

Data elements

J – M

(NOTE: There are no data elements beginning with J or K)

Labour force status

Identifying and Definitional Attributes

Knowledgebase ID: 000670 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/01/03

Definition: The self reported status the person currently has in being either in the labour force (employed/unemployed) or not in the labour force. The categories are determined by a person's status in relation to current economic activity (which is measured by their activities in relation to work in a specified reference period).

Context: Clinical settings:
Labour force status is an indicator of the socio-economic status (economic activity) of a person and is a key element in assessing the circumstances and needs of individuals and families. In all social classes, the mortality rate of unemployed people was higher than that of the employed, particularly for death from cardiovascular disease, lung cancer, accidents and suicide (Mathers CD and Schofield DJ. MJA 1998; 168: 178-182). It is one of a group of items that provide a description of a person's labour force characteristics.

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Employed
2	Unemployed
3	Not in the labour force
4	Not stated/inadequately described

Guide for use: Definitions for these categories are:
Employed:
Employed persons comprise all those aged 15 years and over who, during the reference week:
(a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers');
(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker');
(c) were 'Employees' who had a job but were not at work and were:
– on paid leave
– on leave without pay, for less than four weeks, up to the end of the reference week
– stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week

- on strike or locked out
 - on workers' compensation and expected to be returning to their job
 - receiving wages or salary while undertaking full-time study;
- (d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

Unemployed:

Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:

- (a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then;
- (b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown.

Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

Not in the labour force:

Persons not in the labour force are those persons who, during the reference week, were not in the categories employed or unemployed, as defined. They include persons who were keeping house (unpaid), retired, voluntarily inactive, permanently unable to work, persons in institutions (hospitals, gaols, sanatoriums, etc.), trainee teachers, members of contemplative religious orders, and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Verification rules:

Collection methods: For information about collection, refer to the Australian Bureau of Statistics' (ABS) web site: www.abs.gov.au/

Related metadata: is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: AIHW: 2000 National Community Services Data Dictionary, version 2. Catalogue No. HWI 27. Canberra: AIHW. (Data element 'Labour force status' 000526 V2). Standards for Social, Labour and Demographic Statistics.

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Labour characteristic

Data Set Specifications:	Start date	End date
DSS - Cardiovascular disease (clinical)	01/01/2003	

Comments: This definition is based on the ABS standard definition of labour force status. It is generally measured at the point of coming into contact with (or completion of assistance by) a community services agency.

Laterality of primary cancer

Identifying and Definitional Attributes

Knowledgebase ID:	000774	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/02		
Definition:	<p>Laterality describes which side of a paired organ is the origin of the primary cancer. Each side of a paired organ is considered separately and described as lateral when occurring unless a physician determines that it is bilateral.</p> <p>A paired organ is one in which there are two separate organs of the same kind, one on either side of the body (e.g. kidney, breast, ovary, testis and lung).</p>		
Context:	<p>This information is collected for the purpose of differentiating the site of the primary cancer. For example, a woman may present with a primary cancer in the left breast. She may return at a later stage with a new primary cancer in the right breast.</p>		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<p>1 Left</p> <p>2 Right</p> <p>3 Bilateral (Note: Bilateral cancers are very rare)</p> <p>9 Not known</p> <p>Null Not applicable</p>

Guide for use:	<p>The valid International Classification of Diseases for Oncology values for the variable are provided in the list below:</p> <p>1 Left:</p> <p>Origin of primary site is on the left side of a paired organ</p> <p>Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)</p> <p>2 Right:</p> <p>Origin of primary site is on the right side of a paired organ</p> <p>3 Bilateral:</p> <p>Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3))</p>
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9 Unknown:

It is unknown whether, for a paired organ the origin of the cancer was on the left or right side of the body.

Verification rules:

Collection methods: This information should be obtained from the patient's pathology report, the patient's medical record, or the patient's medical practitioner/nursing staff.

Related metadata: is qualified by Primary site of cancer vers 1

Administrative Attributes

Source document: International Classification of Diseases for Oncology, Second Edition

Source organisation: World Health Organization

Information model link:

NHIM Assessment event

Data Set Specifications: *Start date* *End date*

Comments:

Length of non-admitted patient emergency department service episode

Identifying and Definitional Attributes

Knowledgebase ID:	000829	Version No:	1
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The amount of time, measured in minutes, between when a patient presents at an emergency department for an emergency department service episode, and when the non-admitted component of the emergency department service episode has concluded.		
Context:	Emergency department care.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	MMMMM
Minimum size:	5
Maximum size:	5
Data domain:	Count in minutes to the nearest minute
Guide for use:	A non-admitted patient Emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> is calculated using Date patient presents vers 2 relates to the data element concept Emergency department - public hospital vers 1 relates to the data element concept Non-admitted patient emergency department service episode vers 1 relates to the data element Patient presentation at emergency department vers 1 is calculated using Time patient presents vers 2

Administrative Attributes

Source document:		
Source organisation:	National reference group for non-admitted patient data development, 2001-02	
Information model link:		
	NHIM Exit/leave from service event	
Data Set Specifications:	Start date	End date
NMDS - Non-admitted patient emergency department care	01/07/2003	
Comments:		

Length of stay

Identifying and Definitional Attributes

Knowledgebase ID: 000119 **Version No:** 3

Metadata type: Derived Data Element

Admin. status: Current
01/07/01

Definition: The length of stay of a patient measured in patient days. A same-day patient should be allocated a length of stay of one patient day. The length of stay of an overnight stay patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting total leave days. Total contracted patient days are included in the length of stay.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count of the number of patient days

Guide for use: Formula:
LOS (incl. leave days) = Separation date - Admission date - Total leave days

The calculation is inclusive of admission and separation dates.

