The Australian Institute of Health and Welfare is Australia’s national health and welfare statistics and information agency. The Institute’s mission is to improve the health and well-being of Australians by informing community discussion and decision making through national leadership in developing and providing health and welfare statistics and information.
How to use this book

Format of publication
The National Health Data Dictionary Version 12 has been divided into two volumes to cope with the significant expansion in the number of definitions endorsed for this version.

Volume 1
- Full Contents list for both volumes
- Introduction
- Summary of changes since Versions 10 and 11
  Contains a summary of all changes since Version 10 and 11 of the National Health Data Dictionary, including changes to National Minimum Data Sets and data elements, new data elements and data elements retired from the Dictionary.
- National Health Information Model
  Contains background information to the National Health Information Model Version 2 (Draft) and an index of the data elements and model entities.
- Data elements: A to M in alphabetical order
- Full Index for both volumes

Volume 2
- Full Contents list for both volumes
- Data elements: N to Z in alphabetical order
- Data Set Specifications
  Contains a full description of all data set specifications for National Minimum Data Sets and other data set specifications.
- Appendixes
- Full Index for both volumes

Formatting conventions
- Only metadata items with an Admin. status of CURRENT are published in this book.
- Each metadata item is divided into three sections:
  - Identifying and definitional attributes
    - used to identify the metadata item in the Registry; and
    - used to provide a definition, the context in which the definition is valid and any relevant comments that help in defining the metadata item
  - Relational and representational attributes
    - used to record what such a data item would look like and how it is used.
  - Administrative attributes
    - the attributes of the metadata item that are relevant to the Registry.
- Links to the National Health Information Model are identified in each data element.
Not all attributes have instances of information.
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- Previous specialised treatment
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- Source of referral to alcohol and other drug treatment service
- Source of referral to public psychiatric hospital
- Time patient presents
- Type of visit to emergency department
- Waiting list category
- Year insulin started
- Year of diagnosis of diabetes mellitus

---

**Acute care episode for admitted patients (concept)**
- Anaesthesia administered during labour
- Analgesia administered during labour
- Blood pressure - concept
- Blood pressure-diastolic - measured
- Blood pressure-systolic - measured
- Care type
- Cholesterol-HDL - measured
- Cholesterol-LDL - calculated
- Cholesterol-total - measured
- Clinical intervention (concept)
- Contracted hospital care
- Creatinine serum - measured
- Date of change to qualification status
- Date of commencement of service event
- Date of first delivery of service
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- Episode of care
- Fasting status
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- Group sessions
- Hospital-in-the-home care (concept)
- Indicator procedure
- Individual/group session
- Laterality of primary cancer
- Main treatment type for alcohol and other drugs
- Microalbumin/protein - measured
- Minutes of operating theatre time

---

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- Living arrangement

**Organisation characteristic:**
- Establishment identifier
- Establishment number
- Establishment type
- Quality accreditation/certification standard
- Region code
- Specialised service indicators
- Teaching status

**Party role**

**Organisation role:**
- Contract role
- Contract type

**Recipient role:**
- Admitted patient (concept)
- Centrelink customer reference number
- Department of Veterans’ Affairs file number
- Hospital boarder (concept)
- Inter-hospital contracted patient
- Medicare card number
- Non-admitted patient (concept)
- Overnight-stay patient (concept)
- Patient (concept)
- Person identifier
- Person identifier type – health care
- Same-day patient (concept)

**Service provider role:**
- Division of General Practice number

**Outcome**

**Stated outcome:**
- Health outcome (concept)
- Health outcome indicator (concept)

**Expected outcome:**
- Goal of care
Data Elements

N – Z
Name

Identifying and Definitional Attributes

Knowledgebase ID: 000835     Version No: 1
Metadata type: Data Element Concept
Admin. status: Current
01/01/03

Definition: A person’s full identifying name within any social context in which a person may be identified as an individual.

Context:

Relational and Representational Attributes

Datatype:
Representational form:
Representational layout:
Minimum size:
Maximum size:
Data domain:
Guide for use:
Verification rules:
Collection methods: relates to the data element Family name vers 1
relates to the data element Given name(s) vers 1
relates to the data element Name context flag vers 1
relates to the data element Name suffix vers 1
relates to the data element Name title vers 1
relates to the data element Name type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification, with adaptation.
Source organisation: Standards Australia
Information model link: NHIM Person characteristic

Data Set Specifications:
DSS – Health care client identification

Comments:
Name context flag

Identifying and Definitional Attributes

Knowledgebase ID: 000785
Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: An indicator of specific conditions that should be applied to a particular person’s name.

Context:

Relational and Representational Attributes

Datatype: Numeric
Representation form: Code
Representational layout: N
Minimum size: 0
Maximum size: 1

Data domain:
1 Unreliable information
2 Name not for continued use
3 Special privacy/security requirement

Guide for use:
Field value definitions are:
1 Unreliable information: should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.
2 Name not for continued use: certain tribal names may become ‘not for continued use’.
3 Special privacy/security requirement: may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.

Verification rules: Valid codes or blank.

Collection methods:

Related metadata: relates to the data element Family name vers 1
relates to the data element Given name(s) vers 1
relates to the data element concept Name vers 1
relates to the data element Name suffix vers 1
relates to the data element Name title vers 1
relates to the data element Name type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification
Source organisation: Standards Australia

Information model link:
NHIM  Person characteristic

Data Set Specifications:

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<th>Data Set Specifications</th>
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Comments:
Name suffix

Identifying and Definitional Attributes

Knowledgebase ID: 000783 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: Additional term following a person’s name used to identify a person when addressing them by name, whether by mail, by phone or in person.

Context:

Relational and Representational Attributes

Datatype: Alphabetic
Representational form: Text
Representational layout: A(12)
Minimum size: 0
Maximum size: 12

Data domain: Name suffix should be abbreviated in accordance with Australian Standard AS4590-1999 Interchange of client information. For example:

Jr  Junior
MP  Member of Parliament
QC  Queens Council
Sr  Senior
I   First
II  Second
III Third
IV  Fourth
V   Fifth
VI  Sixth
VII Seventh
VIII Eighth
IX  Ninth
X   Tenth

Guide for use: Mixed case should be used (rather than upper case only).
More than one Name suffix may be collected.
Use a single space between each suffix.

Verification rules:
Collection methods:
Related metadata: relates to the data element Family name vers 1
relates to the data element Given name(s) vers 1
relates to the data element concept Name vers 1
relates to the data element Name context flag vers 1
relates to the data element Name title vers 1
relates to the data element Name type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification, with adaptation.

Source organisation: Standards Australia

Information model link: NHIM Person characteristic

Data Set Specifications:

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Comments:
Name title

Identifying and Definitional Attributes

Knowledgebase ID: 000780 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone or in person.

Context:

Relational and Representational Attributes

Datatype: Alphabetic
Representational form: Text
Representational layout: A(12)
Minimum size: 0
Maximum size: 12

Data domain: Name title should be abbreviated in accordance with Australian Standard AS4590-1999 Interchange of client information. For example:
Br Brother
Dame Dame
Dr Doctor
Mstr Master
Miss Miss
Mr Mister
Mrs Mrs
Ms Ms
Prof Professor
Rev Reverend
Sir Sir
Sr Sister

Guide for use: Name title should not be confused with job title.
Mixed case should be used (rather than upper case only).

Verification rules: Title of Master should only be used for persons less than 15 years of age.
Titles of Doctor and Professor should only be applicable to persons of greater than 20 years of age

Collection methods:

Related metadata: relates to the data element Family name vers 1
relates to the data element Given name(s) vers 1
relates to the data element concept Name vers 1
relates to the data element Name context flag vers 1
relates to the data element Name suffix vers 1
relates to the data element Name type vers 1

Administrative Attributes

Source document: AS 5017 Health care client identification

Source organisation: Standards Australia

Information model link: NHIM Social characteristic

Data Set Specifications: DSS – Health care client identification

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<tbody>
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</table>

Comments:
Name type

Identifying and Definitional Attributes

Knowledgebase ID: 000784
Version No: 1

Metadata type: Data Element
Admin. status: Current
01/01/03

Definition: A classification that enables differentiation between recorded names for a person.

Context:

Relational and Representational Attributes

Datatype: Alphabetic
Representational form: Code
Representational layout: A
Minimum size: 1
Maximum size: 1

Data domain:

A  Alias name
M  Medicare card name
N  Newborn name
P  Preferred name

Guide for use:

More than one name can be recorded for a person who is a health care client. That is, this field is a multiple occurring field. At least one name must be recorded for each person and each name must have an appropriate Name type.

One name is sufficient, however, where the person offers more than one name, clarification should be obtained from the person to ensure accurate identification of the person and recording of the various names. Both currently used names, as well as names by which the person has previously been known, should be recorded if these are known.

Field value definitions for Name type codes are:

Preferred name (P): is the name by which the person chooses to be identified. There should only be one preferred name recorded for a person. Where the person changes their preferred name, record the previously recorded preferred name as an Alias name. Preferred name is the default name type (i.e. if only one name is recorded it should be the person’s Preferred name). There must be a Preferred name recorded except for unnamed newborns where the Newborn name is the only name recorded.

Also, if the person is a health care client, record his/her Medicare card name if different to the Preferred name, and any known Alias names.

Medicare card name (M): is the person’s name as it appears on their Medicare card. The name stated on the Medicare card is required for all electronic Medicare claim lodgement. If the Preferred name of the person is different to the name on the Medicare card, the Medicare card name should also be recorded.

Newborn name (N): type is reserved for the identification of unnamed newborn babies.
Alias name (A): is any other name that a person is also known by, or has been known by in the past; that is, all alias names. This includes misspelt names or name variations that are to be retained as they have been used to identify this person. More than one alias name may be recorded for a person.

Where a person provides a name that can be in more than one Name type category, the Name type with the highest order of precedence should be used. Multiple versions of the same name can however be recorded.

**Verification rules:**

**Collection methods:**

**Related metadata:**
- relates to the data element Family name vers 1
- relates to the data element Given name(s) vers 1
- relates to the data element concept Name vers 1
- relates to the data element Name context flag vers 1
- relates to the data element Name suffix vers 1
- relates to the data element Name title vers 1

**Administrative Attributes**

**Source document:** AS5017 Health care client identification

**Source organisation:** Standards Australia

**Information model link:** NHIM Social characteristic

**Data Set Specifications:**

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**Comments:**
## Narrative description of injury event

### Identifying and Definitional Attributes

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<td>Data Element</td>
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<tr>
<td>Admin. status:</td>
<td>Current 01/07/96</td>
<td></td>
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<tr>
<td>Definition:</td>
<td>A text description of the injury event.</td>
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### Context:

Injury surveillance:

The narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data.

### Relational and Representational Attributes

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<th>Datatype:</th>
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<td>Representational form:</td>
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<td>Representational layout:</td>
<td>A(100)</td>
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<tr>
<td>Minimum size:</td>
<td>0</td>
</tr>
<tr>
<td>Maximum size:</td>
<td>100</td>
</tr>
</tbody>
</table>

**Data domain:**

Text up to 100 characters in length

**Guide for use:**

Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event), the mechanism by which this event led to injury and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should also be indicated.

**Verification rules:**

**Collection methods:**

is qualified by Activity when injured vers 2

is qualified by External cause – human intent vers 4

### Administrative Attributes

**Source document:**

National Injury Surveillance Unit

**Source organisation:**

National Injury Surveillance Unit

**Information model link:**

NHIM Injury event

**Data Set Specifications:**

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<tbody>
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</tbody>
</table>

**Comments:**

This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.
Nature of main injury – non-admitted patient

Identifying and Definitional Attributes
Knowledgebase ID: 000087 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/96
Definition: The nature of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance:
Injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This item, together with data element Bodily location of main injury, indicates the diagnosis.

Relational and Representational Attributes
Datatype: Numeric
Representational form: Code
Representational layout: NN or NN.N
Minimum size: 2
Maximum size: 4

Data domain:
01 Superficial (excludes eye [13])
02 Open wound (excludes eye [13])
03 Fracture (excludes tooth [21])
04 Dislocation (includes ruptured disc, cartilage, ligament)
05 Sprain or strain
06 Injury to nerve (includes spinal cord; excludes intracranial injury [20])
07 Injury to blood vessel
08 Injury to muscle or tendon
09 Crushing injury
10 Traumatic amputation (includes partial amputation)
11 Injury to internal organ
12 Burn or corrosion (excludes eye [13])
13 Eye injury (excludes foreign body in external eye [14.1], includes burns)
14.1 Foreign body in external eye
14.2 Foreign body in ear canal
14.3 Foreign body in nose
14.4 Foreign body in respiratory tract (excludes foreign body in nose [14.3])
14.5 Foreign body in alimentary tract
14.6 Foreign body in genitourinary tract
14.7 Foreign body in soft tissue
14.9 Foreign body, other/unspecified
20 Intracranial injury (includes concussion)
21 Dental injury (includes fractured tooth)
22 Drowning, immersion
23  Asphyxia or other threat to breathing (excludes drowning [22])
24  Electrical injury
25  Poisoning, toxic effect (excludes venomous bite [26])
26  Effect of venom, or any insect bite
27  Other specified nature of injury
28  Injury of unspecified nature
29  Multiple injuries of more than one ‘nature’
30  No injury detected

Guide for use:
If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis). When coding to the full ICD-10-AM code is not possible, use this item with the data elements External cause of injury – non admitted patient, External cause of injury – human intent and Bodily location of main injury.

Select the item which best characterises the nature of the injury chiefly responsible for the attendance, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding ‘multiple injuries’. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as ‘minor’.

If the nature of the injury code is 01 to 12 or 26 to 29 then data element Bodily location of main injury should be used to record the bodily location of the injury. If another code is used, bodily location is implicit or meaningless. Data element Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

Verification rules:
Left justified, zero filled.

