows:

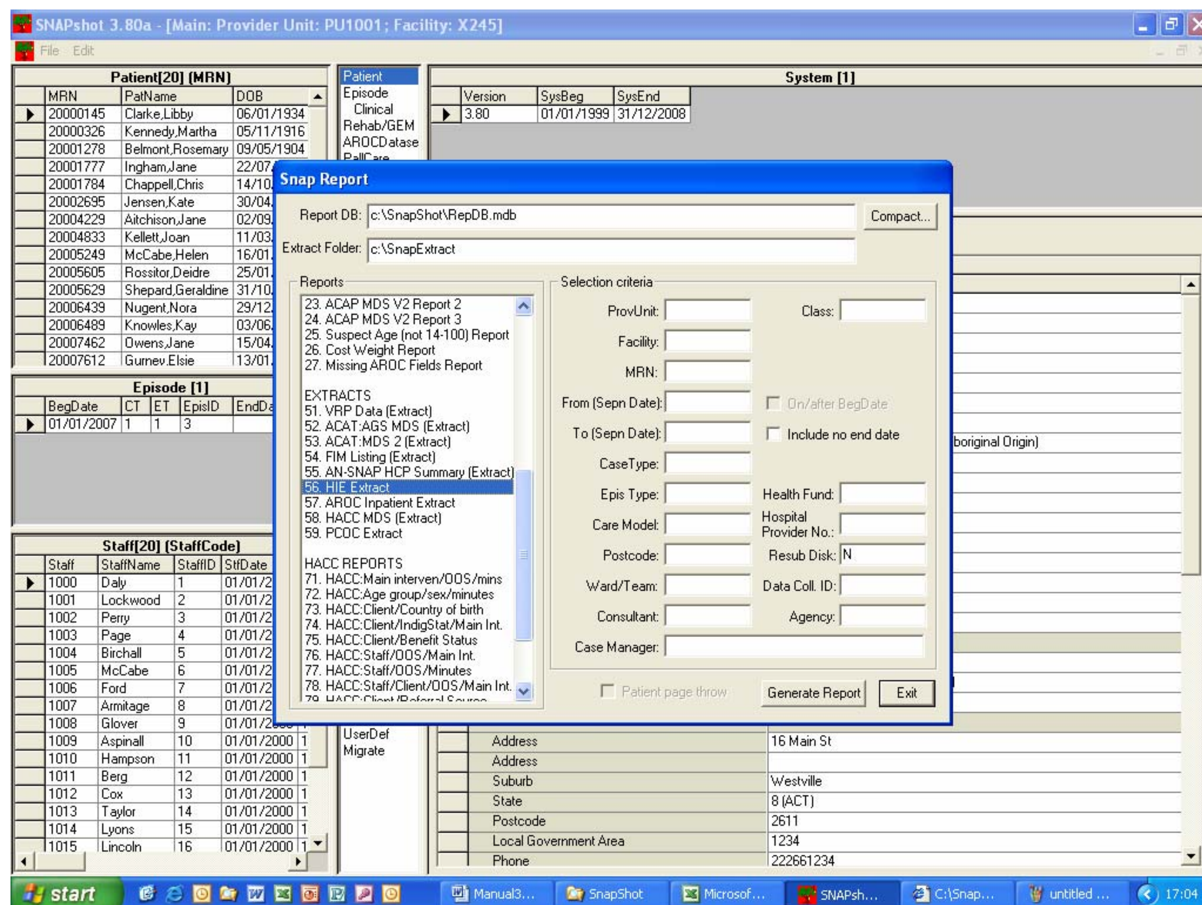


This can be broken down as follows: [Provider No]_[Fund]_[DteFrom]_[DteTo].txt

It is these files that have to be forwarded onto the relevant health funds.

The file HCPExt.txt is written to the folder which contains the RepDB.mdb file – typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.

56. HIE Extract



Select 56. HIE Extract and enter appropriate values for Facility, and From [Sepn Date] and To [Sepn Date] and then click Generate Report. Do not enter a value for ProvUnit.

This produces a set of 9 extract files with names in the format of –
N999_snapepifim_20yymmdd
N999_snapepis_20yymmdd
N999_snapfac_20yymmdd
N999_snapmhis_20yymmdd
N999_snaphase_20yymmdd
N999_snapprov_20yymmdd
N999_snaprehab_20yymmdd
N999_snapstaff_20yymmdd
N999_snapstime_20yymmdd

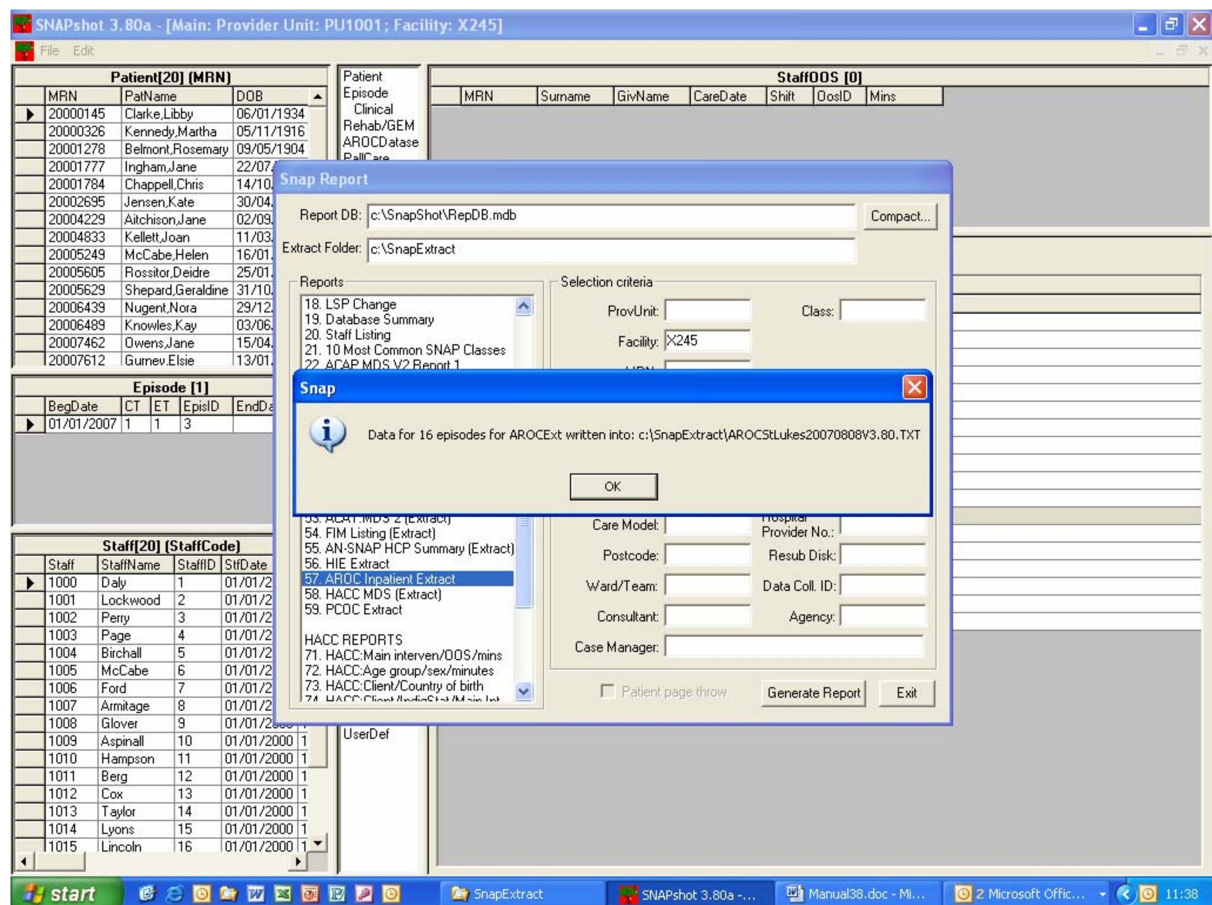
Where N999 is the facility number and 20yymmdd is the To [Sepn date].
The files are written to the folder which contains the RepDB.mdb file – typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.