Verification rules:

Collection methods:

Related metadata: is calculated using Admission date vers 4
supersedes previous data element Length of stay vers 2
is calculated using Separation date vers 5
is calculated using Total leave days vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

Data Set Specifications: **Start date** **End date**

Comments: Perinatal length of stay data elements include leave days and so are not included in this data element.

Length of stay (antenatal)

Identifying and Definitional Attributes

Knowledgebase ID:	000635	Version No:	1
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	The length of stay of a patient measured in days calculated from the admission date of mother to the date of birth of the baby. Total contracted days are included in the length of stay. Leave days are included.		
Context:	Perinatal		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Quantitative value		
Representational layout:	NNN		
Minimum size:	1		
Maximum size:	3		
Data domain:	Calculated number of days		
Guide for use:	<p>Formula:</p> <p>Antenatal LOS = baby's Date of birth - mother's Admission date</p> <p>Antenatal length of stay refers only to the admission associated with the birth. The calculation is inclusive of the day of admission of the mother and the day of birth of the baby and includes any leave days.</p>		
Verification rules:			
Collection methods:			
Related metadata:	<p>is calculated using Admission date vers 4</p> <p>is calculated using Date of birth vers 4</p> <p>relates to the data element Length of stay (including leave days) vers 1</p> <p>relates to the data element Perinatal period vers 1</p>		

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Performance indicator		
Data Set Specifications:	Start date	End date	
Comments:			

Length of stay (including leave days)

Identifying and Definitional Attributes

Knowledgebase ID: 000636 **Version No:** 1

Metadata type: Derived Data Element

Admin. status: Current
01/07/01

Definition: The length of stay of a patient measured in days. A same-day patient should be allocated a length of stay of one day. Total contracted days are included in the length of stay. All leave days are included in length of stay calculation.

Context: All admitted patient care situations where it is required to know the total length of a stay in hospital.

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Calculated number of days

Guide for use: Formula:
LOS (incl. leave days) = Separation date - Admission date
The calculation is inclusive of admission and separation dates.

Verification rules:

Collection methods:

Related metadata: is calculated using Admission date vers 4
relates to the data element Length of stay (antenatal) vers 1
relates to the data element Length of stay (postnatal) vers 1
relates to the data element Perinatal period vers 1
is calculated using Separation date vers 5

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

Data Set Specifications: **Start date** **End date**

Comments:

Length of stay (postnatal)

Identifying and Definitional Attributes

Knowledgebase ID:	000637	Version No:	1
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	The length of stay of a patient measured in days calculated from the Date of birth of baby to Separation date of mother. Total contracted days are included in the length of stay. Leave days are included.		
Context:	Perinatal.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Quantitative value		
Representational layout:	NNN		
Minimum size:	1		
Maximum size:	3		
Data domain:	Calculated number of days		
Guide for use:	<p>Formula for the mother: LOS (post-natal) = mother's Separation date - baby's Date of birth</p> <p>Formula for the baby: LOS (post-natal) = baby's Separation date - baby's Date of birth</p> <p>Both calculations are inclusive of those dates and any leave days are included. Excludes transfers, home births and other non-hospital births.</p>		
Verification rules:			
Collection methods:			
Related metadata:	<p>is calculated using Date of birth vers 4</p> <p>relates to the data element Length of stay (including leave days) vers 1</p> <p>relates to the data element concept Perinatal period vers 1</p> <p>is calculated using Separation date vers 5</p>		

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Performance indicator		
Data Set Specifications:	Start date	End date	

Comments:

Listing date for care

Identifying and Definitional Attributes

Knowledgebase ID:	000082	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/02		
Definition:	The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.		
Context:	Hospital non-admitted patient care. Community health care. Elective surgery (admitted patient care).		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8

Data domain: Valid date

Guide for use: The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral. For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Listing date for care vers 3
is used in conjunction with Patient listing status vers 3
is used in conjunction with Scheduled admission date vers 2
is used in the calculation of Waiting time at a census date vers 2
is used in the calculation of Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	Start date	End date
NMDS - Elective surgery waiting times	01/07/1994	

Comments: The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil State/Territory, local and national reporting requirements.

Live birth

Identifying and Definitional Attributes

Knowledgebase ID: 000083 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/94

Definition: A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Status of the baby vers 1

Administrative Attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, Vol. 1, WHO 1992

Source organisation: National Health Data Committee
National Perinatal Data Development Committee
National Perinatal Data Advisory Committee

Information model link:

NHIM Birth event

Data Set Specifications: **Start date** **End date**

Comments:

Living arrangement

Identifying and Definitional Attributes

Knowledgebase ID:	000629	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether a person usually resides alone or with others.		

Context: Client support needs and clinical setting: It is important to record the type of living arrangements for a person in order to develop a sense of the level of support, both physically and emotionally, to which a person may have access. Whether or not a person lives alone is a significant determinant of risk.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

Data domain:	1	Lives alone
	2	Lives with others
	9	Not stated/inadequately described

Guide for use: The item does not seek to describe the quality of the arrangements but merely the fact of the arrangement. It is recognised that this item may change on a number of occasions during the course of an episode of care.