Collection method
is used in conjunction with Bodily location of main injury vers 1
is used in conjunction with External cause – human intent vers 4
is used in conjunction with External cause – non-admitted patient vers 4

Related metadata:

Administrative Attributes
Source document:
AIHW National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group
Source organisation:
Information model link:
NHIM  Physical wellbeing
Data Set Specifications:  Start date  End date
NMDS – Injury surveillance  01/07/1996

Comments:
This item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the data element Bodily location of main injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.
# Need for interpreter service

## Identifying and Definitional Attributes

<table>
<thead>
<tr>
<th>Knowledgebase ID:</th>
<th>000100</th>
<th>Version No: 1</th>
</tr>
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<tbody>
<tr>
<td>Metadata type:</td>
<td>Data Element</td>
<td></td>
</tr>
<tr>
<td>Admin. status:</td>
<td>Current 01/07/89</td>
<td></td>
</tr>
</tbody>
</table>

**Definition:** Need for interpreter services (yes/no) as perceived by the person.

**Context:** To assist in planning for provision of interpreter services.

## Relational and Representational Attributes

<table>
<thead>
<tr>
<th>Datatype:</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representational form:</td>
<td>Code</td>
</tr>
<tr>
<td>Representational layout:</td>
<td>N</td>
</tr>
<tr>
<td>Minimum size:</td>
<td>1</td>
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<td>1</td>
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</table>

**Data domain:**

<table>
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<tr>
<th></th>
<th>Interpreter not needed</th>
<th>Interpreter needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Guide for use:**
**Verification rules:**
**Collection methods:**
**Related metadata:** is used in conjunction with Preferred language vers 2

## Administrative Attributes

**Source document:**
**Source organisation:** National Health Data Committee

**Information model link:**
NHIM Social characteristic

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** This data element has not been included in the NMDS – Admitted patient care because of reservations about its utility in assessing demand for interpreter services and concerns that a question of this nature might raise expectations of service provision which could not always be fulfilled.
# Neonatal death

## Identifying and Definitional Attributes

<table>
<thead>
<tr>
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<th>000101</th>
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<th>1</th>
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<tbody>
<tr>
<td>Metadata type:</td>
<td>Data Element Concept</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin. status:</td>
<td>Current</td>
<td>01/07/96</td>
<td></td>
</tr>
</tbody>
</table>

**Definition:**
The death of a live birth which occurs during the first 28 days of life. This may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.

**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, Tenth Revision – WHO, 1992

**Source organisation:**
National Perinatal Data Development Committee

**Information model link:**
NHIM  Death event

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

**Comments:**
Age at death during the first day of life (day zero) should be recorded in units of completed minutes or hours of life. For the second (day one), third (day two) and through 27 completed days of life, age at death should be recorded in days (WHO 1992).
# Neonatal morbidity

## Identifying and Definitional Attributes

<table>
<thead>
<tr>
<th>Knowledgebase ID:</th>
<th>000102</th>
<th>Version No:</th>
<th>2</th>
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<tr>
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<td>Data Element</td>
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<tr>
<td>Admin. status:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>01/07/98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definition:</td>
<td>Conditions or diseases of the baby.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Context:**
Perinatal statistics:
Morbidity of a baby is an important determinant of outcome and duration of hospital stay.

## Relational and Representational Attributes

<table>
<thead>
<tr>
<th>Datatype:</th>
<th>Alphanumeric</th>
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</thead>
<tbody>
<tr>
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<td>Code</td>
</tr>
<tr>
<td>Representational layout:</td>
<td>ANN.NN</td>
</tr>
<tr>
<td>Minimum size:</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size:</td>
<td>6</td>
</tr>
</tbody>
</table>

**Data domain:**
ICD-10-AM (3rd edition)

**Guide for use:**
There is no arbitrary limit on the number of conditions specified.

**Verification rules:**
Conditions should be coded within chapter of Volume 1, ICD-10-AM

**Collection methods:**
Is used in conjunction with Congenital malformations vers 2
Is used in conjunction with Congenital malformations – BPA code vers 1
Supersedes previous data element Neonatal morbidity – ICD-9-CM code vers 1

## Administrative Attributes

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Source organisation:</td>
<td>National Perinatal Data Development Committee</td>
</tr>
<tr>
<td>Information model link:</td>
<td>NHIM Physical wellbeing</td>
</tr>
<tr>
<td>Data Set Specifications:</td>
<td>Start date</td>
</tr>
</tbody>
</table>

**Comments:**
Neonate

Identifying and Definitional Attributes

Knowledgebase ID: 000103
Version No: 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/95

Definition: A live birth who is less than 28 days old.

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: 

Administrative Attributes


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

Information model link: NHIM Person characteristic

Data Set Specifications: Start date End date

Comments: The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27. For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October.
New/repeat status

Identifying and Definitional Attributes

Knowledgebase ID: 000435

Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: A new non-admitted patient service event is one for a problem not previously addressed at the same clinical service. All other non-admitted patient service events are repeat service events.

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 New non-admitted patient service event
2 Repeat non-admitted patient service event

Guide for use:

New service events occur as each type of clinical service makes their full assessment consultation with the patient.

Repeat visits include completion of an ambulatory procedure, e.g. removal of sutures and removal of plaster casts.

Examples of clinical services are included in the Guide for use for Non-admitted patient service type.

Verification rules:

Collection methods:

is used in conjunction with Individual/group session vers 1
is used in conjunction with Multi-disciplinary team 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 – patient present status vers 1
is used in conjunction with Non-admitted patient service mode 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:
Newborn qualification status

Identifying and Definitional Attributes

Knowledgebase ID: 000343

Version No: 2

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

Definition: Qualification status indicates whether the patient day within a newborn episode of care is either qualified or unqualified.

Context: Admitted patient care:

To provide accurate information on care provided in newborn episodes of care through exclusion of unqualified patient days.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: A newborn qualification status is assigned to each patient day within a newborn episode of care.

A newborn patient day is qualified if the infant meets at least one of the following criteria:

− is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient

− is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care

− is admitted to, or remains in hospital without its mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

The day on which a change in qualification status occurs is counted as a day of the new qualification status.

If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Admitted patient vers 3

is used in conjunction with Care type vers 4

is used in the calculation of Date of change to qualification status vers 1

is used in the calculation of Number of qualified days for newborns vers 2

supersedes previous data element Qualification status vers 1

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Administrative Attributes

Source document:
Source organisation:
Information model link:
NHIM Service provision event

Comments: All babies born in hospital are admitted patients.
The newborn baby’s qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.
The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.
Non-admitted patient

Identifying and Definitional Attributes

**Knowledgebase ID:** 000104  **Version No:** 1

**Metadata type:** Data Element Concept

**Admin. status:** Current

01/07/94

**Definition:** A patient who does not undergo a hospital’s formal admission process.

There are three categories of non-admitted patient:

- emergency department patient
- outpatient
- other non-admitted patient (treated by hospital employees off the hospital site – includes community/outreach services)

**Context:** Non-admitted patient care.

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 concept Patient vers 1

Administrative Attributes

**Source document:**

**Source organisation:** National Health Data Committee

**Information model link:**

NHIM  Recipient role

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

**Comments:**
Non-admitted patient Emergency department service episode

Identifying and Definitional Attributes

Knowledgebase ID: 000836
Version No: 1
Metadata type: Data Element Concept
Admin. status: Current
01/07/03
Definition: The treatment or care between when a patient presents at an Emergency department and when the non-admitted patient Emergency department treatment or care ends.

Context: Emergency department care.

Relational and Representational Attributes

Datatype:
Representational form:
Representational layout:
Minimum size:
Maximum size:
Data domain:
Guide for use: Includes patients who do not wait for treatment once registered or triaged, and those who are dead on arrival at the Emergency department.
Both a non-admitted patient Emergency department service episode and an admitted patient episode of care should be recorded for patients who subsequently undergo a formal admission. The end of the non-admitted patient Emergency department service episode should indicate the commencement of the admitted episode of care, if applicable.
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: relates to the data element Date patient presents vers 2
relates to the data element concept Emergency department – public hospital vers 1
relates to the data element Length of non-admitted patient Emergency department service episode vers 1
relates to the data element Patient presentation at emergency department vers 1
relates to the data element Time patient presents vers 2

Administrative Attributes

Source document: National reference group for non-admitted patient data development, 2001–02
Source organisation: National reference group for non-admitted patient data development, 2001–02
Information model link:

NHIM Service provision event

Data Set Specifications:

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

Comments:

This data element concept has been defined to support the National Minimum Data Set for Non-admitted patient Emergency department care.
Non-admitted patient service event

Identifying and Definitional Attributes

Knowledgebase ID: 000438  Version No: 1

Metadata type: Data Element Concept

Admin. status: Current 01/07/00

Definition: An interaction between one or more health care professionals with one or more non-admitted patients, for assessment, consultation and/or treatment intended to be unbroken in time. A service event means that a dated entry is made in the patient/client’s medical record.

Context: Hospital non-admitted patient care:

This definition applies to non-admitted hospital patients and is not intended to apply to Community-based services.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

The period of interaction can be broken but still regarded as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons, for example, a clinician is called to assess another patient who requires more urgent care.

Service events can occur in an outpatient, emergency, radiology, pathology and/or pharmacy department or, by a hospital-based outreach service, in a location that is not part of the hospital campus.

Service events may or may not be pre-arranged (except for telephone calls).

Imaging, pathology and/or pharmacy services that are ASSOCIATED with a service event in an outpatient clinic, emergency department or outreach service are NOT regarded as service events themselves.

Imaging, pathology or pharmacy services provided INDEPENDENT of a service event in an outpatient clinic, emergency department or outreach service are regarded as individual service events.

Service events delivered via a telephone call are included if

− they are a substitute for a face-to-face service event
− they are pre-arranged
− a record of the service event is included in the patient’s medical record.

Service events include when the patient is participating via a video link (telemedicine). A service event can be counted at each site participating via the video link.

If a carer/relative accompanies a patient during a service event, this is not considered to be a service event for the carer/relative, provided that the carer/relative is not a patient in their own right for the service contact.

Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.
A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

A service event is regarded as having occurred for each patient who attends a group session such as an antenatal class.

Outpatient department services provided to admitted patients are not regarded as service events.

Work-related services provided in clinics for staff are not service events.

Definitions:

An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Hospital-based outreach services events relate to treatment of patients by hospital staff in a location that is not part of the hospital campus (such as in the patient’s home or place of work).

Verification rules:

Collection methods:

Related metadata:

is used in conjunction with Individual/group session vers 1

is used in conjunction with Multi-disciplinary team status vers 1

is used in conjunction with Non-admitted patient service event – patient present status vers 1

is used in conjunction with Non-admitted patient service event count vers 1

is used in conjunction with Non-admitted patient service mode vers 1

is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

Data Set Specifications: Start date End date

Comments:
Non-admitted patient service event – patient present status

Identifying and Definitional Attributes

Knowledgebase ID: 000436  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/00
Definition: The presence or absence of a patient at a non-admitted patient service event.

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 Patient present with or without carer(s)/relative(s)
2 Carer(s)/relative(s) of the patient only

Guide for use: A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Verification rules:
Collection methods:
Related metadata:
is used in conjunction with Individual/group session vers 1
is used in conjunction with Multi-disciplinary team 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 mode 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:
Non-admitted patient service event count

Identifying and Definitional Attributes

Knowledgebase ID: 000437
Version No: 1

Metadata type: Data Element
Admin. status: Current
01/07/00

Definition: The number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.

Context: Hospital non-admitted patient care – public patients only.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NNNNNNN
Minimum size: 1
Maximum size: 7

Data domain: Count of non-admitted patient service events for each of the clinical service types listed in the data domain of the data element Non-admitted patient service type.

Guide for use: For each non-admitted patient service event count, specify the
- Service type
- Multi-disciplinary team status
- Individual/group session status
- Patient present status
- Service mode

Verification rules:

Collection methods:

Related metadata:
- is used in conjunction with Individual/group session vers 1
- is used in conjunction with Multi-disciplinary team 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 – patient present status vers 1
- is used in conjunction with Non-admitted patient service mode vers 1
- is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:
Source organisation: National Health Data Committee

Information model link:
NHIM Performance indicator

Data Set Specifications: Start date End date

Comments: Public patients are defined in accordance with the 1998-2003 Australian Health Care Agreements.
Non-admitted patient service mode

Identifying and Definitional Attributes

Knowledgebase ID: 000439  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/00
Definition: Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event.

Context: Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: N or N.N
Minimum size: 1
Maximum size: 3

Data domain:
1  Patient and provider in the same physical location
1.1 On the hospital campus of the provider
1.2 Not on the hospital campus of the provider
2  Patient and provider not in the same physical location, and communicating via:
2.1 Telephone
2.2 Telemedicine

Guide for use: Patient and provider in the same physical location refers to face-to-face contacts. If this occurs at the hospital campus of the provider, use code 1.1. If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2.

Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient’s home or place of work).

Patient and provider not in the same physical location refers to service events delivered via a telephone call or video link (telemedicine). The provider may or may not be physically present on their hospital campus.

A service event delivered via a telephone call is included if
- it is a substitute for a face-to-face service event, and
- it is pre-arranged, and
- a record of the service event is included in the patient’s medical record

A service event can be counted at each site participating via a video link.

Verification rules:

Collection methods:
Related metadata:
is used in conjunction with Individual/group session vers 1
is used in conjunction with Multi-disciplinary team 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: National Health Data Committee

Information model link:

NHIM  Service provision event

Data Set Specifications:  

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

Comments:
Non-admitted patient service type

Identifying and Definitional Attributes

Knowledgebase ID: 000440
Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/00
Definition: The type of clinical service provided to a non-admitted patient in a non-admitted patient service event.

Context: Hospital non-admitted patient care:
This definition applies to non-admitted hospital patients and is not intended to apply to Community-based services.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: N or NN
Minimum size: 1
Maximum size: 2

Data domain:

1 Allied health and/or clinical nurse specialist
2 Dental
3 Imaging
4 Medical
5 Obstetrics and gynaecology
6 Paediatrics
7 Pathology
8 Pharmacy
9 Psychiatric
10 Surgical
11 Emergency department

Guide for use:
The following provides a guide to types of clinical services that are included in each of the categories in the data domain. Clinical services that are not specifically identified in this Guide for use should be classified as one of the groups in the data domain on the basis of the type of clinical professional staff involved in providing the service event.

In paediatric hospitals, the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgical should be reported as surgical.