57. AROC Extract

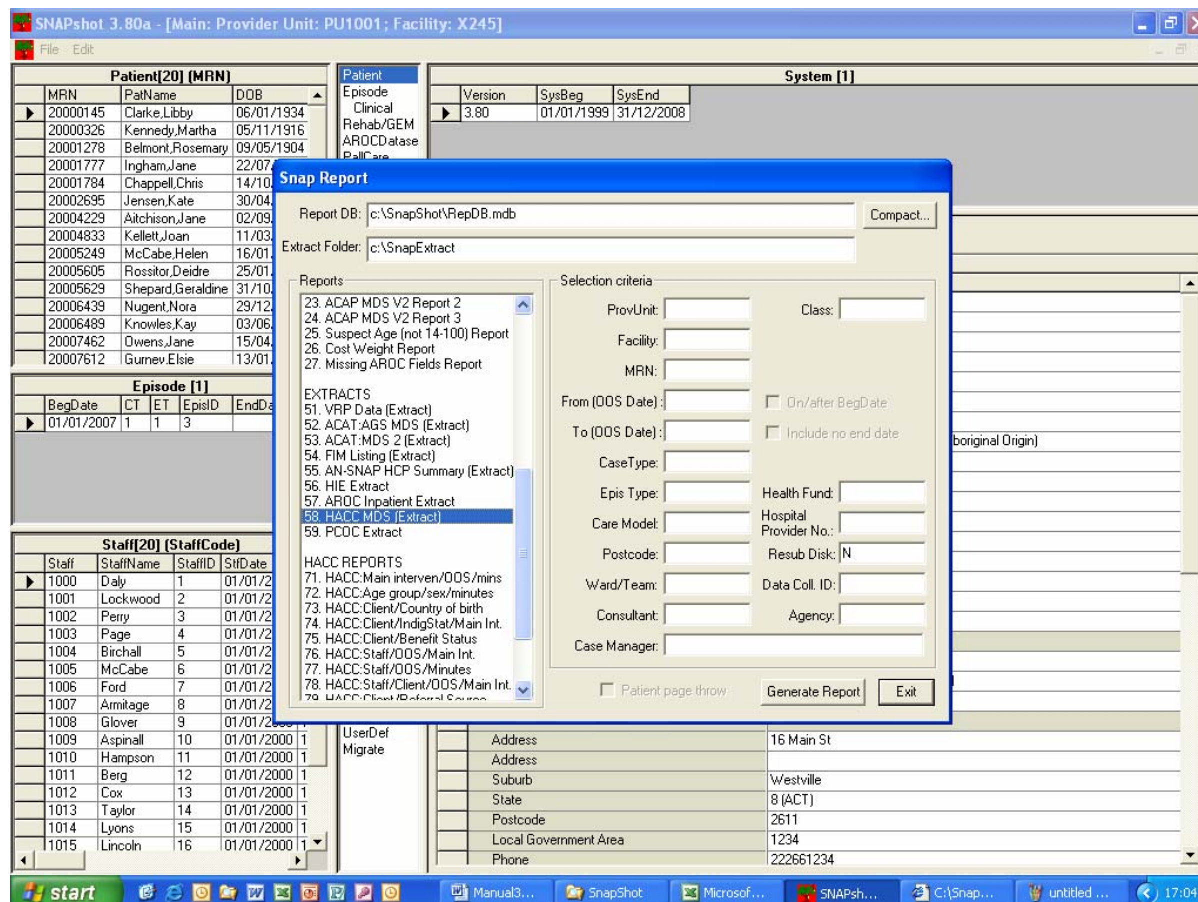
This report produces a fixed format ASCII file that comprises the version 3 AROC data set to be submitted to AROC. To create the AROC Inpatient Extract, press Shift-F8 whilst positioned on any of the data lists in SNAPshot. Select item 57. AROC Inpatient Extract from the list of extracts, enter your Facility Code and then press Generate Report. This produces a text file named "AROCFacilityNameYYYYMMDDV3.8x.txt" where facility-name is the name as entered in the Facility screen and YYYMMDD is today's date (the day the extract is created). <u>Do not change the name of the file created by SNAPshot</u>. Please note that 'from' and 'to' dates should not be selected when creating the AROC Inpatient Extract.

The AROC Inpatient Extract text file is written into the extract folder. The default location of the extract folder is c:\SnapExtract, however, you can specify another folder which can be on any computer including other than the one SNAPshot is installed (for further information please refer to either the SNAPshot V3.8 Manual or to 3.2.3 above).

The file can now be uploaded to AROC via AROC Online Services (AOS) – *note that the extract contains 'client MRN' and 'date of birth', but does not include any other identifying data items*.