Verification rules:

Collection methods:

Related metadata: relates to the data element Carer availability vers 3
relates to the data element Formal community support access status vers 1
is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Functional wellbeing

Data Set Specifications:	Start date	End date
DSS - Cardiovascular disease (clinical)	01/01/2003	

Comments: Living alone may preclude certain treatment approaches (e.g. home dialysis for end-stage renal disease). Social isolation has also been shown to have a negative impact on prognosis in males with known coronary artery disease with several studies suggesting increased mortality rates in those living alone or with no confidant.

Lower limb amputation due to vascular disease

Identifying and Definitional Attributes

Knowledgebase ID:	000830	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Amputation of toe, forefoot or leg (above or below knee), due to vascular disease.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 Lower limb amputation – occurred in the last 12 months 2 Lower limb amputation – occurred prior to the last 12 months 3 Lower limb amputation – occurred both in and prior to the last 12 months 4 No history of lower limb amputation due to vascular disease 9 Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods: Ask the individual if he/she has had an amputated toe or forefoot or leg (above or below knee), not due to trauma or causes other than vascular disease. If so determine when it was undertaken; within or prior to the last 12 months (or both). Alternatively obtain this information from appropriate documentation.

Related metadata:

- relates to the data element Health professionals attended – diabetes mellitus vers 1
- relates to the data element Foot deformity vers 1
- relates to the data element Foot lesion – active vers 1
- relates to the data element Foot ulcer – current vers 1
- relates to the data element Foot ulcer – history vers 1
- relates to the data element Peripheral neuropathy – status vers 1
- relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Source organisation:	National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

DSS - Diabetes (clinical)

Start date**End date**

01/01/2003

Comments:

In people with diabetes, amputations are 15 times more common than in people without diabetes, and 50% of all amputations occur in people with diabetes (The Lower Limb in People With Diabetes; 1997/98 Australian Diabetes Society).

Diabetic foot disease is the most common cause of hospitalisation in people with diabetes. Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45-74 years and sevenfold in population aged over 75 years. As stated by Duffy and authors the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

References:

Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. *Military Medicine*, 155: 575-579.

Edmonds M, Boulton A, Buckenham T et al. Report of the Diabetic Foot and Amputation Group. *Diabet Med* 1996; 13: S27-42.

Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Colagiuri S, Colagiuri R, Ward J. National Diabetes Strategy and Implementation Plan. Canberra: Diabetes Australia, 1998.

Main language other than English spoken at home

Identifying and Definitional Attributes

Knowledgebase ID: 000638 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/01

Definition: The language reported by a person as the main language other than English spoken by a person in his/her home (or most recent private residential setting occupied by the person) on a regular basis, to communicate with other residents of the home or setting and regular visitors.

Context: This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth, this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).

Data on main language spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/translation services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

Data domain: Valid ABS codes

Guide for use: At the most detailed level the ABS classification comprises four-digit codes based on a hierarchical structure. It includes codes for indigenous Australian languages and sign language. Generally for output purposes, four-digit language codes are grouped into language regions, either at two-digit or one-digit level.

Example 1:

The Lithuanian language has a code of 3102.

3 denotes that it is an Eastern European language

1 denotes that it is a Baltic language

02 denotes the specific language.

Example 2:

The Pintupi Aboriginal language has a code of 8217.

8 denotes that it is an Australian Indigenous language

2 denotes that the language is Central Aboriginal

17 denotes the specific language.

Note that the code 9900 should be used where language is Not stated/inadequately described.

Persons not in private residential settings should respond for 'at home' as the most recent private residential setting in which that person has resided.

The reference in the title to 'at home' may cause offence to homeless persons and should be shortened to 'Main language other than English spoken' where applicable.

Verification rules:

Collection methods:

It is recommended that data be collected at the 2- or 4-digit level. Data collected at the 4-digit level will obviously provide more detailed information than that collected at the 2-digit level, but may be more difficult to collect.

Recommended question:

Do you speak a language other than English at home?

No (English only)? ____

Yes, Italian? ____

Yes, Greek? ____

Yes, Cantonese? ____

Yes, Mandarin? ____

Yes, Arabic? ____

Yes, Vietnamese? ____

Yes, German? ____

Yes, Tagalog (Filipino)? ____

Yes, Other (please specify) _____

Related metadata:

relates to the data element Country of birth vers 3

relates to the data element Proficiency in spoken English vers 1

Administrative Attributes

Source document:

Standards for Statistics on Cultural and Language Diversity, 1999, Australian Bureau of Statistics, Cat. No. 1289.0

Source organisation:

Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

Data Set Specifications:

Start date

End date

Comments:

Data may be collected at any level but is most accurate at the 4-digit level.

Main treatment type for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID:	000639	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern.		
Context:	Alcohol and other drug treatment services.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 Withdrawal management (detoxification) 2 Counselling 3 Rehabilitation 4 Pharmacotherapy 5 Support and case management only 6 Information and education only 7 Assessment only 8 Other

Guide for use:	<p>To be completed at assessment or commencement of treatment.</p> <p>The main treatment type is the principal activity, as judged by the treatment provider, that is necessary for the completion of the treatment plan for the principal drug of concern. The Main treatment type for alcohol and other drugs is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.</p> <p>For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.</p> <p>Code 1 refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.</p> <p>Code 2 refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in code 3.</p> <p>Code 3 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration.</p>
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Rehabilitation activities can occur in residential or non-residential settings.

