BRITISH COLUMBIA | Ministry of Health

NATIONAL AMBULATORY CARE REPORTING SYSTEM (NACRS - EMERGENCY HOSPITAL VISITS) DATA DICTIONARY

The National Ambulatory Care Reporting System (NACRS) is a tool for collecting data and reporting on all levels of ambulatory care within Canada including emergency departments (EDs), day surgery, and medical and surgical day clinics within hospitals, the community and private clinics. NACRS facilitates comparisons and benchmarking across jurisdictions provincially and nationally using standardized definitions and coding standards that adhere to national and international standards.

In September 2010, the BC Ministry of Health (the Ministry) mandated the health authorities to work with Canadian Institute for Health Information (CIHI) to implement the NACRS Level 2 at fifteen high volume emergency departments across the province. NACRS Level 2 provides client level, demographic and wait time information and clinical data including presenting complaint and discharge diagnosis. Presently there are a total of 29 facilities in the province reporting to NACRS. The data is available starting in fiscal year 2011/2012.

One NACRS record represents one ED visit recorded at discharge.

Data Changes Over Time

- 2014/15 - The CDU flag and in/out times became mandatory reporting on April 1, 2014.
- 2018/19 – CIHI introduced several changes, including introduction of optional Mental Health Fields and Interventions fields; BC has not utilized these options to date.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Hospital Started NACRS	**20**	**9**							**1 (P13)**	
Hospital Opened (New)							**1**			
Hospital Closed							**1**			
Total NACRS Reporting EDs	**20**	**29**	**29**	**29**	**29**	**29**	**29**	**29**	**30**	**30**

Quality/Accuracy of Information/Field Coding Source

The centralized data processing of the NACRS records, done by the Canadian Institute of Health Information (CIHI), results in increased efficiency and standardization among the participating provinces.

NACRS Reporting Hospitals

HOSPITAL	PARTIAL YEAR REPORTING - START DATE	FULL YEAR REPORTING - START DATE	ED DISCHARGE DIAGNOSIS REPORTING COMPLIANCE (%)	
			2014/15	2019/20
01 INTERIOR HEALTH				
Kelowna General Hospital		13-04-01	0%	0%
Royal Inland Hospital	12-04-01	13-04-01	1.3%	0%
02 FRASER HEALTH				
Royal Columbian Hospital	12-04-01	13-04-01	97.6	99.1
Langley Memorial Hospital	14-01-03	15-04-01	98.3	99.5

Surrey Memorial Hospital	12-04-01	13-04-01	98.3	99.8
Burnaby Hospital	12-04-01	13-04-01	99.3	99.3
Peace Arch District Hospital	13-08-16	14-04-01	95.5	98.2
Delta Hospital	13-06-21	14-04-01	98.9	99.0
Eagle Ridge Hospital and Health Care Centre	13-12-06	14-04-01	98.0	99.6
Chilliwack General Hospital	13-11-08	14-04-01	96.2	99.2
Mission Memorial Hospital	13-10-11	14-04-01	99.0	99.7
Ridge Meadows Hospital and Health Care Centre	13-10-11	14-04-01	99.5	99.4
Fraser Canyon Hospital	13-08-16	14-04-01	98.3	99.3
Abbotsford Regional Hospital and Cancer Centre	12-04-01	13-04-01	99.0	98.8
03 VANCOUVER COASTAL HEALTH				
Vancouver General Hospital	12-04-01	13-04-01	99.5	100
St. Paul's Hospital	12-04-01	13-04-01	92.1	92.5
Mount Saint Joseph Hospital	12-04-01	13-04-01	93.1	93.5
Lions Gate Hospital	12-04-01	13-04-01	89.3	83.1
Richmond Hospital	12-04-01	13-04-01	97.3	98.8
UBC Health Sciences Centre	12-04-01	13-04-01	98.8	97.9
04 VANCOUVER ISLAND HEALTH				
Royal Jubilee Hospital	12-04-01	13-04-01	52.7	78.9
Victoria General Hospital	12-04-01	13-04-01	50.5	87.3
Cowichan District Hospital	12-04-01	13-04-01	0	0
Saanich Peninsula Hospital	12-04-01	13-04-01	0	0
Nanaimo Regional General Hospital	12-04-01	13-04-01	54.2	32.8
St. Joseph's General Hospital	12-04-01	13-04-01 closed 17-10-15	0	N/A
North Island Hospital – Comox Valley	17-10-01	18-04-01	N/A	0
North Island Hospital – Campbell River	12-04-01	13-04-01	0	0
West Coast General Hospital	19-03-02	20-04-01	N/A	0.7
05 NORTHERN HEALTH				
The University Hospital of Northern BC	12-04-01	13-04-01	72.6	77.8
06 PHSA				
B.C. Children's Hospital	12-04-01	13-04-01	92.2	92.5

DATA FIELD	DEFINITION
File year (fiscal year)	The first four digits of the fiscal year of the discharge of the client. A client discharged between April 1, 2001 and March 31, 2002 would be coded '2001'.