Examples of clinical service types follow:
<table>
<thead>
<tr>
<th>Clinical service type</th>
<th>Clinical service examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied health and/or clinical nurse specialist</td>
<td>Audiology</td>
</tr>
<tr>
<td></td>
<td>Clinical pharmacy</td>
</tr>
<tr>
<td></td>
<td>Diabetes education</td>
</tr>
<tr>
<td></td>
<td>Neuropsychology</td>
</tr>
<tr>
<td></td>
<td>Nutrition/dietetics</td>
</tr>
<tr>
<td></td>
<td>Occupational therapy</td>
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<td>Thoracic surgery</td>
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<td>Vascular surgery</td>
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<td>Emergency department</td>
<td>Emergency department</td>
</tr>
</tbody>
</table>

An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

**Verification rules:**
Collection methods:
Related metadata:
is used in conjunction with Individual/group session vers 1
is used in conjunction with Multi-disciplinary team status 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

Administrative Attributes
Source document:
Source organisation:
Information model link:
NHIM  Service provision event

Data Set Specifications:  
Start date   End date

Comments:
Non-elective care

Identifying and Definitional Attributes

Knowledgebase ID: 000105  Version No: 1
Metadata type: Data Element Concept
Admin. status: Current
01/07/96

Definition: Care that, in the opinion of the treating clinician, is necessary and admission for which cannot be delayed for more than 24 hours.

Context: Institutional health care.

Relational and Representational Attributes

Datatype:
Representational form:
Representational layout:
Minimum size:
Maximum size:
Data domain:
Guide for use:
Verification rules:
Collection methods:
Related metadata:

Administrative Attributes

Source document:
Source organisation: Hospital Access Program Waiting Lists Working Group/National Health Data Committee
Information model link: NHIM  Service provision event
Data Set Specifications:  Start date  End date

Comments:
Non-salary operating costs

Identifying and Definitional Attributes

Knowledgebase ID: 000360 Version No: 1
Metadata type: Derived Data Element
Admin. status: Current
01/07/98
Definition: Total expenditure relating to non-salary operating items.
Context: Health care:
This data element is required to monitor trends of expenditure in the sector.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Currency
Representational layout: $999,999,999
Minimum size: 2
Maximum size: 12
Data domain: Australian dollars to the nearest whole dollar.
Guide for use: Record values up to hundreds of millions of dollars.
Total is calculated from expenditure including:
- Payments to visiting medical officers
- Superannuation employer contributions (including funding basis)
- Drug supplies
- Medical and surgical supplies
- Food supplies
- Domestic services
- Repairs and maintenance
- Patient transport
- Administrative expenses
- Interest payments
- Depreciation
- Other recurrent expenditure.
Expenditure should include both the specific costs directly associated with the service and indirect costs for example personnel services.
Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.

Validation rule:

Collection methods:
Related metadata: is calculated using Administrative expenses vers 1
is calculated using Depreciation vers 1
is calculated using Domestic services vers 1
is calculated using Drug supplies vers 1
is calculated using Food supplies vers 1
is calculated using Interest payments vers 1
is calculated using Medical and surgical supplies vers 1
is calculated using Other recurrent expenditure vers 1
is calculated using Patient transport vers 1
is calculated using Payments to visiting medical officers vers 1
is calculated using Repairs and maintenance vers 1
is calculated using Superannuation employer contributions (including funding basis) vers 1

Administrative Attributes

Source document:
Source organisation:
Information model link:
NHIM  Recurrent expenditure

Data Set Specifications:  
NMDS - Community mental health establishments  
Start date  01/07/1998  
End date

Comments:
Number of available beds for admitted patients

Identifying and Definitional Attributes

**Knowledgebase ID:** 000255  
**Metadata type:** Data Element  
**Admin. status:** Current  
01/07/97  
**Definition:** An available bed is a bed which is immediately available to be used by an admitted patient or resident if required. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period. Inclusions: both occupied and unoccupied beds are included. For residential aged care services, the number of approved beds includes beds approved for respite care. Exclusions: surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded and beds designated for same-day non-admitted patient care are excluded. Beds in wards which were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only) are also excluded.

**Context:** Necessary to provide an indicator of the availability and type of service for an establishment.

Relational and Representational Attributes

**Datatype:** Numeric  
**Representational form:** Quantitative value  
**Representational layout:** NNNN  
**Minimum size:** 1  
**Maximum size:** 4  
**Data domain:** Average available beds, rounded to the nearest whole number

**Guide for use:** The average bed is to be calculated from monthly figures.

**Verification rules:**

**Collection methods:**

**Related metadata:** relates to the data element concept Admitted patient vers 3 supersedes previous data element Number of available beds for admitted patients vers 1

Administrative Attributes

**Source document:**

**Source organisation:** National Health Data Committee

**Information model link:** NHIM Aggregate resource
**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set Description</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Public hospital establishments</td>
<td>01/07/1997</td>
<td>01/07/1997</td>
</tr>
<tr>
<td>NMDS – Community mental health establishments</td>
<td>01/07/1997</td>
<td>01/07/1998</td>
</tr>
</tbody>
</table>

**Comments:**
This National Health Data Dictionary entry was amended during 1996–97. Until then, both average and end-of-year counts of available beds were included, and the end-of-year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate characterisation of establishments and comparisons.
Number of contacts (psychiatric outpatient clinic/day program)

Identifying and Definitional Attributes
Knowledgebase ID: 000141  Version No: 1
Metadata type: Data Element
Admin. status: Current 01/07/89
Definition: Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.
Context: Mental health statistics:
This data element gives a measure of the level of service provided.

Relational and Representational Attributes
Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN
Minimum size: 1
Maximum size: 3

Data domain: Count in number of days
Guide for use:
Verification rules:
Collection methods: All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)
Related metadata: is an alternative to Number of service contact dates vers 2

Administrative Attributes
Source document:
Source organisation: National minimum data set working parties
Information model link: NHIM  Service provision event
Data Set Specifications: Start date  End date
Comments: In December 1998, the National Health Information Management Group decided that the new version of this data element (named Number of service contact dates) would be implemented from 1 July 2000 in the NMDS – Community mental health. Until then agencies involved in the NMDS – Community mental health may report either Number of contacts (psychiatric outpatient clinic/day program) or Number of service contact dates with the expectation that agencies will make their best efforts to report against the new version of this data element (Number of service contact dates) from 1 July 1999.
Number of days in special/neonatal intensive care

Identifying and Definitional Attributes

Knowledgebase ID: 000009
Version No: 2

Metadata type: Data Element
Admin. status: Current
01/07/97

Definition: Number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).

Context: Admitted patient care and perinatal statistics:
An indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN
Minimum size: 1
Maximum size: 3

Data domain: Number, representing the number of days spent in the special/intensive care nursery

Guide for use: The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit.

Verification rules: This item is to be completed if baby has been treated in an intensive care unit or a special care nursery (SCN).

Collection methods: SCN are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICN also provide consultative services to other hospitals.

Related metadata: supersedes previous data element Admission to special/neonatal intensive care vers 1

Administrative Attributes

Source document: National Perinatal Data Development Committee

Source organisation: National Perinatal Data Development Committee

Information model link: NHIM Service provision event

Data Set Specifications: Start date End date

Comments:
Number of days of hospital-in-the-home care

Identifying and Definitional Attributes

Knowledgebase ID: 000640          Version No: 1
Metadata type: Derived Data Element
Admin. status: Current
01/07/01

Definition: The number of hospital-in-the-home days occurring within an episode of care for an admitted patient.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN
Minimum size: 0
Maximum size: 3

Data domain: Count of patient days.

Guide for use: The rules for calculating the number of hospital in the home days are outlined below:

− The number of hospital in the home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation.
− The date of admission is counted if the patient was at home at the end of the day.
− The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day.
− The date of separation is not counted, even if the patient was at home at the end of the day.
− The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.

Collection methods: relates to the data element Admission date vers 4
Related metadata: relates to the data element concept Admitted patient vers 3
relates to the data element concept Episode of care vers 1
relates to the data element concept Hospital-in-the-home care vers 1
relates to the data element Separation date vers 5

Administrative Attributes

Source document: National Health Data Committee
Information model link:
NHIM Exit/leave from service event

Data Set Specifications:
<table>
<thead>
<tr>
<th>Data Set</th>
<th>Start date</th>
<th>End date</th>
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<tbody>
<tr>
<td>NMDS - Admitted patient care</td>
<td>01/07/2001</td>
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</table>

Comments:
Number of days of hospital-in-the-home care data will be collected from all States and Territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.
Number of leave periods

Identifying and Definitional Attributes

Knowledgebase ID: 000107
Version No: 3

Metadata type: Data Element
Admin. status: Current
01/07/96

Definition: Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).
Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

Context: Recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NN
Minimum size: 1
Maximum size: 2

Data domain: Count of leave periods.

Guide for use: If the period of leave is greater than seven days or of the patient fails to return from leave, the patient is discharged.

Verification rules:
Collection methods: is used in the derivation of Length of stay vers 3
Related metadata: supersedes previous data element Number of leave periods vers 2
supersedes previous derived data element Number of leave periods exceeding ten days vers 2

Administrative Attributes

Source document:
Source organisation: National Health Data Committee

Information model link: NHIM Exit/leave from service event

Data Set Specifications:
NMDS – Admitted patient care
Start date 01/07/1996

Comments: This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.
Number of qualified days for newborns

Identifying and Definitional Attributes

Knowledgebase ID: 000346
Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/00
Definition: The number of qualified newborn days occurring within a newborn episode of care.
Context: Admitted patient care – newborn episodes of care only.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNNNN
Minimum size: 1
Maximum size: 5

Data domain: Count of the number of days.

Guide for use: The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the date of admission, date of separation and any date(s) of change to qualification status:
- the date of admission is counted if the patient was qualified at the end of the day
- the date of change to qualification status is counted if the patient was qualified at the end of the day
- the date of separation is not counted, even if the patient was qualified on that day
- the normal rules for calculation of patient days apply, for example in relation to leave and same day patients

The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.

Verification rules:
Collection methods:
Related metadata: is used in conjunction with Date of change to qualification status vers 1
is used in conjunction with Newborn qualification status vers 2
supersedes previous data element Number of acute (qualified)/unqualified days for newborns vers 1
is used in the calculation of Patient days vers 3

Administrative Attributes

Source document:
Source organisation:
Information model link:
NHIM Performance indicator

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

Comments:
Number of service contact dates

Identifying and Definitional Attributes

Knowledgebase ID: 000141 Version No: 2

Metadata type: Derived Data Element

Admin. status: Current

01/07/99

Definition: The number of dates where a service contact was recorded for the patient/client.

Context: Community-based mental health care:
This data element gives a measure of the level of service provided to a patient/client.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count of dates of contact

Guide for use: This data element is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once.

For collection from community-based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.

Verification rules:

Collection methods:

Related metadata: is an alternative to Number of contacts (psychiatric outpatient clinic/day program) vers 1
relates to the data element concept Service contact vers 1
is derived from Service contact date vers 1

Administrative Attributes

Source document:

Source organisation: National Mental Health Information Strategy Committee

Information model link:

NHIM Service provision event

Data Set Specifications: Start date End date

Comments:
Number of service contacts within a treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: 000641 Version No: 2
Metadata type: Derived Data Element
Admin. status: Current 01/07/02
Definition: Number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.
Context: Alcohol and other drug treatment services: This data element provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN
Minimum size: 1
Maximum size: 3
Data domain: Count of service contacts
Guide for use: This data element is a count of service contacts related to treatment, that are recorded on a client record. Any client contact that does not constitute part of a treatment should not be considered a service contact. Contact with the client for administrative purposes, such as arranging an appointment, should not be included.
This data element is not collected for residential clients.
Where multiple service provider staff have contact with the client at the same time, on the same occasion of service, the contact is counted only once.
When multiple service contacts are recorded on the same day, each independent contact should be counted separately.

Verification rules:

Collection methods: To be collated at the close of a treatment episode.
Related metadata: relates to the data element concept Cessation of treatment episode for alcohol and other drugs vers 2
relates to the data element concept Commencement of treatment episode for alcohol and other drugs vers 2
supersedes previous data element Number of service contacts within a treatment episode for alcohol and other drugs vers 1
relates to the data element concept Service contact vers 1
relates to the data element concept Treatment episode 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

Comments:
Nursing diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: 000110
Version No: 2

Metadata type: Data Element
Admin. status: Current
01/07/98

Definition: Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

Context: Enables analysis of information by diagnostic variables especially in relation to the development of outcome information, Goal of care and Nursing intervention. Nursing diagnosis and the data element Nursing interventions have shown to be more predictive of resource use than client’s functional status or medical diagnosis.

Relational and Representational Attributes

Datatype: Alphanumeric
Representational form: Code
Representational layout: N.N.N.N.N.N
Minimum size: 3
Maximum size: 11


Guide for use: Up to seven nursing diagnoses may be nominated, according to the following:
1. Nursing diagnosis most related to the principal reason for admission (one only)
2–6. Other nursing diagnoses of relevance to the current episode.
The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Minimum Data Set – Australia (CNMDSA).

Verification rules:
Collection methods: In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.
Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and viable options.
Related metadata: relates to the data element Goal of care vers 2
relates to the data element Nursing interventions vers 2

Administrative Attributes

Source organisation: Australian Council of Community Nursing Services

Information model link: NHIM  Physical wellbeing

Data Set Specifications: Start date  End date

Comments: The CNMDSA Steering Committee considered information from users of the data in relation to Nursing diagnosis. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain NANDA. The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a US project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.
Nursing interventions

Identifying and Definitional Attributes

Knowledgebase ID: 000112 Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/98
Definition: The nursing action/s intended to relieve or alter a person’s responses to actual or potential health problems.

Context: To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of Nursing interventions is critical information for health service monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Relational and Representational Attributes

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

Data domain:
1 Coordination and collaboration of care
2 Supporting informal carers
3 General nursing care
4 Technical nursing treatment or procedure
5 Counselling and emotional support
6 Teaching/education
7 Monitoring and surveillance
8 Formal case management
9 Service needs assessment only

Guide for use: For the purposes of the Community Nursing Minimum Data Set – Australia (CNMDSA), the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person’s need. These summary categories subsume a range of specific actions or tasks. The following definitions are to assist in coding:

1 Coordination and collaboration of care:
   occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).

2 Supporting information carers:
   includes activities, which the nurse undertakes to assist the carer in the delivery of the carer’s role. This does not include care given directly to the
person. Examples of tasks involved in supporting the carer include: 
counselling, teaching, informing, advocacy, coordinating, and grief or 
bereavement support.