Code 4 refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, LAAM and specialist methadone treatment). Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal.

Code 5 refers to support and case management offered to clients (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.

Code 6 refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.

Code 7 refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.

Verification rules:

Collection methods: Only one code to be selected.

Related metadata: relates to the data element Other treatment type for alcohol and other drugs vers 1

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Service provision event

Data Set Specifications:	Start date	End date
NMDS - Alcohol and other drug treatment services	01/07/2001	

Comments:

Major diagnostic category

Identifying and Definitional Attributes

Knowledgebase ID: 000088 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/93

Definition: Major diagnostic categories are 23 mutually exclusive categories into which all possible principal diagnoses fall. The diagnoses in each category correspond to a single body system or aetiology, broadly reflecting the speciality providing care. Each category is partitioned according to whether or not a surgical procedure was performed. This preliminary partitioning into major diagnostic categories occurs before a diagnosis related group is assigned.

The Australian refined diagnosis related groups departs from the use of principal diagnosis as the initial variable in the assignment of some groups. A hierarchy of all exceptions to the principal diagnosis-based assignment to a major diagnostic category has been created. As a consequence, certain Australian refined diagnosis related groups are not unique to a major diagnostic category. This requires both a major diagnostic category and an Australian refined diagnosis related group to be generated per patient.

Context: All admitted patient care contexts:
The generation of a major diagnostic category to accompany each Australian national diagnosis related group is a requirement of the latter as diagnosis related groups are not unique.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Australian refined diagnosis related groups

Guide for use: Version effective 1 July each year

Verification rules:

Collection methods:

Related metadata:

- is derived from Additional diagnosis vers 4
- is derived from Admission date vers 4
- is derived from Date of birth vers 4
- is used in the derivation of Diagnosis related group vers 1
- is derived from Infant weight, neonate, stillborn vers 3
- is derived from Principal diagnosis vers 3

Administrative Attributes

Source document:

Source organisation: Department of Health and Ageing, Acute and Co-ordinated Care Branch

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Admitted patient care	01/07/1993	
NMDS - Admitted patient mental health care	01/07/1997	

Comments:

This data item has been created to reflect the development of Australian refined diagnosis related groups (as defined in the data element Diagnosis related group) by the Acute and Co-ordinated Care Branch, Commonwealth Department of Health and Ageing. Due to the modifications in the diagnosis related group logic for the Australian refined diagnosis related groups, it is necessary to generate the major diagnostic category to accompany each diagnosis related group. The construction of the pre-major diagnostic category logic means diagnosis related groups are no longer unique. Certain pre-major diagnostic category diagnosis related groups may occur in more than one of the 23 major diagnostic categories. For example, liver transplant DRG 005, may occur in any of the major diagnostic categories according to the principal diagnosis. AR-DRGs 950-954 (excluding AR-DRG 952 in most cases) also require the allocation of a major diagnostic category according to the principal diagnosis.

Marital status

Identifying and Definitional Attributes

Knowledgebase ID: 000089 **Version No:** 3

Metadata type: Data Element

Admin. status: Current
01/07/01

Definition: Current marital status of the person.

Context: Marital status is a core data element in a wide range of social, labour and demographic statistics. Its main purpose is to establish the living arrangements of individuals, to facilitate analysis of the association of marital status with the need for and use of services and for epidemiological analysis. The Australian Bureau of Statistics (ABS) has defined registered marital status based on a legal concept and social marital status, a social, marriage-like arrangement (i.e. de facto marriage).

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married (including de facto)
6	Not stated/inadequately described

Guide for use: The category Married (including de facto) should be generally accepted as applicable to all de facto couples, including of the same sex.

Verification rules:

Collection methods: While marital status is an important factor in assessing the type and extent of support needs, such as for the elderly living in the home environment, marital status does not adequately address the need for information about social support and living arrangements and other data elements need to be formulated to capture this information.

Related metadata: supersedes previous data element Marital status vers 2

Administrative Attributes

Source document:

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Admitted patient mental health care	01/07/2001	
NMDS - Community mental health care	01/07/2001	

Comments:

ABS standards identify two concepts of marital status:

- registered marital status-defined as whether a person has, or has had, a legally registered marriage
- social marital status-based on a persons living arrangements (including de-facto marriages), as reported by the person.

ABS recommends that the social marital status concept be collected when information on marital status is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection and only in areas of consent if necessary. Most community services data collections ask clients to self-report their marital status. Hence, the operative concept is one of social marital status.

Maternal medical conditions

Identifying and Definitional Attributes

Knowledgebase ID:	000090	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
Definition:	Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.		
Context:	Perinatal statistics: Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the foetus and perinatal morbidity.		

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANN.NN
Minimum size:	3
Maximum size:	6
Data domain:	ICD-10-AM (3rd edition) disease codes
Guide for use:	Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.
Verification rules:	Conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM
Collection methods:	
Related metadata:	is used in conjunction with Complications of pregnancy vers 2 supersedes previous data element Maternal medical conditions - ICD-9-CM code vers 1

Administrative Attributes

Source document:	International Classification of Diseases - Tenth Revision - Australian Modification (3rd edition 2002) National Centre for Classification in Health, Sydney.		
Source organisation:	National Perinatal Data Development Committee		
Information model link:	NHIM Physical wellbeing		
Data Set Specifications:	Start date	End date	
Comments:			

Medical and surgical supplies

Identifying and Definitional Attributes

Knowledgebase ID:	000239	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	The cost of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.		