58. HACC MDS [Extract]



It is necessary to enter the appropriate data range (this is usually a three month period), a valid HACC Agency code (it is necessary to repeat the extract for each HACC funded program within each facility) and a Data Collection ID, as in the example above.

This produces a comma-separated value file named
Agency_YYYYQ.txt

Where Agency is the HACC Agency code associated with the facility (this must be associated with Staff in the facility via the Staff screen, and these staff must have a valid designation). YYYY is the year taken from the From [Sepn date] and Q is the quarter of the reporting period.

This report will only include occasions of service that have had a ‘yes’ to ‘include in HACC MDS Extract’ entered in the ‘Episode’ screen, and where the occasion of service has been provided by a staff member whose SNAPshot record contains a valid designation and HACC agency code.

The file is written to the folder which contains the RepDB.mdb file – typically the folder: c:\Snapshot, however, you can specify another folder which can even be on a computer other than the one SNAPshot is installed on.

59. PCOC Extract

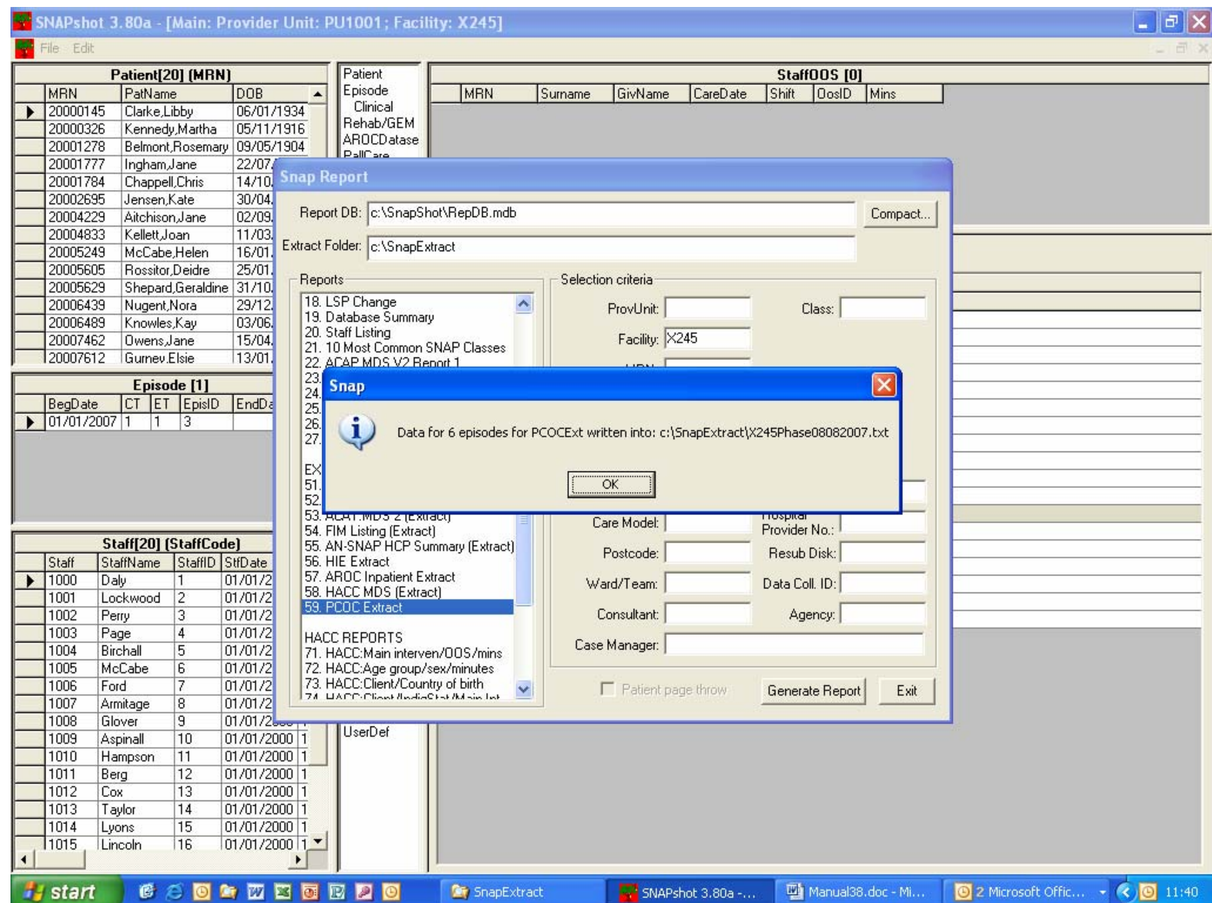
This extract produces three fixed format ASCII files that comprise the Version 2 PCOC dataset to be submitted to PCOC. To create the PCOC Extract, press Shift-F8 whilst positioned on any of the data lists in SNAPshot. Select Extract 59 'PCOC Extract' from the list of extracts, enter your Facility Code and then press Generate Report. This will generate a message that reads: 'Data for XX episodes for PCOCExt written into: C:\SnapExtract\FacilityNamePhaseDDMMYYYY.txt.' However, please note that three files will be generated as follows:

- FacilityNamePatientDDMMYYYY.txt
- FacilityNameEpisodeDDMMYYYY.txt
- FacilityNamePhaseDDMMYYYY.txt

FacilityName is the name as entered in the Facility screen and DDMMYYYY is today's date (the day the extract is created). Do not change the name of the file created by SNAPshot.