3 General nursing care:
includes a broad range of activities, which the nurse performs to directly 
assist the person; in many cases, this assistance will focus on activities of 
daily living. This assistance will help a person whose health status, level 
of dependency, and/or therapeutic needs are such that nursing skills are 
required. Examples of tasks include: assistance with washing, grooming 
and maintaining hygiene, dressing, pressure area care, assistance with 
toileting, bladder and bowel care, assistance with mobility and 
therapeutic exercise, attention to physical comfort and maintaining a 
therapeutic environment.

4 Technical nursing treatment or procedure:
refers to technical tasks and procedures for which nurses receive specific 
training and which require nursing knowledge of expected therapeutic 
effect, possible side-effects, complications and appropriate actions related 
to each. Some examples of technical care activities are: medication 
administration (including injections), dressings and other procedures, 
venipuncture, monitoring of dialysis, and implementation of pain 
management technology.

5 Counselling and emotional support:
focuses on non-physical care given to the person, which aims to address 
the affective, psychological and/or social needs. Examples of these 
include: bereavement, well being, decision-making support and 
values-clarification.

6 Teaching/education:
refers to providing information and/or instruction about a specific body 
of knowledge and/or procedure, which is relevant to the person’s 
situation. Examples of teaching areas include: disease process, technical 
procedure, health maintenance, health promotion and techniques for 
coping with a disability.

7 Monitoring and surveillance:
refers to any action by which the nurse evaluates and monitors physical, 
behavioural, social and emotional responses to disease, injury, and 
nursing or medical interventions.

8 Formal case management:
refers to the specific formal service, which is funded to provide case 
management for a person. Note that coordination and collaboration of 
care (Code 1) is not the same as Formal Case Management.

9 Service needs assessment only:
is assessment of the person when this is the only activity carried out and 
no further nursing care is given; for example, assessment for ongoing care 
and/or inappropriate referrals. Selection of this option means that no 
other intervention may be nominated. Thus, if an assessment for the 
Domiciliary Care Benefit is the reason for a visit, but other interventions 
such as, counselling and support; coordination/collaboration of care are 
carried out, then the Assessment only is not an appropriate code.

Verification rules:
Up to eight codes may be selected. If Code 9 is selected no other nursing 
interventions are collected. If Code 9 is selected then code 7 in Goal of care 
must also be selected.
**Collection methods:** Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the CNMDSA interventions enabling the option of a rich level of detail of activities or summarised information.

**Related metadata:** relates to the data element Nursing diagnosis vers 2
relates to the data element Goal of care vers 2
supersedes previous data element Nursing interventions vers 1

**Administrative Attributes**

**Source document:**
**Source organisation:** Australian Council of Community Nursing Services

**Information model link:**
NHIM  Service provision event

**Data Set Specifications:**

**Comments:** The CNMDSA Nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, Technical nursing treatment or Procedure is the generic term for a broad range of nursing activities such as medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA Nursing interventions or other more relevant code sets.
Occasions of service

Identifying and Definitional Attributes

Knowledgebase ID: 000209 Version No: 1
Metadata type: Derived Data Element
Admin. status: Current
01/07/89

Definition: The number of occasions of examination, consultation, treatment or other service provided to a patient in each functional unit of a health service establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Context: Occasions of service are required as a measure of non-admitted patient service provision.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNNNNNN
Minimum size: 1
Maximum size: 7

Data domain: Count of the number of occasions of service

Guide for use:
Verification rules: The definition does not distinguish case complexity for non-admitted patients. For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average Diagnosis Related Group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

Collection methods: For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Related metadata:

Administrative Attributes

Source document: Source organisation: National minimum data set working parties
Information model link: NHIM Performance indicator

Data Set Specifications: NMDS – Public hospital establishments

Start date End date
01/07/1989
Occupation of person

Identifying and Definitional Attributes

Knowledgebase ID: 000230
Version No: 2

Metadata type: Data Element
Admin. status: Current
01/07/99

Definition: The current job or duties in which the person is principally engaged.

Context: Injury surveillance:
There is considerable user demand for data on occupation-related injury and illness, including from Worksafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 2
Maximum size: 2


Guide for use:
Verification rules:
Collection methods:
Related metadata: supersedes previous data element Occupation of person vers 1

Administrative Attributes


Source organisation: Australian Bureau of Statistics

Information model link: NHIM Labour characteristic

Data Set Specifications: Start date End date

Comments: The structure of the Australian Standard Classification of Occupations has five levels:
9 Major groups 1-digit codes
35 Sub-major groups 2-digit codes
81 Minor groups 3-digit codes
340 Unit groups 4-digit codes
986 Occupations 5-digit codes
For example:

<table>
<thead>
<tr>
<th>Level</th>
<th>Code</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major group</td>
<td>2</td>
<td>Professionals</td>
</tr>
<tr>
<td>Sub-major group</td>
<td>23</td>
<td>Health professionals</td>
</tr>
<tr>
<td>Minor group</td>
<td>231</td>
<td>Medical practitioners</td>
</tr>
<tr>
<td>Unit group</td>
<td>2311</td>
<td>Generalist medical practitioners</td>
</tr>
<tr>
<td>Occupation</td>
<td>2311-11</td>
<td>General medical practitioner</td>
</tr>
</tbody>
</table>

A Computer Assisted Coding system is available from the Australian Bureau of Statistics to assist in coding occupational data to Australian Standard Classification of Occupations codes.
Onset of labour

Identifying and Definitional Attributes

Knowledgebase ID: 000113  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/00
Definition: Manner in which labour started.
Context: Perinatal care:
How labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

Relational and Representational Attributes

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

Data domain:
1  Spontaneous
2  Induced
3  No labour
4  Not stated

Guide for use: Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

Verification rules: ‘No labour’ can only be associated with caesarean section.
Collection methods: If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.
Related metadata: is used in conjunction with Method of birth vers 1
supersedes previous data element Onset of labour vers 1
is used in conjunction with Type of labour induction vers 1

Administrative Attributes

Source document:
Source organisation: National Perinatal Data Development Committee
Information model link: NHIM   Birth event
Data Set Specifications: NMDS – Perinatal  Start date   End date
                      01/07/2000
Comments:
Ophthalmological assessment – outcome

Identifying and Definitional Attributes

Knowledgebase ID: 000837

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The result of an ophthalmological assessment done during the last 12 months.

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: 1 Normal

2 Diabetes abnormality

3 Non-diabetes abnormality

4 Not visualised

9 Not stated/inadequately described

Guide for use: This is a repeating record of both eyes.

1st field – Right retina

2nd field – Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/or Not visualised.

Examples:

- code 12 for right retina Normal and left retina Diabetes abnormality.
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality.

Only the result of an assessment carried out in the last 12 months should be recorded.

Verification rules:

Collection methods: Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart – correct with pinhole if indicated

- Examination of cataract

- Examination of fundi with pupils dilated.
Related metadata:
relates to the data element Health professionals attended – diabetes mellitus vers 1
relates to the data element Blindness – diabetes complication vers 1
relates to the data element Cataract – history vers 1
relates to the data element Ophthalmoscopy – performed vers 1
relates to the data element Referred to ophthalmologist – diabetes mellitus vers 1
relates to the data element Visual acuity vers 1

Administrative Attributes


Source organisation: National Diabetes Data Working Group

Information model link: NHIM Assessment event

Data Set Specifications: DSS – Diabetes (clinical) 01/01/2003

Comments:
Patients with diabetes have increased risk of developing several eye complications including retinopathy, cataract and glaucoma that lead to loss of vision.

Many diabetes eye-related problems are asymptomatic and require appropriate eye assessment to be detected. Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone complications and prevent blindness in people with diabetes.

According to Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a comprehensive ophthalmological examination should be carried out:
- at diagnosis and then every 1–2 years for patients whose diabetes onset was at age 30 years or more
- within five years of diagnosis and then every 1–2 years for patients whose diabetes onset was at age less than 30 years.

Assessment by an ophthalmologist is essential:
- at initial examination if the corrected visual acuity is less than 6/6 in either eye
- at subsequent examinations if declining visual acuity is detected
- if any retinal abnormality is detected
- if clear view of retina is not obtained.

References:
Vision Australia, No 2, 1997/8; University of Melbourne.
US National Eye Institute.
Ophthalmoscopy – performed

Identifying and Definitional Attributes

Knowledgebase ID: 000838       Version No: 1
Metadata type: Data Element
Admin. status: Current
  01/01/03
Definition: Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist as a part of the ophthalmological assessment has been undertaken.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

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

Data domain: 1 Yes, ophthalmoscopy performed
               2 No, ophthalmoscopy not performed
               9 Not stated/inadequately described

Guide for use: Record whether or not a fundus examination of the eye has occurred.

Verification rules: Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

Collection methods: Requires collection of data on the performance of ophthalmoscopy.

Related metadata: relates to the data element Health professionals attended – diabetes mellitus vers 1
                   relates to the data element Blindness – diabetes complication vers 1
                   relates to the data element Cataract – history vers 1
                   relates to the data element Ophthalmological assessment – outcome vers 1
                   relates to the data element Referred to ophthalmologist – diabetes mellitus vers 1
                   relates to the data element Visual acuity vers 1

Administrative Attributes


Source organisation: National Diabetes Data Working Group
Information model link:
NHIM Request for/entry into service event

Data Set Specifications:
DSS – Diabetes (clinical)

Start date: 01/01/2003

Comments:
When reporting:

- Record whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist as a part of the ophthalmological assessment has been undertaken in the last 12 months.

Patients with diabetes have an increased risk of developing several eye complications including retinopathy, cataract and glaucoma that lead to loss of vision.

Eye examinations should be commenced at the time diabetes is diagnosed. If no retinopathy is present, repeat the eye examination at least every 2 years. Once retinopathy is identified more frequent observation is required.

Diabetic retinopathy is a leading cause of blindness. Retinopathy is characterised by proliferation of the retina’s blood vessels, which may project into the vitreous, causing vitreous haemorrhage, proliferation of fibrous tissue and retinal detachment. It is often accompanied by microaneurysms and macular oedema, which can express as a blurred vision. The prevalence of retinopathy increases with increasing duration of diabetes. In the early stage, retinopathy is asymptomatic, however up to 20% of people with diabetes Type 2 have retinopathy at the time of diagnosis of diabetes. Cataract and glaucoma are also associated diabetic eye problems that could lead to blindness.

Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications.

References:
Vision Australia, No. 2 – 1997/8; University of Melbourne.
Organ procurement – posthumous

Identifying and Definitional Attributes

**Knowledgebase ID:** 000441  **Version No:** 1

**Metadata type:** Data Element Concept

**Admin. status:** Current

01/07/00

**Definition:** Organ procurement – posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.

**Context:** Hospital activity.

Relational and Representational Attributes

**Datatype:**

**Representational form:**

**Representational layout:**

**Minimum size:**

**Maximum size:**

**Data domain:**

**Guide for use:**

This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian Coding Standards.

Declarations of brain death are made in accordance with relevant State/Territory legislation.

**Verification rules:**

**Collection methods:**

**Related metadata:**

 Administrative Attributes

**Source document:**

**Source organisation:**

**Information model link:**

NHIM  Service provision event

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

**Comments:**
Other drug of concern

Identifying and Definitional Attributes

Knowledgebase ID: 000442  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/03
Definition: A drug apart from the Principal drug of concern which the client states as being a concern.

Context: Alcohol and other drug treatment services:
This item complements Principal drug of concern. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NNNN
Minimum size: 4
Maximum size: 4


Guide for use: Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type.

Verification rules: There should be no duplication with Principal drug of concern.

Collection methods: More than one drug may be selected.
Any other drug of concern for the client should be recorded upon commencement of a treatment episode.
For clients whose treatment episode is related to the alcohol and other drug use of another person, this data element should not be collected.

Related metadata: is qualified by Client type – alcohol and other drug treatment services vers 3
supersedes previous data element Other drugs of concern vers 1
relates to the data element Other treatment type for alcohol and other drugs vers 1
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  Physical wellbeing
Data Set Specifications:  
NMDS – Alcohol and other drug treatment services  
01/07/2003

Comments:
Other recurrent expenditure

Identifying and Definitional Attributes

Knowledgebase ID: 000247 Version No: 1
Metadata type: Data Element
Admin. status: Current 01/07/89

Definition: Other payments are all other recurrent expenditure not included elsewhere in any of the recurrent expenditure categories. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Context: Health expenditure: This category is required for balancing purposes and to capture all those additional expenditures which can be significant in aggregate.

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 as currency 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 minimum data set working parties
Information model link: NHIM Recurrent expenditure
Data Set Specifications: NMDS – Public hospital establishments Start date 01/07/1989

Comments:
Other revenues

Identifying and Definitional Attributes

Knowledgebase ID: 000323  
Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments). This would include revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors.

See text relating to offsetting practices. Gross revenue should be reported (except in relation to payments for inter-hospital transfers of goods and services).

Context: Health services:

In aggregate, other revenues as defined above constitute a significant source of income for many establishments and are necessary to complete the revenue picture for health financing studies or analyses at the national level.

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 as currency 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  Financial resource item

Data Set Specifications:

NMDS – Public hospital establishments  
Start date  End date

01/07/1989

Comments:
Other treatment type for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: 000642 Version No: 1

Metadata type: Data Element
Admin. status: Current
01/07/01

Definition: All other forms of treatment provided to the client in addition to the data element Main treatment type for alcohol and other drugs.

Context: Alcohol and other drug treatment services:
Information about treatment provided is of fundamental importance to service delivery and planning.

Relational and Representational Attributes

Data type: Numeric
Representational form: Code
Representational layout: N
Minimum size: 1
Maximum size: 1

Data domain:
1 Withdrawal management (detoxification)
2 Counselling
3 Rehabilitation
4 Pharmacotherapy
5 Other

Guide for use:
To be completed at cessation of treatment episode.
Only report treatment recorded in the client’s file that is in addition to, and not a component of, the Main treatment type for alcohol and other drugs.
Treatment activity reported here is not necessarily for Principal drug of concern in that it may be treatment for a Other drug of concern.
Code 1 refers to any form of withdrawal management, including medicated and non-medicated.
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 selection excludes counselling activity that is part of a rehabilitation program as defined in code 3.
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. 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.
Verification rules:

Collection methods: More than one code may be selected. This field should be left blank if there are no other treatment types for the episode.