DATA FIELD	DEFINITION
Client study ID	Project-specific anonymized client identification replacing PHN.
Client gender	Client's gender.
Client birth year and month	Abbreviated (BRTHMTH) date of birth of the client. The format for BRTHMTH is YYYYMM.
Age in years at admission	Client's age in years and is calculated by subtracting date of birth from date of admission. This value is zero for clients less than one year old. For extended care, subtract the date of birth from the date of discharge.
Age in months at admission (< one year old)	Age in months for clients less than one year old.
Client Health Authority (HA)	One-digit code that identifies the BC Health Authority for the client's address. BC is divided into five regional Health Authorities.
Client Health Service Delivery Area (HSDA)	Two-digit code that identifies the BC Health Service Delivery Area for the client's address. Each HA is further sub-divided into three or four HSDAs for a total of 16 in BC.
Client Local Health Area (LHA)	Three-digit code that identifies the BC Local Health Area for the client's address. Each HSDA is sub-divided into several LHAs.
Client Community Health Service Area (CHSA)	Four-digit code that identifies the BC Community Health Service Area for the client's address. Each LHA is sub-divided into several CHSAs. (Not available from NACRS at this point)
Client Forward Sortation Area (FSA)	The first three characters of the client's postal code.
Province issuing health care number	The provincial/territorial or federal government from which the health care number was issued.
Province of ED (hospital)	The province in which the hospital is located.
BC Hospital study ID	Project-specific anonymized BC hospital number. The original (identifiable) hospital ID is a three-digit number and is only supplied with special justification.
Visit disposition	The discharge disposition of the client upon leaving the emergency. Details are available upon request.
Registration date/time	The date and time that the client was formally registered as a patient to the emergency department or other ambulatory care centre of the reporting facility. The format is YYYY-MM-DD HH12:MI:SS AM/PM.
Triage date/time	The date and time that when a client is triaged at the emergency department or ambulatory care centre of the reporting facility. The format is YYYY-MM-DD HH12:MI:SS AM/PM.
Physician/practitioner initial assessment date/ time	The date and time that the client was first assessed by a practitioner at the emergency department or ambulatory care centre of the reporting facility. The format is YYYY-MM-DD HH12:MI:SS AM/PM.

DATA FIELD	DEFINITION
Date/time client left ED	The date and time that the client left the treating emergency department of the reporting facility. The format is YYYY-MM-DD HH12:MI:SS AM/PM.
Disposition date/time	The date and time that the client was formally discharged from the emergency department or ambulatory care centre of the reporting facility, including admission as an inpatient. The format is YYYY-MM-DD HH12:MI:SS AM/PM.
Time waiting for physician's/practitioner's initial assessment	The time in hours between the earlier of registration or triage date-time and the date-time a client was first assessed by a practitioner in the emergency department.
Time waiting for an inpatient bed	The time in hours spent within the emergency department, from the time the decision to admit was made until the time the client left for an inpatient bed.
Time to disposition from earlier of registration/ triage time in hours	The time in hours between the earlier of registration or triage date-time and the date-time when the decision to admit a client occurred or the client's disposition was finalized.
Time spend in ED	The time in hours between the earlier of registration or triage date-time and either the date-time when a client's disposition was finalized or the date-time the client left for an inpatient bed.
Triage level	The categorization of the client's triage into levels, according to the type and severity of the client's initial presenting signs and symptoms
Ambulance code	The code for the type of transport used when a client was brought to the facility by ambulance. A Air ambulance G Ground ambulance W Water ambulance C Combination of any N Patient did not arrive by ambulance
Responsible for payment	The party responsible for a client's hospitalization payment. 01 Provincial/Territorial responsibility 02 Worker's Compensation Board (WCB) or Worker's Service Insurance Board (WSIB) 03 Other province/territory (resident of Canada, but not reporting province) 04 Department of Veteran Affairs (DVA) or Veteran Affairs Canada (VAC) 05 First Nations and Inuit Health Branch (formally called the Medical Service Branch) 06 Other federal government (RCMP, Department of National Defense, Penitentiary Inmate) 07 Canadian resident self-pay (includes ICBC in BC) 08 Other country resident self-pay 09 Missing description for 09
Presenting complaint 1-3	The symptoms, complaints, problems or reasons for seeking emergency medical care as identified by the client expressed in terms as close as possible to those used by the client or responsible informant, 1-3.

DATA FIELD	DEFINITION
	Complaint3 has been available since 2012. Lookup tables are available in the following CIHI website: https://secure.cihi.ca/estore/productSeries.htm?pc=PCC515
ED discharge diagnosis 1-3	The practitioner's first to third ICD10-CA diagnoses codes (when available) of the client at the time of discharge from ED. EDDIAG2 and 3 have been available since 2012.
Clinical decision unit flag	The indicator assigned if the client was placed in a Clinical Decision Unit during their emergency visit.
Clinical decision unit in date/time	The date and time when the client formally arrived in the Clinical Decision Unit. The format is YYYY-MM-DD HH12:MI:SS AM/PM.
Clinical decision unit out date/time	The date and time when the client formally left the Clinical Decision Unit. The format is YYYY-MM-DD HH12:MI:SS AM/PM.
Physician/practitioner study ID	Project-specific anonymized identification of the practitioner most responsible for the client's care during hospitalization.
Physician/practitioner specialty	A code which identifies the training or specialty of the practitioner most responsible for the client's care during hospitalization.
ED visit indicator	An indicator documenting whether a visit reported under the emergency MIS functional center account code is a 'true' ED visit (EDVISIT = 1) or an arranged day surgery/ clinic visit taking place in the emergency department (EDVISIT = 0).