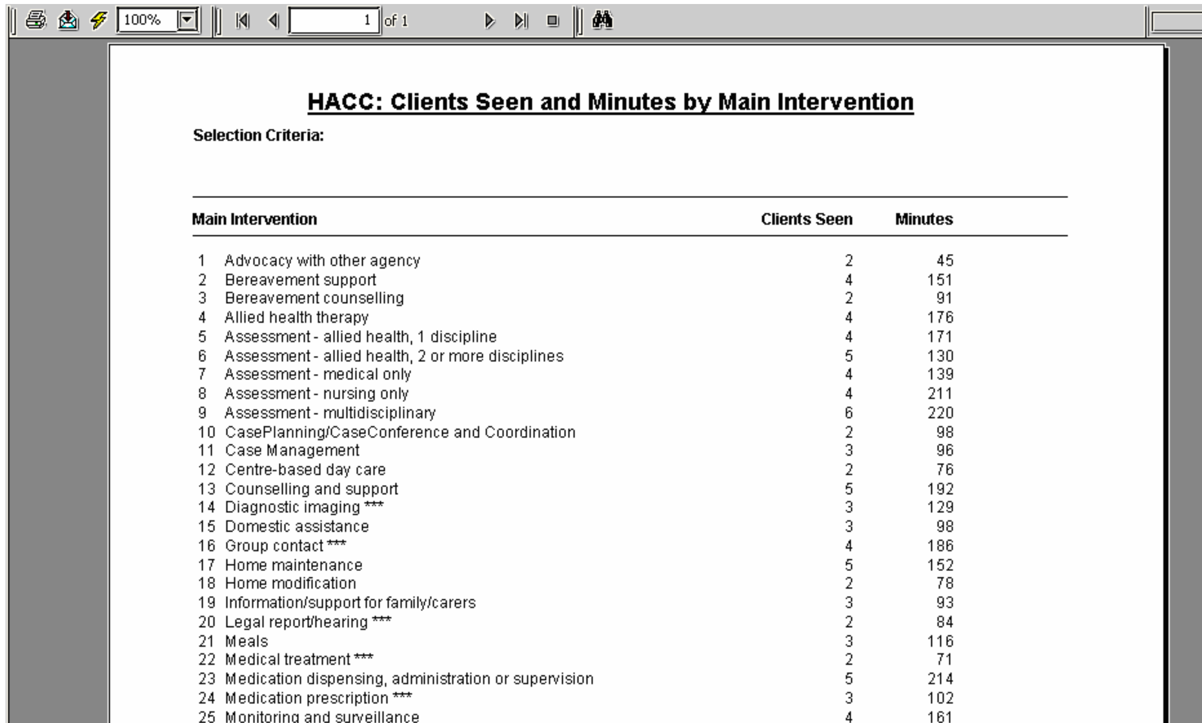
Please note that 'from' and 'to' dates should not be selected when creating the PCOC Extract.

The PCOC Extract text file is written into the extract folder. The default location of the extract folder is c:\SnapExtract, however, you can specify another folder which can be on any computer including other than the one SNAPshot is installed (for further information please refer to either the SNAPshot V3.8 Manual or to 3.2.3 above). The file can now be emailed to PCOC at PCOC@uow.edu.au – *note that the extract contains 'client MRN' and 'date of birth', but does not include any other identifying data items.*



HACC Reports

71. HACC:Main Interven/OOS/Mins Report



HACC: Clients Seen and Minutes by Main Intervention

Selection Criteria:

Main Intervention	Clients Seen	Minutes
1 Advocacy with other agency	2	45
2 Bereavement support	4	151
3 Bereavement counselling	2	91
4 Allied health therapy	4	176
5 Assessment - allied health, 1 discipline	4	171
6 Assessment - allied health, 2 or more disciplines	5	130
7 Assessment - medical only	4	139
8 Assessment - nursing only	4	211
9 Assessment - multidisciplinary	6	220
10 CasePlanning/CaseConference and Coordination	2	98
11 Case Management	3	96
12 Centre-based day care	2	76
13 Counselling and support	5	192
14 Diagnostic imaging ***	3	129
15 Domestic assistance	3	98
16 Group contact ***	4	186
17 Home maintenance	5	152
18 Home modification	2	78
19 Information/support for family/carers	3	93
20 Legal report/hearing ***	2	84
21 Meals	3	116
22 Medical treatment ***	2	71
23 Medication dispensing, administration or supervision	5	214
24 Medication prescription ***	3	102
25 Monitoring and surveillance	4	161

This report shows the number of OOS and total minutes by main intervention code. This report will only include occasions of service that have had a ‘yes’ to ‘include in HACC MDS Extract’ entered in the ‘Episode’ screen.

72. HACC:Age Group/Sex/Minutes Report

Report:

100% | 1 of 1

HACC: Minutes by Age Group by Sex

Age Group	Sex	Minutes
36-64	Female	676
65-79	Female	1,148
80+	Female	2,023
Total		**3,847**

This report shows number of minutes by sex by age group for the following age group ranges: 0-14; 15-36; 36-64; 65-79; 80+. This report will only include occasions of service that have had a ‘yes’ to ‘include in HACC MDS Extract’ entered in the ‘Episode’ Screen.

73. HACC:Client/Country of Birth Report

Report:

HACC: Number of Clients by Country of Birth

Country	Name	Number of Clients	Percent
1101	Australia	15	75.00 %
2102	England	1	5.00 %
2303	France	1	5.00 %
3213	Yugoslavia, Federal Republic of	1	5.00 %
6101	China (excludes SARs and Taiwan Province)	1	5.00 %
8104	United States of America	1	5.00 %
	Total	**20**	

This report shows the number of client episodes and percentage by country of birth.

74. HACC:Client/IndigStat/Main Intervention Report

Report:

100% | 1 of 1

Number of Clients by Indigenous Status by Main Interventi

Indigenous Status		Main Intervention		Client Number	Perc
2	TSI/not Aborig Origin	1	Advocacy with other agency	3	3.0
2	TSI/not Aborig Origin	2	Bereavement support	1	1.0
2	TSI/not Aborig Origin	3	Bereavement counselling	1	1.0
2	TSI/not Aborig Origin	5	Assessment - allied health, 1 discipline	4	4.0
2	TSI/not Aborig Origin	6	Assessment - allied health, 2 or more disciplines	5	5.1
2	TSI/not Aborig Origin	7	Assessment - medical only	8	8.1
2	TSI/not Aborig Origin	9	Assessment - multidisciplinary	2	2.0
2	TSI/not Aborig Origin	11	Case Management	6	6.1
2	TSI/not Aborig Origin	13	Counselling and support	1	1.0
2	TSI/not Aborig Origin	14	Diagnostic imaging ***	3	3.0
2	TSI/not Aborig Origin	15	Domestic assistance	5	5.1
2	TSI/not Aborig Origin	16	Group contact ***	4	4.0
2	TSI/not Aborig Origin	17	Home maintenance	3	3.0
2	TSI/not Aborig Origin	18	Home modification	3	3.0
2	TSI/not Aborig Origin	19	Information/support for family/carers	2	2.0
2	TSI/not Aborig Origin	20	Legal report/hearing ***	1	1.0
2	TSI/not Aborig Origin	21	Meals	2	2.0
2	TSI/not Aborig Origin	22	Medical treatment ***	1	1.0
2	TSI/not Aborig Origin	23	Medication dispensing, administration or supervision	3	3.0
2	TSI/not Aborig Origin	24	Medication prescription ***	1	1.0
2	TSI/not Aborig Origin	25	Monitoring and surveillance	3	3.0
2	TSI/not Aborig Origin	26	Nursing - technical intervention not elsewhere specified	5	5.1
2	TSI/not Aborig Origin	27	Other food services	1	1.0
2	TSI/not Aborig Origin	28	Pathology testing ***	3	3.0
2	TSI/not Aborig Origin	29	Patient education	5	5.1

This report shows the number of OOS and percentage by main intervention and indigenous status (codes 1 to 3 only).