Related metadata: relates to the data element Main 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 Exit/leave from service event

Data Set Specifications: Start date End date

NMDS – Alcohol and other drug treatment services 01/07/2001

Comments:
Outcome of last previous pregnancy

Identifying and Definitional Attributes

Knowledgebase ID: 000114 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/96
Definition: Outcome of the most recent pregnancy preceding this pregnancy.
Context: Perinatal statistics:
Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Relational and Representational Attributes

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

Data domain:
1 Single live birth – survived at least 28 days
2 Single live birth – neonatal death (within 28 days)
3 Single stillbirth
4 Spontaneous abortion
5 Induced abortion
6 Ectopic pregnancy
7 Multiple live birth – all survived at least 28 days
8 Multiple birth – one or more neonatal deaths (within 28 days) or stillbirths

Guide for use: In the case of multiple pregnancy with foetal loss before 20 weeks, code on outcome of surviving foetus(es) beyond 20 weeks.

Verification rules:
Collection methods:
Related metadata: is a qualifier of Date of completion of last previous pregnancy vers 1

Administrative Attributes

Source document:
Source organisation: National Perinatal Data Development Committee
Information model link: NHIM Physical wellbeing
Data Set Specifications: Start date End date

Comments: This data item is recommended by the World Health Organization. It is collected in some States and Territories.
Overdue patient

Identifying and Definitional Attributes

Knowledgebase ID: 000085   Version No: 3
Metadata type: Derived Data Element
Admin. status: Current
01/07/97

Definition: An overdue patient is one whose wait has exceeded the time that has been
determined as clinically desirable in relation to the urgency category to which
they have been assigned.

Context: Elective surgery:
The numbers and proportions of overdue patients represent a measure of the
hospital’s performance in provision of elective hospital care.

Relational and Representational Attributes

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

Data domain: 1 Overdue patient
2 Other

Guide for use: This data element is only required for patients in clinical urgency categories
with specified maximum desirable waiting times. Overdue patients are those
for whom the hospital system has failed to provide timely care and whose wait
may have an adverse effect on the outcome of their care. They are identified by
a comparison of Waiting time at removal from elective surgery waiting list or
Waiting time at a census date and the maximum desirable time limit for the
Clinical urgency classification.

A patient is classified as overdue if ready for care and Waiting time at removal
from elective surgery waiting list or Waiting time at a census date is longer than
30 days for patients in Clinical urgency category 1 or 90 days for patients in
Clinical urgency category 2.

Verification rules: Collection methods:
Related metadata: is qualified by Clinical urgency vers 2
supersedes previous data element Overdue patient vers 2
is derived from Waiting time at a census date vers 2
is derived from Waiting time at removal from elective surgery waiting list
vers 2
is derived from 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 Performance indicator

Data Set Specifications: 

Comments: This data item is not used for patients in Clinical urgency category 3 as there is no specified timeframe within which it is desirable that they are admitted. The data element Extended wait patient identifies patients in Clinical urgency category 3 who have waited longer than one year at admission or at the time of a census.
Overnight-stay patient

Identifying and Definitional Attributes

Knowledgebase ID: 000116 Version No: 3
Metadata type: Data Element Concept
Admin. status: Current
01/07/01
Definition: A patient who, following a clinical decision, receives hospital treatment for a minimum of one night, i.e. who is admitted to and separated from the hospital on different dates.
Context: Admitted patient care.

Relational and Representational Attributes

Datatype:
Representational form:
Representational layout:
Minimum size:
Maximum size:
Data domain:
Guide for use:
An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital, unless they are receiving contracted care. If not under a hospital contract, a patient must be separated from one hospital and admitted to the other hospital on each occasion of transfer.
An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) on a contracted basis is to be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for contracted hospital care.
Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient is regarded as part of the overnight episode.
A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient’s episode of care.
Patients who leave of their own accord, die or are transferred on their first day in hospital are not overnight-stay patients.

Verification rules:
Collection methods: relates to the data element concept Admitted patient vers 3
Related metadata: supersedes previous data element Overnight-stay patient vers 2

Administrative Attributes

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

Comments:
Patient

Identifying and Definitional Attributes

Knowledgebase ID: 000117  
Version No: 1

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

Definition: A patient is a person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patient – admitted and non-admitted patients. Boarders are not patients.

Context: Admitted patient care and public hospital establishments.

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 concept Admitted patient vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link: NHIM Recipient role

Data Set Specifications: Start date  End date

Comments: While the concept of a person for whom a service provider accepts responsibility for treatment or care is also applicable to non-admitted patient and public hospital establishments care and to welfare services, different terminology is often used in these other care settings e.g. client, resident.
Patient days

Identifying and Definitional Attributes

Knowledgebase ID: 000206  Version No: 3
Metadata type: Derived Data Element
Admin. status: Current
01/07/00
Definition: The number of patient days is the total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.

Context: Admitted patient care:
Needed as the basic count of the number of services provided by an establishment.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNNNNNNN
Minimum size: 1
Maximum size: 8

Data domain: Count of patient days for the period

Guide for use: A day is measured from midnight to 2359 hours.
The following basic rules are used to calculate the number of patient days for overnight stay patients:
- the day the patient is admitted is a patient day
- if the patient remains in hospital from midnight to 2359 hours, count as a patient day
- the day a patient goes on leave is counted as a leave day
- if the patient is on leave from midnight to 2359 hours, count as a leave day
- the day the patient returns from leave is counted as a patient day
- the day the patient is separated is not counted as a patient day.
The following additional rules cover special circumstances and in such cases, override the basic rules:
- patients admitted and separated on the same date (same-day patients) are to be given a count of one patient day
- if the patient is admitted and goes on leave on the same day, count as a patient day
- if the patient returns from leave and goes on leave on the same date, count as a leave day.
- if the patient returns from leave and is separated, it is not counted as either a patient day or a leave day
if a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

When calculating total patient days for a specified period:

- count the total patient days of those patients separated during the specified period including those admitted before the specified period
- do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period
- contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element Total contract patient days.

**Verification rules:**

**Collection methods:**

**Related metadata:**
relates to the data element Admission date vers 4
relates to the data element Discharge date vers 4
supersedes previous derived data element Patient days vers 2
relates to the data element Total contract patient days vers 1
relates to the data element Total leave days vers 3

**Administrative Attributes**

**Source document:**

**Source organisation:**  National Health Data Committee

**Information model link:**

NHIM  Performance indicator

**Data Set Specifications:***  

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
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</table>

**Comments:**
Patient listing status

Identifying and Definitional Attributes

Knowledgebase ID: 000120  Version No: 3
Metadata type: Data Element
Admin. status: Current
01/07/97
Definition: An indicator of the person’s readiness to begin the process leading directly to being admitted to hospital for the awaited procedure. A patient may be ‘ready for care’ or ‘not ready for care’.

Context:

Relational and Representational Attributes

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

Data domain: 1 Ready for care
2 Not ready for care

Guide for use: Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time, or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability; for example, surgeon unavailable, operating theatre time unavailable owing to emergency workload. These patients are still ‘ready for care’.

Periods when patients are not ready for care should be excluded in determining Waiting time at removal from elective surgery waiting list and Waiting time at a census date.

Verification rules:

Collection methods:
Related metadata: is a qualifier of Category reassignment date vers 2
relates to the data element concept Hospital waiting list list vers 2
supersedes previous data element Patient listing status vers 2
is used in conjunction with Waiting list category vers 3
is a qualifier of Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group
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 01/07/1997

Comments: Only patients ready for care are to be included in the NMDS – Elective surgery waiting times. The dates when a patient listing status changes need to be recorded. A patient’s classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes clinical review. The need for clinical review varies with the patient’s condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate the data elements Patient listing status and Clinical urgency as the combination of these items had led to confusion.
Patient presentation at emergency department

Identifying and Definitional Attributes

Knowledgebase ID: 000349  Version No: 1
Metadata type: Data Element Concept
Admin. status: Current
01/07/98
Definition: The presentation of a patient at an Emergency department occurs following the arrival of the patient at the Emergency department and is the earliest occasion of being:
- registered clerically
- triaged.

Context: Institutional health care.

Relational and Representational Attributes

Datatype:
Representational form:
Representational layout:
Minimum size:
Maximum size:
Data domain:
Guide for use: Provided with a service by a treating medical officer or nurse. (In hospital data collection systems, the time and date of the first contact would be selected from the earliest three different recorded times.)
The act of receiving treatment in the Emergency department is logically preceded by some form of triage event – either formally or informally. For instance, a patient may be so critically ill that they by-pass the formal triage process to receive resuscitative intervention. However, the act of prioritising access to care according to the level of need has still occurred.

Verification rules:
Collection methods:
Related metadata:

Administrative Attributes

Source document:
Source organisation:
Information model link: NHIM Request for/entry into service event
Data Set Specifications: Start date  End date

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMD5 - Emergency department waiting times.
Patient revenue

Identifying and Definitional Attributes

**Knowledgebase ID:** 000296  
**Version No:** 1

**Metadata type:** Data Element  
**Admin. status:** Current  
01/07/89

**Definition:**  
Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. All patient revenue is to be grouped together regardless of source of payment (Commonwealth, health fund, insurance company, direct from patient) or status of patient (whether inpatient or non-inpatient, private or compensable). Gross revenue should be reported.

Note: The Commonwealth contribution in respect of residential aged care service patients should be included under patient revenue.

**Context:**  
Health expenditure:

Patient revenue is a significant source of income for most establishments. For some establishments (principally the private sector) it is the major source of income. Patient revenue data is important for any health financing analyses or studies at the national level.

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 as currency 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 minimum data set working parties

**Information model link:**  
NHIM    Financial resource item

**Data Set Specifications:**

**Start date**  
**End date**

NMDS – Public hospital establishments  
01/07/1989

**Comments:**
Patient transport

Identifying and Definitional Attributes
Knowledgebase ID: 000243    Version No: 1
Metadata type: Data Element
Admin. status: Current
  01/07/89
Definition: The direct cost of transporting patients excluding salaries and wages of transport staff.
Context: Health expenditure:
  Considered to be a significant element of non-salary recurrent expenditure for many establishments within the data set and is thus required for any health expenditure analysis at the national level.

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 as currency 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 minimum data set working parties
Information model link:
NHIM  Recurrent expenditure
Data Set Specifications:
  NMDS – Public hospital establishments
  Start date  01/07/1989

Comments:
## Patients in residence at year end

### Identifying and Definitional Attributes

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<tr>
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<td></td>
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</table>

**Metadata type:** Derived Data Element  
**Admin. status:** Current  
01/07/89  

**Definition:** A headcount of all formally admitted patients/clients in residence in long-stay facilities (public psychiatric hospitals, alcohol and drug hospitals, residential aged care services) at midnight, to be done on 30 June.

**Context:** The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

### Relational and Representational Attributes

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</tbody>
</table>

**Data domain:** Count of admitted patients/clients in residence

### Guide for use:

**Verification rules:**

**Collection methods:**

For public psychiatric hospitals and alcohol and drug hospitals, all States have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Family Service is able to carry out a statistical census from its residential aged care service databases.

A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach.

There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds.

Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.

**Related metadata:** relates to data element concept Admitted patient vers 3

### Administrative Attributes

**Source document:**

**Source organisation:** Morbidity Working Party

**Information model link:** NHIM Performance indicator

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
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</table>

**Comments:**
Payments to visiting medical officers

Identifying and Definitional Attributes

Knowledgebase ID: 000236
Version No: 1

Metadata type: Data Element

Admin. status:
Current
01/07/89

Definition:
All payments made by an institutional health care establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis.

A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian Standard Classification of Occupations codes as the salaried medical officers category.

Context:
Health expenditure:
This is a significant element of expenditure for many hospitals (although not for other establishments) and needed for health financing and health expenditure analysis at the national level. Any analysis of health expenditures at the national level would tend to break down if significant components of expenditure were not available.

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 as currency 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 minimum data set working parties

Information model link:

NHIM Recurrent expenditure

Data Set Specifications:

Start date End date
NMDS – Public hospital establishments 01/07/1989

Comments:
Although accepting the need to include visiting medical officer payments, the Resources Working Party decided not to include data on visiting medical officer services (whether hours or number of sessions or number of services
provided) due to collection difficulties and the perception that use of visiting medical officers was purely a hospital management issue.
Perinatal period

Identifying and Definitional Attributes

Knowledgebase ID: 000124    Version No: 1
Metadata type: Data Element Concept
Admin. status: Current
01/07/96
Definition: The perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

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:

Administrative Attributes

Source document: 
Source organisation: National Perinatal Data Development Committee
Information model link: NHIM  Physical wellbeing
Data Set Specifications:  

Comments: This definition of perinatal period differs from that recommended by the World Health Organization (WHO). In the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (WHO 1992) the perinatal period is defined as commencing at 22 completed weeks (154 days) of gestation (the time when birthweight is normally 500 g) and ends seven completed days after birth.

At the time that WHO first recommended 500 g (and now 22 weeks) as the lower limits for reporting perinatal and infant mortality, Australia had already adopted legal and statistical definitions for birthweight (400 g) and gestational age (20 weeks) limits that were lower than the WHO limits. Also, the upper limit for the perinatal period in Australia was 28 days. These broader definitions in Australia obviously comply with, and extend, the WHO definitions.

To avoid unnecessary confusion between legal and statistical definitions in Australia, for the purposes of perinatal data collection it is recommended that the perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.
Perineal status

Identifying and Definitional Attributes

Knowledgebase ID: 000125 Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/01
Definition: State of the perineum following birth.

Context: Perinatal:
Perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational and Representational Attributes

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

Data domain:
1 Intact
2 1st degree laceration/vaginal graze
3 2nd degree laceration
4 3rd degree laceration
5 Episiotomy
6 Combined laceration and episiotomy
7 4th degree laceration
8 Other
9 Not stated

Guide for use: Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.

Verification rules:
Collection methods:
Related metadata: is used in conjunction with Anaesthesia administered during labour vers 1
is used in conjunction with Method of birth vers 1
supersedes previous data element Perineal status vers 1
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  Physical wellbeing

Data Set Specifications:  

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

Comments: While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a new data domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing data domain identifier.
Period of residence in Australia

Identifying and Definitional Attributes

Knowledgebase ID: 000126 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/89
Definition: Length of time in years.