Context:	Health expenditure:
	As for the data element Drug supplies, this is a significant element of non-salary expenditure and national-level data on medical and surgical supplies is of considerable interest in its own right to a wide range of persons and organisations.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Currency
Representational layout:	\$999,999,999
Minimum size:	2
Maximum size:	12
Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
	NHIM Recurrent expenditure		
Data Set Specifications:		Start date	End date
	NMDS - Public hospital establishments	01/07/1989	

Comments:

Medicare card number

Identifying and Definitional Attributes

Knowledgebase ID:	000091	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.		
Context:	Medicare utilisation statistics. Persons eligible for Medicare services		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:			
Representational layout:	N(11)		
Minimum size:	11		
Maximum size:	11		
Data domain:	Full Medicare card number for an individual (i.e. family number plus person (individual reference) number).		
Guide for use:	<p>As a person can be identified on more than one Medicare card this is not a unique identifier for a person.</p> <p>The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.</p> <p>Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.</p>		
Verification rules:			
Collection methods:			
Related metadata:	supersedes previous data element Medicare number vers 1		

Administrative Attributes

Source document:	AS5017 Health care client identification		
Source organisation:	Standards Australia		
Information model link:	NHIM Recipient role		
Data Set Specifications:		Start date	End date
DSS - Health care client identification		01/01/2003	

Comments:

The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person.

Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card.

Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related.

A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents.

Medicare eligibility status

Identifying and Definitional Attributes

Knowledgebase ID:	000414	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	The patient's eligibility for Medicare as specified under the Commonwealth Health Insurance Act 1973.		
Context:	Admitted patient care:		
	To facilitate analyses of hospital utilisation and policy relating to health care financing.		

Relational and Representational Attributes

Datatype:	Numeric						
Representational form:	Code						
Representational layout:	N						
Minimum size:	1						
Maximum size:	1						
Data domain:	<table> <tr> <td>1</td> <td>Eligible</td> </tr> <tr> <td>2</td> <td>Not eligible</td> </tr> <tr> <td>9</td> <td>Not stated/unknown</td> </tr> </table>	1	Eligible	2	Not eligible	9	Not stated/unknown
1	Eligible						
2	Not eligible						
9	Not stated/unknown						

Guide for use:	<p>An eligible person includes a person who resides in Australia and is one of the following:</p> <ul style="list-style-type: none"> - an Australian citizen - a permanent resident - a New Zealand citizen - a temporary resident who has applied for permanent residency and who has either an authority to work in Australia or an immediate family member who is an Australian citizen or permanent resident - a person, or class of persons, who has been declared eligible for Medicare for the purposes of the <i>Health Insurance Act 1973</i>. <p>Other persons, as temporary residents, who are fully eligible for Medicare include:</p> <ul style="list-style-type: none"> - a person who is a head or member of a diplomatic mission or consular post or is a member of such a person's family, where there is a Reciprocal Health Care Agreement in place between Australia and the country they represent (currently United Kingdom, Republic of Ireland, the Netherlands, Malta, Italy, Sweden and Finland) - with the exception of New Zealand diplomats. <p>Other persons, as visitors or temporary residents, who are eligible for Medicare, in certain circumstances, include:</p> <ul style="list-style-type: none"> - persons who are visiting Australia and are eligible persons because there is a Reciprocal Health Care Agreement in place between Australia and their usual country of residence (currently United Kingdom, Republic of Ireland, the Netherlands, Malta (eligibility limited to 6 months), Italy
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(eligibility limited to 6 months), Sweden, Finland and New Zealand – it should be noted that the RHCA with New Zealand and the Republic of Ireland limits the access to medical services for their residents to that of public patients in public hospitals) – with the exception of New Zealand diplomats.

With respect to hospital services, persons covered by an RHCA (except RHCA diplomats as they have full Medicare eligibility) are eligible only as public patients in a public hospital and are ineligible persons if they are admitted as a private patient in either a public or a private hospital;

It should also be noted that some patients can be both an 'eligible person' and either personally or a third party liable for the payment of charges for hospital services received; for example:

- prisoners
- patients with Defence Force personnel entitlements
- compensable patients
- Department of Veterans' Affairs beneficiaries
- nursing home type patients.

Newborn babies take the eligibility status of the mother.

Verification rules:

Collection methods:

Commencing with Version 9.0 of the Dictionary, three separate data elements are recorded in the Dictionary:

- admitted patient accommodation status
- Medicare eligibility status
- compensable status.

This is because each element relates to a separate concept and requires separate information to be reported. These three data elements replace the previous data elements Patient accommodation eligibility status and Compensable status.

Related metadata:

supersedes previous data element Patient accommodation eligibility status vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Insurance/benefit characteristic

Data Set Specifications:

NMDS - Admitted patient care

Start date

End date

01/07/2000

Comments:

Mental health legal status

Identifying and Definitional Attributes

Knowledgebase ID: 000092 **Version No:** 5

Metadata type: Data Element

Admin. status: Current
01/07/00

Definition: Whether a person is treated on an involuntary basis under the relevant State or Territory mental health legislation, at any time during an episode of care for an admitted patient or treatment of a patient/client by a community-based service during a reporting period.

Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Context: Mental health care:

This data element is required to monitor trends in the use of compulsory treatment provisions under State and Territory mental health legislation by Australian hospitals and community health care facilities, including 24-hour community-based residential services. For those hospitals and community mental health services which provide psychiatric treatment to involuntary patients, mental health legal status information is an essential data element within local record systems.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

- 1 Involuntary patient
- 2 Voluntary patient
- 3 Not permitted to be reported under legislative arrangements in the jurisdiction

Guide for use: Code 3. This code is to be used for reporting to the NMDS – Community mental health care, where applicable.

Approval is required under the State or Territory mental health legislation in order to detain patients for the provision of mental health care or for patients to be treated compulsorily in the community.

Code 1 involuntary status should only be used by facilities which are approved for this purpose. While each State and Territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity. Each State/Territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.

The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care.

Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.

Verification rules:

Collection methods:

Admitted patients: to be collected if the patient is involuntary at any time during the episode of care.

Patients in 24-hour staffed community-based residential services: to be collected if the patient is involuntary at any time during the stay in the residence.

Non-admitted patients: to be collected if the patient is involuntary at any time during a specified collection period.

Related metadata:

supersedes previous data element Mental health legal status vers 4

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Legal characteristic

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Admitted patient care	01/07/2000	
NMDS - Admitted patient mental health care	01/07/2000	
NMDS - Community mental health care	01/07/2000	

Comments:

Method of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000093	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	The method of complete expulsion or extraction from its mother of a product of conception.		
Context:	Perinatal statistics: The method of delivery may affect the health status of the mother and the baby at birth and during the postpartum period.		

Relational and Representational Attributes

Datatype:	Numeric														
Representational form:	Code														
Representational layout:	N														
Minimum size:	1														
Maximum size:	1														
Data domain:	<table> <tr><td>1</td><td>Spontaneous vaginal</td></tr> <tr><td>2</td><td>Forceps (assisted vaginal birth)</td></tr> <tr><td>3</td><td>Vaginal breech</td></tr> <tr><td>4</td><td>Caesarean section</td></tr> <tr><td>5</td><td>Vacuum extraction</td></tr> <tr><td>8</td><td>Other</td></tr> <tr><td>9</td><td>Not stated</td></tr> </table>	1	Spontaneous vaginal	2	Forceps (assisted vaginal birth)	3	Vaginal breech	4	Caesarean section	5	Vacuum extraction	8	Other	9	Not stated
1	Spontaneous vaginal														
2	Forceps (assisted vaginal birth)														
3	Vaginal breech														
4	Caesarean section														
5	Vacuum extraction														
8	Other														
9	Not stated														

Guide for use: In a vaginal breech with forceps to the after coming head, code as vaginal breech.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Presentation at birth vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

Data Set Specifications:	Start date	End date
NMDS - Perinatal	01/07/1997	

Comments:

Method of use for principal drug of concern

Identifying and Definitional Attributes

Knowledgebase ID:	000433	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	The client's usual method of administering the Principal drug of concern as stated by the client.		
Context:	Alcohol and other drug treatment services: Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.		

Relational and Representational Attributes

Datatype:	Numeric														
Representational form:	Code														
Representational layout:	N														
Minimum size:	1														
Maximum size:	1														
Data domain:	<table> <tr><td>1</td><td>Ingests</td></tr> <tr><td>2</td><td>Smokes</td></tr> <tr><td>3</td><td>Injects</td></tr> <tr><td>4</td><td>Sniffs (powder)</td></tr> <tr><td>5</td><td>Inhales (vapour)</td></tr> <tr><td>6</td><td>Other</td></tr> <tr><td>9</td><td>Not stated/inadequately described</td></tr> </table>	1	Ingests	2	Smokes	3	Injects	4	Sniffs (powder)	5	Inhales (vapour)	6	Other	9	Not stated/inadequately described
1	Ingests														
2	Smokes														
3	Injects														
4	Sniffs (powder)														
5	Inhales (vapour)														
6	Other														
9	Not stated/inadequately described														

Guide for use: Code 1 Refers to eating or drinking as the method of administering the Principal drug of concern.

Verification rules:

Collection methods: Collect only for Principal drug of concern.
To be collected on commencement of treatment with a service.

Related metadata: relates to the data element Injecting drug use status vers 2
relates to the data element Principal drug of concern vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Lifestyle characteristic

Data Set Specifications:	Start date	End date
NMDS - Alcohol and other drug treatment services	01/07/2001	

Comments:

Microalbumin – units

Identifying and Definitional Attributes

Knowledgebase ID:	000832	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The units used for measuring microalbumin dependent upon laboratory methodology.		