75. HACC:Client/Benefit Status Report

Report:

100% | 1 of 1

Number of Clients by Benefit Status

	Benefit Status	Clients Number	Clients Percent
1	Aged pension	5	25.00 %
2	Veterans Affairs Pension	4	20.00 %
3	Disability Support Pension	3	15.00 %
4	Carer Payment	2	10.00 %
5	Unemployment Pension	2	10.00 %
6	Other gov pension or benefit	2	10.00 %
7	No gov pension or benefit	1	5.00 %
99	Not stated/inadequately described	1	5.00 %
	Total	**20**	

This report shows the number of client episodes and percentage by benefit status.

76. HACC:Staff/OOS/Main Intervention Report

Report:

100% | 1 of 1+

OOS by Staff Member by Main Intervention

Staff Member		Main Intervention	OOS	Minutes
1004	Whelan	Advocacy with other agency ***	2	98
1004	Whelan	Assessment - allied health, 1 discipline	3	78
1004	Whelan	Assessment - allied health, 2 or more disciplines	1	20
1004	Whelan	Counselling and support	1	59
1004	Whelan	Diagnostic imaging ***	1	37
1004	Whelan	Home modification	2	71
1004	Whelan	Meals	1	23
1004	Whelan	Medical treatment ***	1	57
1004	Whelan	Medication dispensing, administration or supervision	1	60
1004	Whelan	Nursing - technical intervention not elsewhere specified	1	23
1004	Whelan	Other food services	1	51
1004	Whelan	Patient education	2	81
1004	Whelan	Personal Care Including Assist With Persoanl Care	1	42
1004	Whelan	Provision of linen	1	51
1004	Whelan	Referral to other agency ***	1	55
1005	Perry	Advocacy with other agency ***	2	95
1005	Perry	Allied health therapy	2	92
1005	Perry	Assessment - allied health, 1 discipline	1	28
1005	Perry	Assessment - medical only	1	46
1005	Perry	Centre-based day care	1	59
1005	Perry	Counselling and support	1	58
1005	Perry	Domestic assistance	1	59
1005	Perry	Group contact ***	1	58
1005	Perry	Home maintenance	1	23
1005	Perry	Home modification	1	51
1005	Perry	Medication dispensing, administration or supervision	1	37
1005	Perry	Nursing - technical intervention not elsewhere specified	1	57
1005	Perry	Pathology testing ***	1	35
1005	Perry	Patient education	1	25
1005	Perry	Personal Care Including Assist With Persoanl Care	1	24
1005	Perry	Provision of aids or appliances	1	56
1005	Perry	Social support	1	56
1005	Perry	Transport	1	59
1006	Chivers	Advocacy with other agency ***	1	53
1006	Chivers	Allied health therapy	1	31
1006	Chivers	Assessment - allied health, 1 discipline	1	25
1006	Chivers	Assessment - allied health, 2 or more disciplines	3	138
1006	Chivers	Assessment - medical only	1	20
1006	Chivers	Assessment - multidisciplinary	2	102
1006	Chivers	Bereavement counselling	2	97

This report shows the number of OOS and minutes by main intervention by staff member. This report will only include occasions of service that have had a ‘yes’ to ‘include in HACC MDS Extract’ entered in the ‘Episode’ screen.

77. HACC:Staff/OOS/Minutes Report

Report:

100% 1 of 1

OOS and Minutes by Staff Member

Staff Member		OOS	Minutes
1004	Whelan	20	806
1005	Perry	20	918
1006	Chivers	20	814
1007	Lowe	16	541
1008	Barton	10	318
1009	Wheeler	6	225
1010	Birchall	4	143
1011	Woodford	2	82
Total		**98**	**3,847**

This report shows number of OOS and minutes by staff member. This report will only include occasions of service that have had a 'yes' to 'include in HACC MDS Extract' entered in the 'Episode' screen.

78. HACC:Staff/Client/OOS/Main Intervention Report

Report:

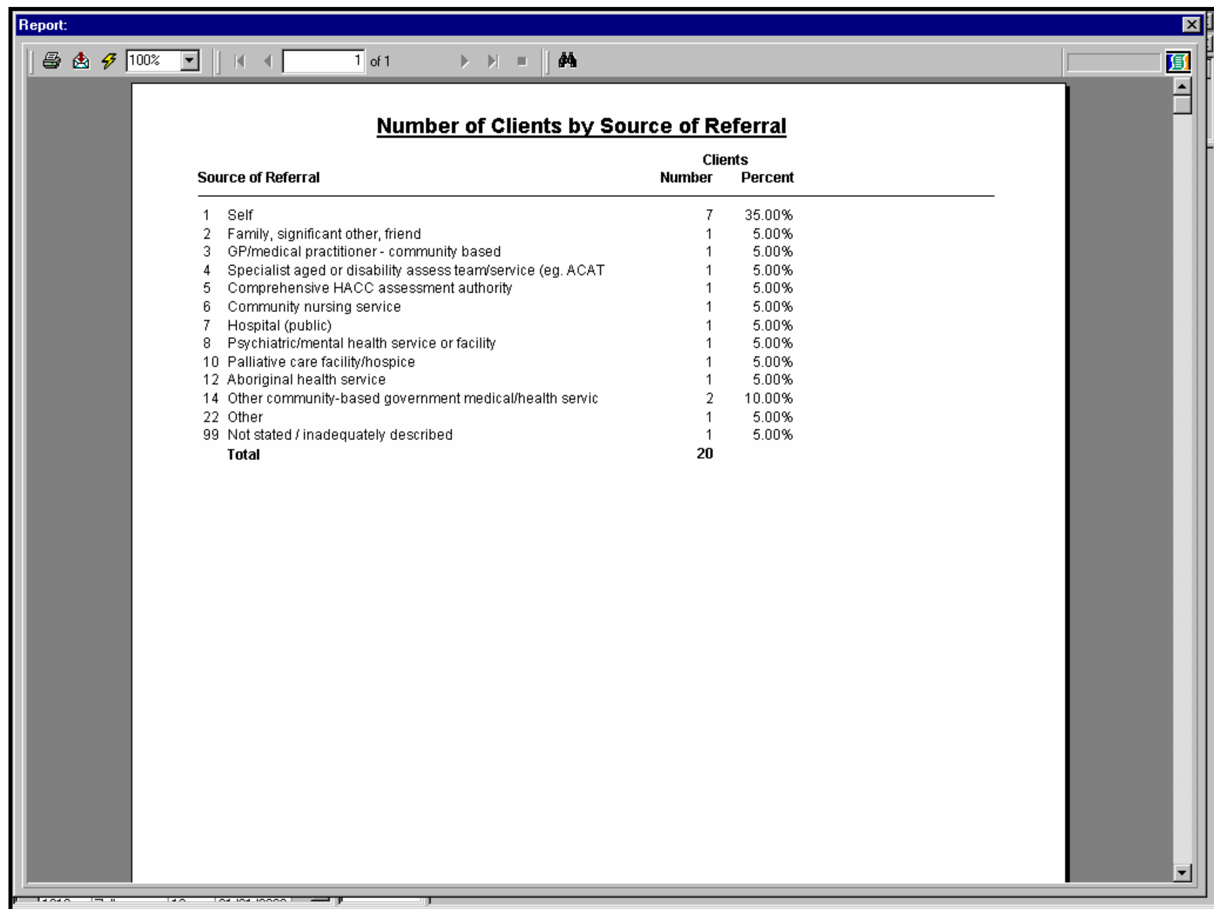
75% 1 of 1+

OOS by Main Intervention by Client by Staff Member

Staff Member		Patient Name	Main Intervention	OOS
1004	Whelan	Anderson Deidre	Meals	1
1004	Whelan	Armitage Jane	Case Management	1
1004	Whelan	Armitage Margaret	Personal Care Including Assist With Personal Ca	1
1004	Whelan	Barker Melinda	Patient education	1
1004	Whelan	Chappell Gillian	Domestic assistance	1
1004	Whelan	Clements Sandra	Nursing - technical intervention not elsewhere s	1
1004	Whelan	Collins Martha	Telephone contact ***	1
1004	Whelan	Connor Gerry	Assessment - allied health, 1 discipline	1
1004	Whelan	Cox Rosemary	Domestic assistance	1
1004	Whelan	Davies Melinda	Wound management	1
1004	Whelan	Dunn Beryl	Assessment - medical only	1
1004	Whelan	Freeman Chris	Advocacy with other agency	1
1004	Whelan	Handley Joan	Pathology testing ***	1
1004	Whelan	Jackson Florence	Provision of aids or appliances	1
1004	Whelan	Jensen Beryl	Case Management	1
1004	Whelan	Remington Alice	Assessment - multidisciplinary	1
1004	Whelan	Rossitor Lena	Bereavement counselling	1
1004	Whelan	Selleck Betty	Patient education	1
1004	Whelan	Soul Rosalind	Group contact ***	1
1004	Whelan	Vickers Margaret	Assessment - allied health, 2 or more disciplines	1
1005	Perry	Anderson Deidre	Case Management	1
1005	Perry	Armitage Jane	Medication prescription ***	1
1005	Perry	Armitage Margaret	Case Management	1
1005	Perry	Barker Melinda	Information/support for family/carers	1
1005	Perry	Chappell Gillian	Group contact ***	1
1005	Perry	Clements Sandra	Meals	1
1005	Perry	Collins Martha	Diagnostic imaging ***	1
1005	Perry	Connor Gerry	Case Management	1
1005	Perry	Cox Rosemary	Social support	1
1005	Perry	Davies Melinda	Information/support for family/carers	1
1005	Perry	Dunn Beryl	Nursing - technical intervention not elsewhere s	1
1005	Perry	Freeman Chris	Home modification	1
1005	Perry	Handley Joan	Home maintenance	1
1005	Perry	Jackson Florence	Other food services	1
1005	Perry	Jensen Beryl	Counselling and support	1
1005	Perry	Remington Alice	Pathology testing ***	1

This report shows number of OOS by main intervention by client by staff member. This report will only include occasions of service that have had a 'yes' to 'include in HACC MDS Extract' entered in the 'Episode' screen.