Context: This data item was included in the recommended second-level data set by the National Committee on Health and Vital Statistics (1979) to allow analyses relating to changes in morbidity patterns of ethnic subpopulations related to length of stay in host country; for example, cardiovascular disease among Greek immigrants in Australia.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain: 00 Under one year residence in Australia
1–97 1 to 97 years residence in Australia
98 Born in Australia
99 Unknown

Guide for use:
Verification rules: This information may be obtained either from:
Collection methods: - a direct question with response values as specified in the data domain or
- derived from other questions about date of birth, birthplace and year of arrival in Australia.

Related metadata: is used in conjunction with Country of birth vers 3

Administrative Attributes

Source document: National minimum data set working parties
Source organisation: National minimum data set working parties
Information model link: NHIM Demographic characteristic
Data Set Specifications: Start date End date

Comments: This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only Country of birth and Indigenous status are considered by the National Health Data Committee to be justified for inclusion in the NMDS – Admitted patient care.
Peripheral neuropathy – status

Identifying and Definitional Attributes

Knowledgebase ID: 000839  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: The outcome of assessment for the presence of peripheral neuropathy.
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: 1 Yes, peripheral neuropathy is present
2 No, peripheral neuropathy is not present
9 Not stated/inadequately described

Guide for use: Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a biothesiometer or monofilament).

Verification rules: The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise.

Collection methods: The ‘Touch-Test’ Sensory Evaluation (Semmens-Weinstein Monofilaments) application guidelines:
• Occlude the patient’s vision by using a shield or by having the patient look away or close his or her eyes.
• Instruct the patient to respond when a stimulus is felt by saying ‘touch’ or ‘yes’.
• Prepare to administer the stimulus to the foot (dorsal or plantar surface)
• Press the filament of the Touch.
• Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:
• The patient must not be able to view the administration of the stimuli so that false indications are avoided.
• The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
• If the patient does not feel the filament, then protective pain sensation has been lost.
**Biothesiometer method**

Testing vibration sensation with a biothesiometer – application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30–40 volts.

**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 Lower limb amputation due to vascular disease 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 Assessment event

**Data Set Specifications:**
DSS – Diabetes (clinical)  
**Start date** 01/01/2003

**Comments:**

Peripheral neuropathy is a general term indicating peripheral nerve disorders of any cause. The most important aspect of grading diabetic neuropathy from a foot ulceration point of view is to assess the degree of loss of sensation in the feet.

Examine for neuropathy by testing reflexes and sensation preferably using a tuning fork (standard vibration fork 128 hz), pinprick, 10 g monofilament and/or biothesiometer.

Diabetic neuropathy tends to occur in the setting of long-standing hyperglycaemia.

Peripheral neuropathy, which affects about 30% of people with either type 1 or type 2 diabetes, is the major predisposing disorder for diabetic foot disease.

Peripheral neuropathy in feet results in loss of sensation and autonomic dysfunction. Neuropathy can occur either alone (neuropathic feet) or in combination with peripheral vascular disease causing ischaemia (neuro-ischaemic feet). Purely ischaemic feet are unusual, but are managed in the same way as neuro-ischaemic feet (see Australian Diabetes Society: Position Statement: The Lower Limb in People With Diabetes).

As stated by Duffy and others, the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.
Diabetes polyneuropathy is frequently asymptomatic but may be associated with numbness, tingling and paraesthesia in the extremities, and less often with hyperesthesias. The most common form is a distal, symmetric, predominantly sensory polyneuropathy, which begins and is usually most marked in the feet and legs.

If symptomatic neuropathy is present consult with endocrinologist or physician specialising in diabetes care since options are available for the relief of symptoms.

Peripheral nerve function should be checked at least yearly in the patient with diabetes.

References:
1997 North Coast Medical, INC. San Jose, CA 95125; 800 821–9319.
Peripheral vascular disease in feet – status

Identifying and Definitional Attributes

Knowledgebase ID: 000840 
Version No: 1

Metadata type: Data Element

Admin. status: Current 
01/01/03

Definition: The outcome of assessment for the presence of peripheral vascular disease in either foot.

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: 
1 Yes, peripheral vascular disease is present in the feet
2 No, peripheral vascular disease is not present in the feet
9 Not stated/inadequately described

Guide for use: Record whether or not there is an absence of both dorsalis pedis and posterior tibial pulses in either foot.

Verification rules: 

Collection methods: 

If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration.

Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be impaired.

Palpate pulses:
The simplest method to estimate blood flow and to detect ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular disease is small.

Test capillary return:
A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1–2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:
If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could
be completed by measuring the ankle brachial index (ankle pressure/brachial pressure). Normal ankle brachial index is 0.9–1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

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 Lower limb amputation due to vascular disease vers 1
relates to the data element Peripheral neuropathy – status vers 1

Administrative Attributes


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: Peripheral vascular disease is the leading cause of occlusion of blood vessels of the extremities with increasing prevalence in individuals with hypertension, hypercholesterolemia and diabetes mellitus, and in cigarette smokers. Peripheral vascular disease is estimated to occur 11 times more frequently and develop about 10 years earlier in people with diabetes. Presence of symptomatic peripheral vascular disease requires an interdisciplinary approach including a vascular surgeon, an endocrinologist or physician specialising in diabetes care.

References:
Foot Examination – an interactive guide; Australian Prescriber
## Person identifier

### Identifying and Definitional Attributes

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### Administrative Attributes

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</table>

### Comments:
Person identifier type – health care

Identifying and Definitional Attributes

Knowledgebase ID: 000841 Version No: 1
Metadata type: Data Element
Admin. status: Current 01/01/03
Definition: A code based on the geographical or administrative breadth of applicability of Person identifier.

Context:

Relational and Representational Attributes

Datatype: Alphabetic
Representational form: Code
Representational layout: A
Minimum size: 1
Maximum size: 1

Data domain: A Area/region/district
L Local
S State or Territory

Guide for use:

Code L: is for an identifier that is applicable only inside the issuing health care establishment
Code A: is for an identifier that is applicable to:
  − all the Area/region/district health care services but not across all services in the State or Territory
  − all of a specific health care service (e.g. Community mental health) in an Area/region/district health care services but not across all those services in the State or Territory
Code S: is for identifiers that are applicable across all State or Territory health care services.

A person can have more than one Person identifier. Each Person identifier must have an appropriate Person identifier type code recorded.
Use this field to record only Person identifier type. It must not be used to record any other person-related information.

Verification rules:

Collection methods:
Related metadata: is a qualifier of Person identifier 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:
Physical activity sufficiency status

Identifying and Definitional Attributes

Knowledgebase ID: 000672  Version No: 1

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Sufficiency of moderate or vigorous physical activity to confer a health benefit.

Context: Public health, health care and clinical setting:

To monitor health risk factors for national health priority areas and other chronic diseases.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1   Sufficient
2   Insufficient
3   Sedentary
9   Not stated/inadequately described

Guide for use:

The clinician makes a judgment based on assessment of the person’s reported physical activity history for a usual 7-day period where:

Code 1: Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity.

Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.

Code 2: Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.

Code 3: Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.

Code 9: There is insufficient information to more accurately define the person’s physical activity sufficiency status or the information is not known.

Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to ‘huff and puff’, and where talking in a full sentence between breaths is difficult.

Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.
Verification rules:
Collection methods:
Related metadata: relates to the data element Behaviour-related risk factor intervention vers 1
is used in conjunction with Service contact date vers 1

Administrative Attributes

National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion and Research, Sydney, for the Commonwealth Department of Health and Ageing.

Source organisation: CV-Data Working Group

Information model link:
NHIM Lifestyle characteristic

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

Comments: The above grouping subdivides a population into three mutually exclusive categories.
A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity – health benefit for vigorous physical activity is calculated by:
- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate and/or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.
A sedentary person is a person who does not engage in any regular weekly physical activity.
Place of occurrence of external cause of injury

Identifying and Definitional Attributes

Knowledgebase ID: 000384  Version No: 5
Metadata type: Data Element
Admin. status: Current 01/07/00
Definition: The place where the external cause of injury, poisoning or adverse effect occurred.
Context: Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: N(N)
Minimum size: 1
Maximum size: 2

Data domain:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Home</td>
</tr>
<tr>
<td>1</td>
<td>Residential institution</td>
</tr>
<tr>
<td>2</td>
<td>School, other institution and public administration area</td>
</tr>
<tr>
<td>21</td>
<td>School</td>
</tr>
<tr>
<td>22</td>
<td>Health service area</td>
</tr>
<tr>
<td>23</td>
<td>Building used by general public or public group</td>
</tr>
<tr>
<td>3</td>
<td>Sports and athletics area</td>
</tr>
<tr>
<td>4</td>
<td>Street and highway</td>
</tr>
<tr>
<td>5</td>
<td>Trade and service area</td>
</tr>
<tr>
<td>6</td>
<td>Industrial and construction area</td>
</tr>
<tr>
<td>7</td>
<td>Farm</td>
</tr>
<tr>
<td>8</td>
<td>Other specified places</td>
</tr>
<tr>
<td>9</td>
<td>Unspecified place</td>
</tr>
</tbody>
</table>

Guide for use:

Admitted patients:
Use the appropriate codes as fourth and fifth characters to Y92 when using the ICD-10-AM 3rd edition. Used with all ICD-10-AM external cause codes V01–Y89 and assigned according to the Australian Coding Standards.

Non-admitted patients:
to be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Verification rules:
Admitted patients: to be used with ICD-10-AM external cause codes V01–Y89.
Collection methods:

Related metadata: relates to the data element Diagnosis onset type vers 1
is used in conjunction with External cause – admitted patient vers 4
is used in conjunction with External cause – non-admitted patient vers 4
supersedes previous data element Place of occurrence of external cause of injury – admitted patient vers 4
supersedes previous data element Place of occurrence of external cause of injury – non-admitted patient vers 3

Administrative Attributes

Source document: National Health Data Committee
Source organisation: National Centre for Classification in Health
AIHW National Injury Surveillance Unit
National Data Standards for Injury Surveillance Advisory Group

Information model link: NHIM Other setting

Data Set Specifications:|
<table>
<thead>
<tr>
<th>Data Set Specifications:</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Admitted patient care</td>
<td>01/07/2000</td>
<td></td>
</tr>
<tr>
<td>NMDS – Injury surveillance</td>
<td>01/07/2000</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

This data item has been modified to recognise the use of this information in injury surveillance. There has been no change to the coding requirements for patients admitted to hospital. The addition of an extended classification has been necessary to cater for the information requirements of the wide range of settings undertaking injury surveillance.

Place of occurrence for injury surveillance (type of place) has been extended to improve the identification of some important places where injuries occur. This also enables linking of the classification with ICD-10. Use of the number '0' has been avoided to ensure there are fewer problems with the data collection. This item will be reviewed when ICD-10 is adopted.

Further information on the national injury surveillance program may be obtained from the National Injury Surveillance Unit, Australian Institute of Health and Welfare, Adelaide. The recommended classification for injury surveillance purposes is as follows:

Injury surveillance – type of place:

1. Home (includes farm house)
2. Residential institution (excludes hospital – code 4)
3. School, other institutional or public administrative area
4. Hospital or other health service
5. Place of recreation (mainly for informal recreational activities)
6. Sports and athletics area (mainly for formal sports etc.)
7. Street or highway
8. Trade or service area
9. Industrial or construction area
10. Mine or quarry
11. Farm (excludes farm house – code 1)
12. Other specified places
13. Unspecified place
Postal delivery point identifier

Identifying and Definitional Attributes

Knowledgebase ID: 000789
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: A unique number assigned to a postal address as recorded on the Australia Post Postal Address File (PAF).

Context:

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: N(8)
Minimum size: 0
Maximum size: 8

Data domain: Valid Delivery Point Identifier (DPID) Code or blank

Guide for use: Australia Post maintains a PAF database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a delivery point identifier (DPID). While the PAF is concerned with postal address, many persons’ postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data entry.

The PAF may be used at the time of data entry to confirm that the combined data elements of Suburb/town/locality, State/Territory Identifier and Postcode are accurately recorded.

Verification rules: Field may be blank (where the person’s address is not a recognised Australia Post delivery address).

Collection methods: The DPID is assigned electronically to recognised Australia Post delivery addresses following reference to the PAF database.

Related metadata: relates to the data element Address type vers 1
relates to the data element Australian postcode vers 1
relates to the data element State/Territory identifier vers 3
relates to the data element Suburb/town/locality vers 1

Administrative Attributes

Source document: AS5017 Health care client identification
Source organisation: Standards Australia
Information model link: NHIM Address element
<table>
<thead>
<tr>
<th>Data Set Specifications:</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS – Health care client identification</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Health care establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (used by most major hospitals), the postage cost is reduced.

Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.
Postpartum complication

Identifying and Definitional Attributes

Knowledgebase ID: 000131  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/98
Definition: Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.

Context: Perinatal statistics:
Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

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
Guide for use: There is no arbitrary limit on the number of conditions specified.
Verification rules: Complications 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 Complication of labour and delivery vers 2

Administrative Attributes

Source organisation: National Perinatal Data Development Committee
Information model link: NHIM  Physical wellbeing
Data Set Specifications:

Comments: Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease.
Preferred language

Identifying and Definitional Attributes

Knowledgebase ID: 000132  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/98

Definition: The language (including sign language) most preferred by the person for communication. This may be a language other than English even where the person can speak fluent English.

Context: Health and welfare services:
An important indicator of ethnicity, especially for persons born in non-English-speaking countries. Its collection will assist in the planning and provision of multilingual services and facilitate program and service delivery for migrants and other non-English speakers.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain:
00 Afrikaans
01 Albanian
02 Alyawarr (Alyawarra)
03 Arabic (including Lebanese)
04 Armenian
05 Arrernte (Aranda)
06 Assyrian (including Aramaic)
07 Australian Indigenous languages, not elsewhere classified
08 Bengali
09 Bisaya
10 Bosnian
11 Bulgarian
12 Burarra
13 Burmese
14 Cantonese
15 Cebuano
16 Croatian
17 Czech
18 Danish
19 English
20 Estonian
21 Fijian
22 Finnish
23 French
24 German
25 Gilbertese
26 Greek
27 Gujarati
28 Hakka
29 Hebrew
30 Hindi
31 Hmong
32 Hokkien
33 Hungarian
34 Indonesian
35 Irish
36 Italian
37 Japanese
38 Kannada
39 Khmer
40 Korean
41 Kriol
42 Kuurinji (Gurindji)
43 Lao
44 Latvian
45 Lithuanian
46 Macedonian
47 Malay
48 Maltese
49 Mandarin
50 Mauritian Creole
51 Netherlandic
52 Norwegian
53 Persian
54 Pintupi
55 Pitjantjatjara
56 Polish
57 Portuguese
58 Punjabi
59 Romanian
60 Russian
61 Samoan
62 Serbian
63 Sinhalese
64 Slovak
65 Slovene
66 Somali
67 Spanish
Guide for use: The classification used in this data element is a modified 2-digit level version of the Australian Bureau of Statistics' (ABS) classification: Australian Standard Classification of Languages (ASCL).