Context:	Public health, health care and clinical settings: A small amount of protein (albumin) in the urine (Microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin.
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Relational and Representational Attributes

Datatype:	Numeric										
Representational form:	Code										
Representational layout:	N										
Minimum size:	1										
Maximum size:	1										
Data domain:	<table> <tr> <td>1</td> <td>mg/L (milligrams per litre)</td> </tr> <tr> <td>2</td> <td>µg/min (micrograms per minute)</td> </tr> <tr> <td>3</td> <td>mg/24hr (milligrams per 24-hour period)</td> </tr> <tr> <td>4</td> <td>albumin/creatinine ratio</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	mg/L (milligrams per litre)	2	µg/min (micrograms per minute)	3	mg/24hr (milligrams per 24-hour period)	4	albumin/creatinine ratio	9	Not stated/inadequately described
1	mg/L (milligrams per litre)										
2	µg/min (micrograms per minute)										
3	mg/24hr (milligrams per 24-hour period)										
4	albumin/creatinine ratio										
9	Not stated/inadequately described										

Guide for use:	Record the units used for the microalbumin normal reference range.
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Verification rules:

Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. Report the methodology used by the laboratory. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.
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Related metadata:	relates to the data element Microalbumin – upper limit of normal range vers 1 relates to the data element Microalbumin/protein – measured vers 1
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Administrative Attributes

Source document: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Surveillance/monitoring event

Data Set Specifications:	Start date	End date
DSS - Diabetes (clinical)	01/01/2003	

Comments:

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Microalbumin – upper limit of normal range

Identifying and Definitional Attributes

Knowledgebase ID:	000833	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Laboratory standard for the value of Microalbumin that is the upper boundary of the normal reference range.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN.N
Minimum size:	3
Maximum size:	5
Data domain:	Measured value or 999.9 Not stated/inadequately described
Guide for use:	Record the upper limit of the microalbumin normal reference range for the Laboratory
Verification rules:	
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.
Related metadata:	is qualified by Microalbumin – units vers 1 relates to the data element concept Microalbumin/protein – measured vers 1

Administrative Attributes

Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.	
Source organisation:	National Diabetes Data Working Group	
Information model link:	NHIM Surveillance/monitoring event	
Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	

Comments:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with ACE inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantitate albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin/protein – measured

Identifying and Definitional Attributes

Knowledgebase ID:	000831	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	A person's measured total microalbumin in a spot test, 24 hour or timed collection.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNN.N
Minimum size:	3
Maximum size:	6
Data domain:	Measured in different units dependant upon laboratory methodology 9999.9 Not stated/inadequately described
Guide for use:	Record the result expressed as the absolute amount of albumin (mg/L) or as albumin excretion rate (AER: µg/min or mg/24hr) or albumin/creatinine ratio.
Verification rules:	
Collection methods:	Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate. Test for albuminuria by measuring microalbumin in timed or first morning urine sample. The results considered elevated are: <ul style="list-style-type: none"> - spot urine 30 to 300mg/L - timed urine (24 hr collection) 20 to 200 µg / min.
Related metadata:	relates to the data element Microalbumin – units vers 1 relates to the data element Microalbumin – upper limit of normal range vers 1

Administrative Attributes

Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Source organisation:	National Diabetes Data Working Group

Information model link:

NHIM Assessment event

Data Set Specifications:

DSS - Diabetes (clinical)

Start date**End date**

01/01/2003

Comments:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a 6-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes.
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Minutes of operating theatre time

Identifying and Definitional Attributes

Knowledgebase ID:	000094	Version No:	1
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	Total time spent by a patient in operating theatres during current episode of hospitalisation.		
Context:	Admitted patient care.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	MMMM
Minimum size:	4
Maximum size:	4
Data domain:	Calculated number of minutes
Guide for use:	
Verification rules:	Right justified, zero filled
Collection methods:	
Related metadata:	

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Service provision event		
Data Set Specifications:	<i>Start date</i>	<i>End date</i>	

Comments:	This item was recommended for inclusion in the <i>National Health Data Dictionary</i> by Hindle (1988a, 1988b) to assist with diagnosis related group costing studies in Australia.
	This data element has not been accepted for inclusion in the NMDS – Admitted patient care.

Mode of admission

Identifying and Definitional Attributes

Knowledgebase ID:	000385	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/99		
Definition:	Describes the mechanism by which a person begins an episode of care.		
Context:	To assist in analyses of intersectoral patient flow and health care planning.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

Data domain:	1	Admitted patient transferred from another hospital
	2	Statistical admission – episode type change
	3	Other

Guide for use:	Code 2: use this code where a new episode of care is commenced within the same hospital stay.
	Code 3: use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Verification rules:

Collection methods:

Related metadata:	supplements the data element Mode of separation vers 3
	supersedes previous data element Source of referral to acute hospital or private psychiatric hospital vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	Start date	End date
NMDS – Admitted patient care	01/07/1999	
NMDS – Admitted patient palliative care	01/07/2000	

Comments:

Mode of separation

Identifying and Definitional Attributes

Knowledgebase ID:	000096	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).		
Context:	Required for outcome analyses, for analyses of intersectoral patient flows and to assist in the continuity of care and classification of episodes into diagnosis related groups.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ol style="list-style-type: none"> 1 Discharge/transfer to an(other) acute hospital 2 Discharge/transfer to a nursing home 3 Discharge/transfer to an(other) psychiatric hospital 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals and hostels recognised by the Commonwealth Department of Health and Ageing, unless this is the usual place of residence) 5 Statistical discharge - type change 6 Left against medical advice/discharge at own risk 7 Statistical discharge from leave 8 Died 9 Other (includes discharge to usual residence, own accommodation or welfare institution (includes prisons, hostels and group homes providing primarily welfare services))
Guide for use:	Code 4: In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of code 1.
Verification rules:	
Collection methods:	
Related metadata:	<p>is used in the derivation of Diagnosis related group vers 1</p> <p>is supplemented by the data element Source of referral to acute hospital or private psychiatric hospital vers 3</p> <p>is supplemented by the data element Source of referral to public psychiatric hospital vers 3</p>

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2000	
NMDS - Admitted patient mental health care	01/07/1997	
NMDS - Admitted patient palliative care	01/07/2000	

Comments:

The terminology of the modes relating to statistical separation have been modified to be consistent with the changes to data element Care type and other data elements related to admissions and separations.