79. HACC:Client/Referral Source Report

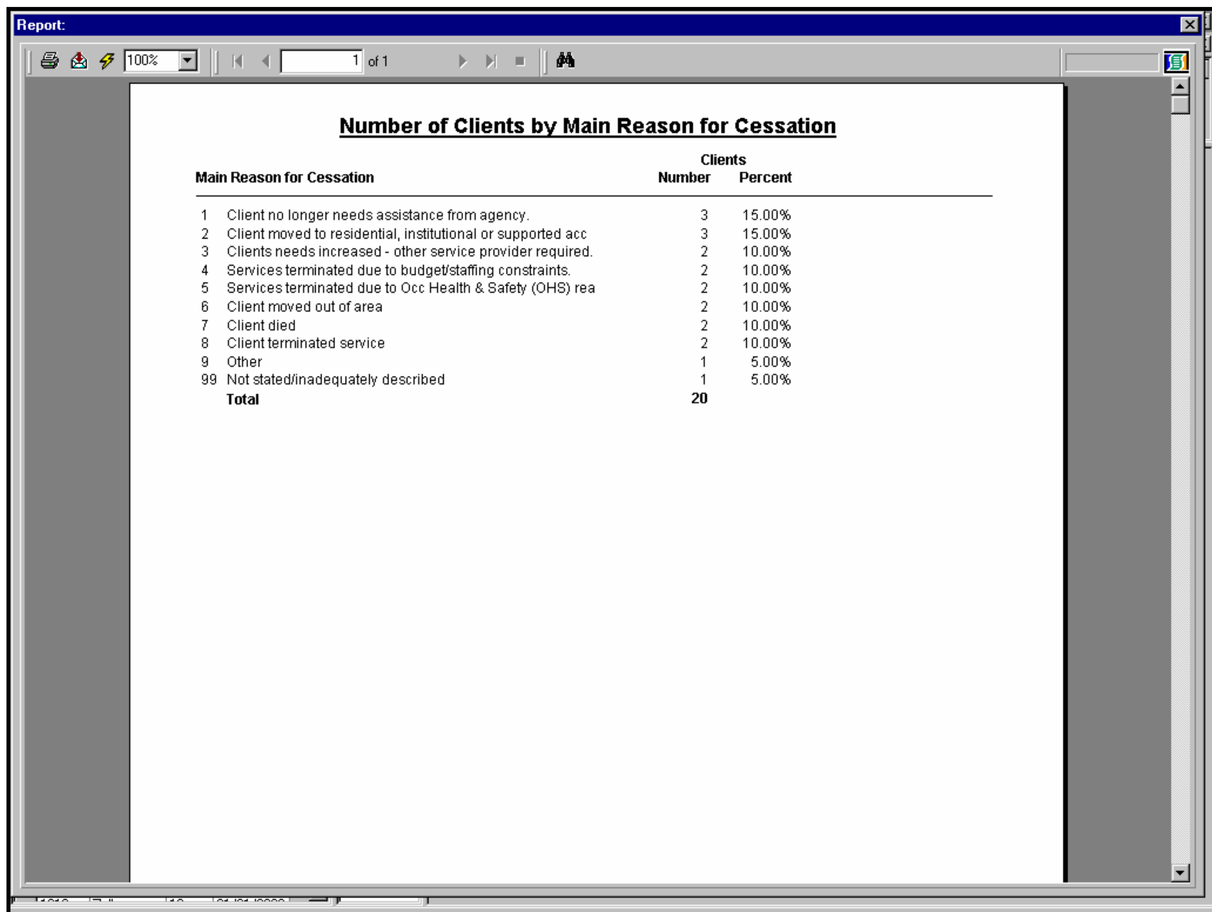


Number of Clients by Source of Referral

Source of Referral		Clients Number	Clients Percent
1	Self	7	35.00%
2	Family, significant other, friend	1	5.00%
3	GP/medical practitioner - community based	1	5.00%
4	Specialist aged or disability assess team/service (eg. ACAT	1	5.00%
5	Comprehensive HACC assessment authority	1	5.00%
6	Community nursing service	1	5.00%
7	Hospital (public)	1	5.00%
8	Psychiatric/mental health service or facility	1	5.00%
10	Palliative care facility/hospice	1	5.00%
12	Aboriginal health service	1	5.00%
14	Other community-based government medical/health servic	2	10.00%
22	Other	1	5.00%
99	Not stated / inadequately described	1	5.00%
	Total	**20**	

This report shows number of client episodes and percentage by source of referral.

80. HACC:Client/Cessation Reason Report



Number of Clients by Main Reason for Cessation

	Main Reason for Cessation	Clients Number	Clients Percent
1	Client no longer needs assistance from agency.	3	15.00%
2	Client moved to residential, institutional or supported acc	3	15.00%
3	Clients needs increased - other service provider required.	2	10.00%
4	Services terminated due to budget/staffing constraints.	2	10.00%
5	Services terminated due to Occ Health & Safety (OHS) rea	2	10.00%
6	Client moved out of area	2	10.00%
7	Client died	2	10.00%
8	Client terminated service	2	10.00%
9	Other	1	5.00%
99	Not stated/inadequately described	1	5.00%
	Total	**20**	

This report shows number of client episodes and percentage by main reason for cessation of service.

81. HACC:Client/CarerResid/AgeGroup Report

Report:

100% | 1 of 1

HACC: Clients by Carer Residency Status by Age Group

Carer Status	Age Group	Clients Number	Clients Percent
1 Co-resident carer	36-64	1	5.00 %
	65-79	4	20.00 %
	80+	6	30.00 %
2 Non-resident carer	36-64	2	10.00 %
	65-79	2	10.00 %
	80+	3	15.00 %
9 Not stated/inadequately described	80+	2	10.00 %
Total		**20**	

This report shows number of client episodes and percentage by age group by care status.

82. HACC:Client/Accom Setting Report

Report:

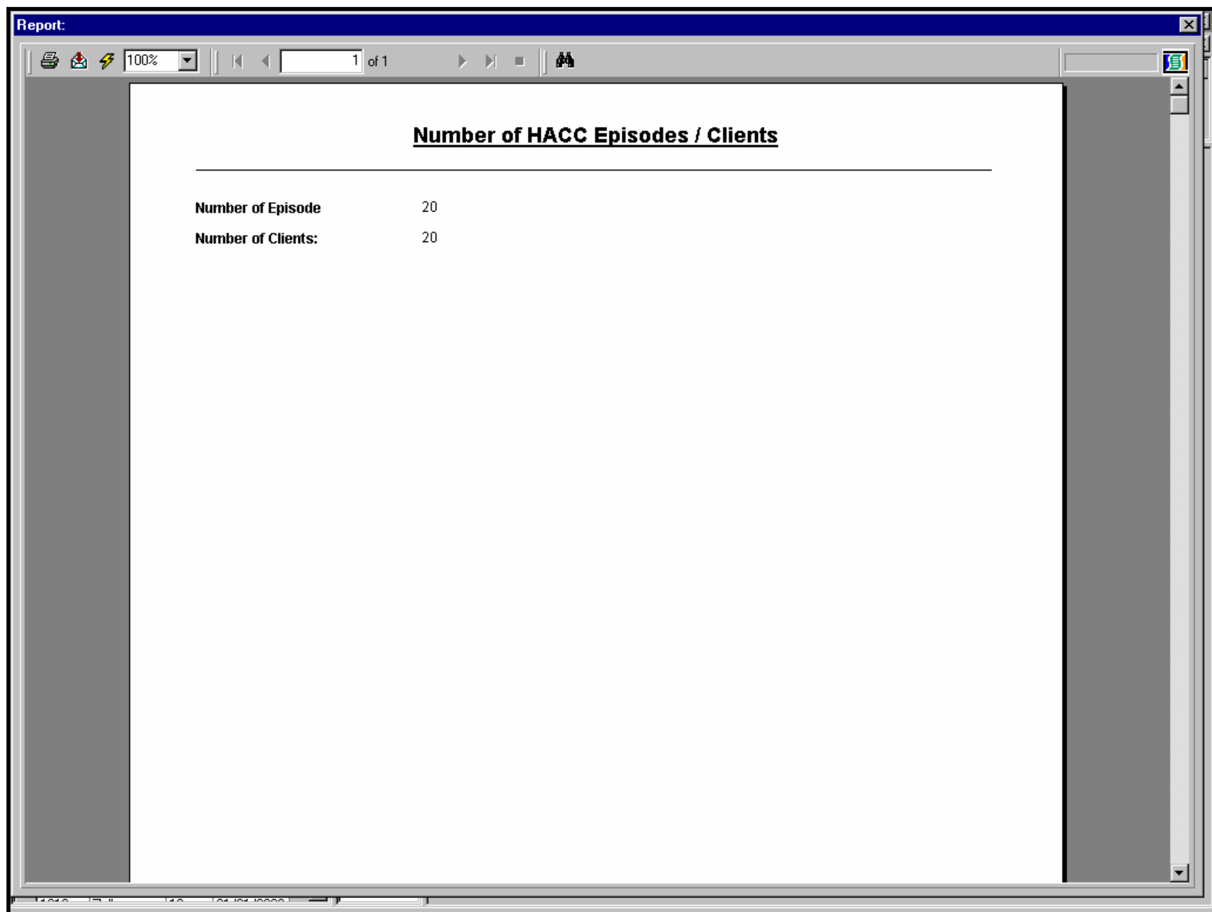
100% | 1 of 1

Number of Clients by Accommodation Setting

Accommodation Setting		Clients Number	Percent
1	Private residence - owned/purchasing	9	47.37%
2	Private residence - private rental	1	5.26%
3	Private residence - public rental	1	5.26%
4	Private residence - mobile home	1	5.26%
5	Independent living unit within a retirement village	1	5.26%
6	Boarding house/private hotel	1	5.26%
7	Short term crisis,emergency fac (eg night shelters,refuges)	1	5.26%
8	Domestic-scale supported living facility	2	10.53%
14	Temporary shelter within an Aboriginal Community	1	5.26%
99	Not stated / inadequately described	1	5.26%
	Total	**19**	

This report shows number of client episodes and percentage by accommodation setting.

83. HACC:Number of Episodes/Clients Report



The report shows the total number of HACC episodes and clients.

84. HACC:Agency/Staff/OOS/Main Int

Report:

100% | 1 of 1+

Agency by Staff Member by Main Intervention

Selection Criteria:

Agency	Staff Member		Main Intervention	OOS	Minutes
12345					
12345	1004	Birchall	Allied health therapy	1	47
12345	1004	Birchall	Assessment - allied health, 1 discipline	2	88
12345	1004	Birchall	Assessment - allied health, 2 or more disciplines	2	48
12345	1004	Birchall	Assessment - multidisciplinary	1	37
12345	1004	Birchall	Bereavement counselling	1	35
12345	1004	Birchall	Case Management	1	32
12345	1004	Birchall	Diagnostic imaging ***	1	39
12345	1004	Birchall	Domestic assistance	1	48
12345	1004	Birchall	Home maintenance	1	25
12345	1004	Birchall	Legal report/hearing ***	1	32
12345	1004	Birchall	Medication dispensing, administration or supervision	1	44
12345	1004	Birchall	Nursing - technical intervention not elsewhere specifie	1	51
12345	1004	Birchall	Pathology testing ***	1	32
12345	1004	Birchall	Patient education	1	40
12345	1004	Birchall	Respite care	1	59
12345	1004	Birchall	Telephone contact ***	1	60
12345	1004	Birchall	Transport	1	33
12345	1005	McCabe	Allied health therapy	1	26
12345	1005	McCabe	Assessment - allied health, 1 discipline	1	60
12345	1005	McCabe	Assessment - allied health, 2 or more disciplines	1	27
12345	1005	McCabe	Assessment - medical only	2	51
12345	1005	McCabe	Bereavement support	2	54
12345	1005	McCabe	Case Management	1	21
12345	1005	McCabe	Diagnostic imaging ***	1	56
12345	1005	McCabe	Domestic assistance	1	26
12345	1005	McCabe	Home maintenance	1	50
12345	1005	McCabe	Medication dispensing, administration or supervision	3	132
12345	1005	McCabe	Monitoring and surveillance	1	54
12345	1005	McCabe	Nursing - technical intervention not elsewhere specifie	1	27
12345	1005	McCabe	Other food services	1	57
12345	1005	McCabe	Provision of linen	1	55
12345	1005	McCabe	Referral to other agency	1	31
12345	1006	Ford	Allied health therapy	1	60

The report shows the HACC interventions by HACC agency code. It is possible to limit the report to a time period, this would be useful if you wish to ensure that all occasions of service for a collection period had been entered. The agency code is shown as blank for those OOS for episodes identified as HACC eligible but which don't have a corresponding HACC agency code in the staff record – it is important to assign the appropriate agency code to ensure that these records will be included in the HACC extract.

Troubleshooting

If, on opening up the main screen and logging on, you do not see any data, you will need to re-set which Facility and Provider unit SNAPshot should be focusing on. To do this, simply highlight Facility and then click on Reset (this button can be found in the middle of the right hand window), now highlight ProvUnit and click Reset again. At this point your data should 'magically' reappear. [If you have more than one Facility or Provider Unit as shown in the example below, you will need to select the appropriate one in the top right hand window]

Resetting the Facility

Once the Facility has been reset, the Facility wide data items will be visible.

Resetting the Provider Unit

Once the provider Unit has been reset the data sets under that provider unit will be visible.

Data Quality

There are a number of standard reports that can be run to assist facilities to ensure that the data entered is of a high standard.

- Report 10. 90 Day Review – this report shows those patients who have an open with a length of stay of more than 90 days.
- Report 20. Database Summary – this provides a count of the different records held in the database as well as MRNs of those records which appear to be incomplete – greater than 90 days or missing an end date; Patient details without any episode data; those records where the DOBs are the same (the majority of these will be simply people who share a birth date, however it may highlight instances where two medical record numbers have been issued to the same patient); those records with the same MRN but with different DOBs (which could be the result of a clerical error on data entry); and a list of Ungroupable episodes. Prior to running this report you should first bulk group all the records in the database, as this will ensure that the report reflects the current data.
- Report 26. Suspect age (not 14-100) Report – this shows those patients where their age at the time of the episode was younger than 14 or older than 100, whilst it is possible that this is correct it may highlight records that have an incorrect DOB.