All non-verbal means of communication, including sign languages, are to be coded to 97.

Code 96 should be used where some information, but insufficient, is provided.

Code 98 is to be used when no information is provided.

All Australian indigenous languages not shown separately on the code list are to be coded to 07.

Verification rules: This information may be collected in a variety of ways. It may be collected by using a predetermined shortlist of languages that are most likely to be encountered from the above code list accompanied by an open text field for Other language or by using an open ended question that allows for recording of the language nominated by the person. Regardless of the method used for data collection the language nominated should be coded using the above ABS codes.

Related metadata: supersedes previous data element Preferred language vers 1

Administrative Attributes

Source document: Australian Standard Classification of Languages, Australian Bureau of Statistics, Catalogue No. 1267.0
Source organisation: National Health Data Committee
Australian Bureau of Statistics

Information model link:
NHIM  Social characteristic

Data Set Specifications:  
<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Alcohol and other drug treatment services</td>
<td>01/07/2002</td>
<td></td>
</tr>
<tr>
<td>DSS – Cardiovascular disease (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

Comments: The ABS has developed a detailed 4-digit language classification of 193 language units which was used in the 1996 Census. Although it is preferable to use the classification at a 4-digit level, the requirements of administrative collections have been recognised and the ABS has developed a classification of 86 languages at a 2-digit level from those most frequently spoken in Australia. Mapping of this 2-digit running code system to the 4-digit ASCL is available from ABS. The classification used in this data element is a modified version of the 2-digit level ABS classification. The National Health Data Committee considered that the grouping of languages by geographic region was not useful in administrative settings. Thus the data domain includes an alphabetical listing of the 86 languages from the ABS 2-digit level classification with only one code for Other languages, not further defined. By removing the geographic groupings from the classification information about the broad geographic region of languages that are not specifically coded is lost. However, the NHDC considered that the benefits to data collectors gained from simplifying the code listing outweighed this disadvantage.
Pregnancy – current status

Identifying and Definitional Attributes

Knowledgebase ID: 000842  Version No: 1

Metadata type: Data Element
Admin. status: Current
01/01/03

Definition: Whether a female person is currently pregnant.

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:
1  Yes, currently pregnant
2  No, not currently pregnant
9  Not stated/inadequately described

Guide for use: Record whether or not the female individual is currently pregnant

Verification rules:

Collection methods: Ask the individual if she is currently pregnant.

Related metadata: relates to the data element Diabetes status vers 1

Administrative Attributes


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 01/01/2003

Comments: Pregnancy in women with pre-existing diabetes is a potentially serious problem for both the mother and foetus. Good metabolic control and appropriate medical and obstetric management will improve maternal and foetal outcomes. The diagnosis or discovery of diabetes in pregnancy (gestational diabetes), identifies an at risk pregnancy from the foetal perspective, and identifies the mother as at risk for the development of type 2 diabetes later in life.
Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus diabetes management during pregnancy includes:

- routine medical review every 2–3 weeks during the first 30 weeks and then every 1–2 weeks until delivery
- monitor HbA1c every 4-6 weeks or more frequently if indicated to ensure optimal metabolic control during pregnancy
- advise patients to monitor blood glucose frequently and urinary ketones
- initial assessment and on going monitoring for signs or progression of diabetes complications
- regular routine obstetric review based on the usual indicators.

Management targets:

- blood glucose levels:
  - Fasting < 5.5 mmol/L
  - Post-prandial < 8.0 mmol/L at 1 hour, < 7mmol/L at 2 hours
- HbA1c levels within normal range for pregnancy. (The reference range for HbA1c will be lower during pregnancy)
- the absence of any serious or sustained ketonuria.

Normal indices for foetal and maternal welfare. Oral hypoglycaemic agents are contra-indicated during pregnancy and therefore women with pre-existing diabetes who are treated with oral agents should ideally be converted to insulin prior to conception.

What to do if unsatisfactory metabolic control:

- Explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise, and review management.
- Review and adjust treatment.
- Consider referral to diabetes educator, dietitian, endocrinologist or physician experienced in diabetes care, or diabetes centre.
Premature cardiovascular disease family history – status

Identifying and Definitional Attributes

Knowledgebase ID: 000659  
Version No: 1

Metadata type: Data Element

Admin. status: Current  
01/01/03

Definition: Identifies a person who has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years.

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:

1 Yes
2 No
3 Family history status not known
9 Not recorded

Guide for use:

Code 1: Yes, the person has a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

Code 2: No, the person does not have a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

Code 3: Family history status not known, the existence of a premature family history for cardiovascular disease cannot be determined.

Code 9: Not recorded, the information as to the existence of a premature family history for cardiovascular disease has not been recorded.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes


Source organisation: CV-Data Working Group

Information model link: NHIM Physical wellbeing

Data Set Specifications:

DSS – Cardiovascular disease (clinical)  
Start date: 01/01/2003

End date:
Comments: DSS – Cardiovascular disease (clinical):
Having a family history of cardiovascular disease (CVD) is a risk factor for CVD and the risk increases if the event in the family member occurs at a young age. For vascular risk assessment a premature family history is considered to be present where a first-degree relative under age 60 years (woman or man) has had a vascular event/condition diagnosed. The evidence of family history being a strong risk factor for stroke only applies to certain limited stroke subtypes in certain populations.
Presentation at birth

Identifying and Definitional Attributes
Knowledgebase ID: 000133  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/96
Definition: Presenting part of the foetus (at lower segment of uterus) at birth.
Context: Perinatal statistics:
Presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.

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

Data domain:
1  Vertex
2  Breech
3  Face
4  Brow
8  Other
9  Not stated

Guide for use:
Verification rules:
Collection methods:
Related metadata: is used in conjunction with Method of 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

Comments:
Previous pregnancies

Identifying and Definitional Attributes

Knowledgebase ID: 000134  Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: The total number of previous pregnancies, specified as pregnancies resulting in:

- live birth
- stillbirth – at least 20 weeks’ gestational age or 400 g birthweight
- spontaneous abortion (less than 20 weeks’ gestational age, or less than 400 g birthweight if gestational age is unknown)
- induced abortion (termination of pregnancy before 20 weeks’ gestation)
- ectopic pregnancy.

Context: Perinatal statistics:
The number of previous pregnancies is an important component of the woman’s reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes. A previous history of stillbirth or spontaneous abortion identifies the mother as high risk for subsequent pregnancies. A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: 2-digit numeric field representing the number of pregnancies for each of the categories above, or 99 for not stated

Guide for use: A pregnancy resulting in multiple births should be counted as one pregnancy. In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

Verification rules:

Collection methods:

Related metadata: is qualified by Date of completion of last previous pregnancy vers 1 is used in conjunction with Outcome of last previous pregnancy vers 1
Administrative Attributes

Source document: National Perinatal Data Development Committee

Information model link: NHIM Physical wellbeing

Data Set Specifications:

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

Comments:
Previous specialised treatment

Identifying and Definitional Attributes

Knowledgebase ID: 000139  Version No: 3
Metadata type: Data Element
Admin. status: Current
01/07/99
Definition: Whether a patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided.

Context:

Relational and Representational Attributes

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

Data domain:

1 Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
2 Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided
5 Unknown/not stated

Guide for use: Codes 2–4: Includes patients who have been seen at any time in the past within the specialty within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).

Admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission should be coded as 1.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element First admission for psychiatric treatment vers 2
relates to the data element concept Service contact vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee
National Mental Health Information Strategy Committee
**Information model link:**

NHIM  Request for/entry into service event

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Admitted patient mental health care</td>
<td>01/07/1999</td>
<td></td>
</tr>
<tr>
<td>NMDS – Admitted patient palliative care</td>
<td>01/07/2000</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

This data item was originally developed in the context of mental health institutional care data development (originally the data element Problem status and later First admission for psychiatric treatment). More recent data development work, particularly in the area of palliative care, led to the need for this data item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.
Primary site of cancer

Identifying and Definitional Attributes

Knowledgebase ID: 000776  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/02

Definition: The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.

Context: This information is collected for the purpose of:
- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type
- monitoring the number of new cases of cancer for planning treatment services
- epidemiological studies.

Relational and Representational Attributes

Datatype: Alphanumeric
Representational form: Code
Representational layout: ANNNN
Minimum size: 3
Maximum size: 5

Data domain: Cancer registries:
The current version of International Classification of Diseases for Oncology
Hospitals:
ICD-10-AM 3rd edition

Guide for use: Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer. In ICD-10-AM, primary site is identified using a single 4-digit code Cxx.x or Dxx.x. In ICDO, primary site is identified using both the Cxx.x code
Identifying site and the behaviour code to identify whether the site is the primary site. The 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: Cancer registries use Site codes from the current version of ICDO.
Collection methods: In a hospital setting, primary site of cancer should be recorded on the patient’s medical record by the patient’s attending clinician or medical practitioner, and coded by the hospital’s medical records department.

Hospitals use Diagnosis codes from ICD-10-AM. Valid codes must start with C or D.

In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a ‘Principal Diagnosis’ or an ‘Additional Diagnosis’ as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10.

Some ICD-10-AM diagnosis codes e.g. mesothelioma and Kaposi’s sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Related metadata: is a qualifier of Laterality of primary cancer vers 1

Administrative Attributes


Source organisation: World Health Organization.

Information model link: NHIM Assessment event

Data Set Specifications: Start date   End date

Comments:
Principal area of clinical practice

Identifying and Definitional Attributes

Knowledgebase ID: 000135  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/95

Definition: Principal area of clinical practice is defined as either the field of principal professional clinical activity or the primary area of responsibility, depending on the profession. It may be described in terms of the particular discipline, skills or knowledge field of the profession, whether general or specialised; or described in terms of the principal client group; or described by the principal activity of an institution, or section of an institution, where clinical practice takes place.

Context: Health labour force:
To analyse distribution of clinical service providers by the area of their principal clinical practice. Cross-classified with other data, this item allows analysis of geographic distribution and profiles of population subsets. Required for health labour force modelling.

Relational and Representational Attributes

Datatype: Alphanumeric
Representational form: Code
Representational layout: ANN
Minimum size: 3
Maximum size: 3

Data domain:
A11 GP/primary medical care practitioner – general practice
A12 GP/primary medical care practitioner – a special interest area (specified)
A21 GP/primary medical care practitioner – vocationally registered
A22 GP/primary medical care practitioner – holder of fellowship of RACGP
A23 GP/primary medical care practitioner – RACGP trainee
A24 GP/primary medical care practitioner – other
B31 Non-specialist hospital (salaried) – RMO/intern
B32 Non-specialist hospital (salaried) – other hospital career
B41 Non-specialist hospital (salaried) – holder of Certificate of Satisfactory Completion of Training
B42 Non-specialist hospital (salaried) – RACGP trainee
B44 Non-specialist hospital (salaried) – other
B51 Non-specialist hospital (salaried) – specialist (includes private and hospital)
B52 Non-specialist hospital (salaried) – specialist in training (e.g. registrar)
B90 Non-specialist hospital (salaried) – not applicable
C The following nursing codes are subject to revision because of changes in the profession and should be read in the context of the comments below:
C01 Nurse labour force – mixed medical/surgical nursing
C02 Nurse labour force – medical nursing
Guide for use:
Specifcics will vary for each profession as appropriate and will be reflected in the classification/coding that is applied. Classification within the National Health Labour Force Collection is profession-specific.

Verification rules:
Collection methods:
Related metadata:

Administrative Attributes
Source document:
Source organisation: National Health Labour Force Data Working Group
Information model link:
NHIM Labour characteristic

Data Set Specifications:
NMDS - Health labour force
Start date 01/07/1995

Comments:
The comments that follow apply to the nurse labour force specifically.
It is strongly recommended that, in the case of the nurse labour force, further disaggregation be avoided as much as possible. The reason for this recommendation is that any expansion of the classification to include specific specialty areas (e.g. cardiology, otolaryngology, gynaecology etc.) will only capture data from hospitals with dedicated wards or units; persons whose clinical practice includes a mix of cases within a single ward setting (as in the majority of country and minor metropolitan hospitals) will not be included in any single specialty count, leading to a risk of the data being misinterpreted. The data would show a far lower number of practitioners involved in providing services to patients with some of the listed specialty conditions than is the case.
Principal diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: 000136  Version No: 3

Metadata type: Data Element
Admin. status: Current
01/07/98

Definition: The diagnosis established after study to be chiefly responsible for occasioning the patient’s episode of care in hospital (or attendance at the health care facility).

Context: Health services:
The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.
Admitted patients:
The principal diagnosis is a major determinant in the classification of Australian refined diagnosis related groups and Major diagnostic categories.

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)

Guide for use: The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health in 1998 and implemented from July 1998. The second edition was published for use from July 2000 and the third edition for use from July 2002.

For the NMDS for Community Mental Health Care, codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health in 2002.

Verification rules: As a minimum requirement the Principal diagnosis code must be a valid code from ICD-10-AM (3rd edition).

Some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian refined diagnosis related groups, Version 4. A list of these diagnosis codes is available from the Acute and Coordinated Care Branch, Health Services Division, Department of Health and Ageing.