Morphology of cancer

Identifying and Definitional Attributes

Knowledgebase ID: 000775 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/02

Definition: The morphology of a cancer refers to the histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour). The designation is based on a microscopic diagnosis of morphology by the pathologist (Esteban, Whelan, Laudico & Parkin 1995).

Context: This information is collected for the purpose of:

- classifying tumours into clinically relevant groupings on the basis of both their morphology (cell type) and their degree of invasion or malignancy as indicated by the behaviour code component (the last digit of the morphology code)
- monitoring the number of new cases of cancer for planning treatment services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNN

Minimum size: 5

Maximum size: 5

Data domain: The current version of the International Classification of Diseases for Oncology (ICDO).

Guide for use: ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations. In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9. Record morphology codes in accordance with ICDO coding standards. Use the 5th digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:

- 0 Benign
- 1 Uncertain whether benign or malignant
 - borderline malignancy
 - low malignant potential
- 2 Carcinoma in situ
 - intraepithelial
 - non-infiltrating
 - non-invasive
- 3 Malignant, primary site
- 6 Malignant, metastatic site
 - malignant, secondary site
- 9 Malignant, uncertain whether primary or metastatic site

Verification rules:**Collection methods:****Cancer registry use:**

In cancer registries morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.

Hospital morbidity use:

In hospitals, the morphology code is modified for use with ICD-10-AM. The morphology code consists of histologic type (4 digits) and behaviour code (1 digit) ranging from 8000/0 to 9989/9. The '/' between the fourth and fifth digits is not supplied.

Related metadata:**Administrative Attributes****Source document:**

International Classification of Diseases for Oncology, Second Edition (ICDO-2)
New South Wales Inpatient Statistics Collection Manual, 2000/2001

Source organisation:

World Health Organization.
New South Wales Health Department.
State and Territory Cancer Registries.

Information model link:

NHIM Assessment event

Data Set Specifications:**Start date****End date****Comments:**

Mother's original family name

Identifying and Definitional Attributes

Knowledgebase ID:	000793	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The original family name of the person's mother as reported by the person.		

Context:

Relational and Representational Attributes

Datatype:	Alphabetic
Representational form:	Text
Representational layout:	A(40)
Minimum size:	0
Maximum size:	40

Data domain: Text

Guide for use: May be used to confirm the identity of a person.
Mixed case should be used (rather than upper case only).

Verification rules:

Collection methods: See relevant paragraphs in the collection methods section of the data element Family name.

Related metadata:

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

Data Set Specifications:	Start date	End date
DSS - Health care client identification	01/01/2003	

Comments:

Multi-disciplinary team status

Identifying and Definitional Attributes

Knowledgebase ID: 000434 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/00

Definition: A non-admitted multi-disciplinary team patient service event is one for which there is at most one appointment and the patient is assessed and/or treated by more than one medical practitioner, allied health practitioner and/or specialist nurse practitioner.

Context: Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Non-admitted multi-disciplinary team patient service event
2	Other non-admitted patient service event

Guide for use:

Verification rules:

Collection methods:

Related metadata:

- is used in conjunction with Individual/group session vers 1
- is used in conjunction with New/repeat status vers 1
- is used in conjunction with Non-admitted patient service event vers 1
- is used in conjunction with Non-admitted patient service event count vers 1
- is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Assessment event

Data Set Specifications: **Start date** **End date**

Comments:

Myocardial infarction – history

Identifying and Definitional Attributes

Knowledgebase ID:	000834	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether the individual has had a myocardial infarction.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 Myocardial infarction – occurred in the last 12 months 2 Myocardial infarction – occurred prior to the last 12 months 3 Myocardial infarction – occurred both in and prior to the last 12 months 4 No history of myocardial infarction 9 Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods: Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both). Record if evidenced by ECG changes or plasma enzyme changes.
Alternatively obtain this information from appropriate documentation.

Related metadata:

relates to the data element Blood pressure – diastolic measured vers 1
relates to the data element Blood pressure – systolic measured vers 1
relates to the data element Cholesterol-HDL – measured vers 1
relates to the data element Cholesterol-total – measured vers 1
relates to the data element Tobacco smoking status – diabetes mellitus vers 1
relates to the data element Triglycerides – measured vers 1

Administrative Attributes

Source document: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

DSS - Diabetes (clinical)

Start date

01/01/2003

End date**Comments:**

Myocardial infarction (MI) generally occurs as a result of a critical imbalance between coronary blood supply and myocardial demand. Decrease in coronary blood flow is usually due to a thrombotic occlusion of a coronary artery previously narrowed by atherosclerosis. MI is one of the most common diagnoses in hospitalised patients in industrialised countries.

The most widely used in the detection of MI are creatinine kinase (CK) and (CK-MB), aspartate aminotransferase (AST) and lactate dehydrogenase (LD). Characteristic ECG changes include ST elevation, diminution of the R wave and a Q wave development. A recent study on Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI study) indicated that in diabetic patients with AMI, mortality is predicted by age, previous heart failure, and severity of the glycometabolic state at admission, but not by conventional risk factors or sex (American Heart Association 1999).

Reference:

Long-Term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study *Circulation*. 1999;99: 2626-2632.