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes, cannot be used as principal diagnosis.
**Collection methods:** A principal diagnosis should be recorded and coded upon separation, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Admitted patients:

Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital patients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

**Related metadata:**
relates to the data element Additional diagnosis vers 4
is an alternative to Bodily location of main injury vers 1
relates to the data element Diagnosis onset type vers 1
relates to the data element Diagnosis related group vers 1
relates to the data element External cause – admitted patient vers 4
relates to the data element External cause – human intent vers 4
relates to the data element External cause – non-admitted patient vers 4
is used in the derivation of Major diagnostic category vers 1
is used as an alternative to Nature of main injury - non-admitted patient vers 1
supersedes previous data element Principal diagnosis – ICD-9-CM code vers 2
relates to the data element Procedure vers 5

**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 Health Data Committee
National Centre for Classification in Health
National Data Standard for Injury Surveillance Advisory Group

**Information model link:**
NHIM  Physical wellbeing

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
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<tbody>
<tr>
<td>NMDS – Admitted patient care</td>
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<tr>
<td>NMDS – Admitted patient mental health care</td>
<td>01/07/1997</td>
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<tr>
<td>NMDS – Community mental health care</td>
<td>01/07/2000</td>
<td></td>
</tr>
<tr>
<td>NMDS – Admitted patient palliative care</td>
<td>01/07/2000</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
Principal drug of concern

Identifying and Definitional Attributes

Knowledgebase ID: 000443  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/03
Definition: The main drug, as stated by the client, that has led a person to seek treatment from the service.
Context: Alcohol and other drug treatment services: Required as an indicator of the client’s treatment needs.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NNNN
Minimum size: 4
Maximum size: 4

Data domain: Value found in the Australian Standard Classification of Drugs of Concern

Guide for use: The principal drug of concern should be the main drug of concern to the client and is the focus of the client’s treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client’s referral should be chosen.

Verification rules: To be collected on commencement of the treatment episode.
Collection methods: For clients whose treatment episode is related to the alcohol and other drug use of another person, this data element should not be collected.

Related metadata: is qualified by Client type – alcohol and other drug treatment services vers 3 relates to the data element Main treatment type for alcohol and other drugs vers 1 relates to the data element Method of use for principal drug of concern vers 1 relates to the data element Other drug of concern vers 2 relates to the data element Other treatment type for alcohol and other drugs vers 1 supersedes previous data element Principal drug of concern vers 1

Administrative Attributes

Source organisation: Intergovernmental Committee on Drugs NMDS WG
Information model link: NHIM Lifestyle characteristic
**Data Set Specifications:**

<table>
<thead>
<tr>
<th>NMDS – Alcohol and other drug treatment services</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/07/2003</td>
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</tbody>
</table>

**Comments:**
Principal role of health professional

Identifying and Definitional Attributes

Knowledgebase ID: 000138          Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/95

Definition: The principal role of a health professional is that in which the person usually works the most hours each week.

Context: Health labour force:
This data element provides information on the principal professional role of respondents who currently work within the broad context/discipline field of their profession (as determined by data element Professional labour force status). Identification of clinicians provides comparability with other labour force collections that just include clinicians.

Relational and Representational Attributes

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

Data domain: 1 Clinician
2 Administrator
3 Teacher/educator
4 Researcher
5 Public health/health promotion
6 Occupational health
7 Environmental health
8 Other (specify)
9 Unknown/inadequately described/not stated

Guide for use: Code 1: A clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).
Code 2: An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, e.g. directors of nursing, medical superintendents, medical advisors in government health authorities, health profession union administrators (e.g. Australian Medical Association, Australian Nurses Federation).
Code 3: A teacher/educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.
Code 4: A researcher in a health profession is a person whose main job is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug companies and other bodies.

Codes 5, 6 and 7: Public health/health promotion, occupational health and environmental health are specialties in medicine, and fields of practice for some other health professions. They are public health rather than clinical practice, and hence are excluded from clinical practice.

**Verification rules:**

**Collection methods:** For respondents indicating that their principal professional role is in clinical practice, a more detailed identification of that role is established according to profession-specific categories.

**Related metadata:**

**Administrative Attributes**

**Source document:**

**Source organisation:** National Health Labour Force Data Working Group

**Information model link:**

NHIM Labor characteristic

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/07/1995</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
Procedure

Identifying and Definitional Attributes

Knowledgebase ID: 000137 Version No: 5
Metadata type: Data Element
Admin. status: Current
01/07/99
Definition: A clinical intervention that:
- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting.

Context: This item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian refined diagnosis related groups.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NNNNN-NN
Minimum size: 8
Maximum size: 8

Data domain: ICD-10-AM (3rd edition) procedure codes

Guide for use: Admitted patients:
Record all procedures undertaken during an episode of care in accordance with the ICD-10-AM Australian Coding Standards.
The order of codes should be determined using the following hierarchy:
- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

Verification rules: As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and State and Territory information systems.
Collection methods:
Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Procedures are derived from and must be substantiated by clinical documentation.

Related metadata:
is qualified by Additional diagnosis vers 4
supersedes previous data element Additional procedures - ICD-10-AM code vers 4
supersedes previous data element Additional procedures - ICD-9-CM code vers 3
relates to the data element Date of procedure vers 1
is used in conjunction with Indicator procedure vers 3
is qualified by Principal diagnosis vers 3
supersedes previous data element Principal procedure - ICD-10-AM code vers 4
supersedes previous data element Principal procedure - ICD-9-CM code vers 3

Administrative Attributes

Source organisation:
National Centre for Classification in Health
National Health Data Committee

Information model link:
NHIM  Service provision event

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

Comments:
The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM.
Profession labour force status of health professional

Identifying and Definitional Attributes

Knowledgebase ID: 000140 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/95

Definition:
For the national health labour force collections, profession labour force status of a health professional in a particular profession is defined by employment status according to the classification/coding frame below at the time of renewal of registration.

Employment in a particular health profession is defined by practice of that profession or work that is principally concerned with the discipline of the profession (for example, research in the field of the profession, administration of the profession, teaching of the profession or health promotion through public dissemination of the professional knowledge of the profession).

Context:
Health labour force:
This data element provides essential data for estimating the size and distribution of the health labour force, monitoring growth, forecasting future supply, and addressing work force planning issues. It was developed by the National Committee for Health and Vital Statistics during the 1980s and endorsed by the Australian Health Ministers' Advisory Council in 1990 as a national minimum data set item for development of the national health labour force collections.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: N or N.N
Minimum size: 1
Maximum size: 3

Data domain:
1 Employed in the profession: working in/practising the reference profession - in reference State
2 Employed in the profession: working in/practising the reference profession - mainly in other State(s) but also in reference State
3 Employed in the profession: working in/practising the reference profession - mainly in reference State but also in other State(s)
4 Employed in the profession: working in/practising the reference profession - only in State(s) other than reference State
5.1 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking either full-time or part-time work
5.2 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking full-time work
5.3 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking part-time work
5.9 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession – seeking work (not stated)

6.1 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking either full-time or part-time work

6.2 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking full-time work

6.3 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking part-time work

6.9 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking work (not stated)

7 Not in the labour force for the profession: not in work/practice in the profession and not looking for work/practice in the profession

8 Not in the labour force for the profession: working overseas

9 Unknown/not stated

Guide for use:

The term ‘employed in the profession’ equates to persons who have a job in Australia in the field of the reference profession.

A person who is normally employed in the profession but is on leave at the time of the annual survey is defined as being employed.

A health professional who is not employed but is eligible to work in, and is seeking employment in the profession, is defined as unemployed in the profession.

A health professional looking for work in the profession, and not currently employed in the profession, may be either unemployed or employed in an occupation other than the profession.

A registered health professional who is not employed in the profession, nor is looking for work in the profession, is defined as not in the labour force for the profession.

Registered health professionals not in the labour force for the profession may be either not employed and not looking for work, or employed in another occupation and not looking for work in the profession.

Verification rules:

Collection methods:

For the national health labour force collection survey questionnaire, this is the key filter question. It excludes from further survey questions at this point:

− persons working overseas although working/practising in the reference profession
− respondents working only in States other than the reference state
− respondents not working in the reference profession and not looking for work in the reference profession

It also directs respondents working in the reference State and other States to respond to subsequent questions only in respect of work in the reference State. These distinctions are necessary in order to eliminate multiple counting for respondents renewing licenses to practise in more than one State.


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The main differences are:

- The National Health Labour Force Collection includes persons other than clinicians working in the profession as persons employed in the profession. ABS uses the Australian Standard Classification of Occupations where, in general, classes for health occupations do not cover non-clinicians. The main exception to this is nursing where, because of the size of the profession, there are classes for nursing administrators and educators.

- The Labour force collection includes health professionals working in the Defence Forces; ABS does not, with the exception of the population census.

- ABS uses a tightly defined reference period for employment and unemployment; the Labour force collection reference period is self-defined by the respondent as his/her usual status at the time of completion of the survey questionnaire.

- The Labour force collection includes, among persons looking for work in the profession, those persons who are registered health professionals but employed in another occupation and looking for work in the profession; ABS does not.

- The Labour force collection includes in the category not in the Labour force health professionals registered in Australia but working overseas; such persons are excluded from the scope of ABS censuses and surveys.

**Related metadata:**
- relates to the data element concept Health labour force vers 1
- relates to the data element concept Occupation vers 1

**Administrative Attributes**

**Source document:**

**Source organisation:** National Health Labour Force Data Working Group

**Information model link:**

NHIM Labour characteristic

**Data Set Specifications:**

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<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/07/1995</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
Proficiency in spoken English

Identifying and Definitional Attributes

Knowledgebase ID: 000643  Version No: 1
Metadata type: Data Element
Admin. status: Current 01/07/01
Definition: A person’s self-stated proficiency in spoken English.
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, Main language other than English spoken at home 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).

Relational and Representational Attributes

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

Data domain:
0 Not applicable (person under 5 years of age)
1 Very well
2 Well
3 Not well
4 Not at all
5 Not stated/inadequately described

Guide for use: This item is only used in conjunction with ‘Main language other than English spoken at home’. The question should only be asked if a YES answer is given to the question ‘Do you speak a language other than English at home?’ Code 9 should only be used for past collections where this item was not collected or if the person does not respond to the question. It should not be a response included on the collection form.

Verification rules: Suggested question:
How well do you (does the person) speak English?
Very well? ___
Well? ___
Not well? ___
Not at all? ___
Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person’s self-assessed proficiency in spoken English be recorded wherever possible. This data element does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.
This data element is not relevant to and should not be collected for persons under the age of 5.
**Related metadata:**
relates to the data element Country of birth vers 3
relates to the data element Main language other than English spoken at home vers 1

**Administrative Attributes**

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

**Source organisation:** Australian Bureau of Statistics

**Information model link:** NHIM  Social characteristic

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

**Comments:** The ABS advises that the most useful information provided by this data element is in the distinction between the two category groups of Very well/Well and Not well/Not at all.
Proteinuria – status

Identifying and Definitional Attributes

Knowledgebase ID: 000673
Version No: 1

Metadata type: Data Element
Admin. status: Current
01/01/03

Definition: The presence of excessive protein in the urine of the person.

Context: Health care and clinical settings:
Proteinuria is one of several indicators for renal disease or of conditions leading to renal disease. Renal disease when detected early is often responsive to intervention.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: N(.N)
Minimum size: 1
Maximum size: 3

Data domain:
1 Negative for proteinuria
1.1 Microalbuminuria present
1.2 Microalbuminuria not present
1.3 Microalbuminuria not tested
2 Proteinuria
3 Not tested
9 Not stated/inadequately described

Guide for use:
Dipstick testing can be used to test for protein in a urine specimen. Proteinuria (i.e. excessive protein in the urine) on Dipstick urinalysis is described as one or more pluses of protein and for a 24-hour urine collection where the patient excretes more than 300mg/day of protein.

Microalbuminuria can be determined using any one of the following tests: Spot urine, Timed urine (24-hour collection) or Albumin/creatinine ratio. Although the presence of microalbuminuria does not warrant categorisation as proteinuria, it is clinically significant in the diagnosis and treatment of diabetes.

Code 1 Negative for proteinuria – less than 1 plus on dipstick-testing or excretion of 300 mg or less of protein from 24-hour urine collection
Code 1.1 Microalbuminuria present
Code 1.2 Microalbuminuria not present
Code 1.3 Microalbuminuria not tested
Code 2 Proteinuria – one or more pluses of protein in Dipstick urinalysis or for a 24-hour urine collection, where the patient excretes more than 300 mg/per day of protein.
Code 3 Not tested – no urinalysis for proteinuria was taken.
Code 9 Not stated/ inadequately described

**Verification rules:**

**Collection methods:** Three test options are available for determining microalbuminuria and consist of spot urine or timed urine (24-hour collection) or Albumin/creatinine ratio. Where laboratory testing is used to determine Proteinuria status the categorisation must be substantiated by clinical documentation such as an official laboratory report.

**Related metadata:** relates to the data element Date of diagnosis 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 Assessment event

**Data Set Specifications:**

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<th>DSS – Cardiovascular disease (clinical)</th>
<th>Start date</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** In settings where the monitoring of a person’s health is ongoing and where a measure can change over time (such as general practice), the date of diagnosis should be recorded.
Quality accreditation/certification standard

Identifying and Definitional Attributes

Knowledgebase ID: 000777  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/02

Definition: The quality accreditation/certification standard met by the hospital establishment as a whole.

Context: Hospitals:
Required to identify the quality accreditation/certification standard met by the providers of services.

Relational and Representational Attributes

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

Data domain:
1 Yes, accredited or certified compliant with the standard
2 No, not accredited or certified compliant with the standard

Guide for use:
Report the status code as at 30 June for each of the following standards (this is a repeating field; one for each of the four accreditation standards listed):
2nd field: Australian Council on Health Care Standards EQuIP
3rd field: Quality Improvement Council (QIC)
4th field: Australian Quality Council (AQC)

Verification rules:
Collection methods:
Related metadata:

Administrative Attributes

Source document:

Source organisation: Australian Institute of Health & Welfare

Information model link:

NHIM Organisation characteristic

Data Set Specifications: Start date End date

Comments:
Reason for cessation of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: 000423  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/01
Definition: The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service.


Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 1
Maximum size: 2

Data domain:
1  Treatment completed
10  Ceased to participate by mutual agreement
11  Drug court and/or sanctioned by court diversion service
12  Imprisoned, other than drug court sanctioned
13  Died
2  Change in main treatment type
3  Change in the delivery setting
4  Change in the principal drug of concern
5  Transferred to another service provider
6  Ceased to participate against advice
7  Ceased to participate without notice
8  Ceased to participate involuntary (non-compliance)
9  Ceased to participate at expiation
98  Other
99  Not stated/inadequately described

Guide for use:
Code 1 is to be used when all of the immediate goals of the treatment plan have been fulfilled.
Code 2 a treatment episode will end if there is a change in the Main treatment type for alcohol and other drugs.
Code 3 a treatment episode will end if there is a change in the Treatment delivery setting for alcohol and other drugs.
Code 4 a treatment episode will end if there is a change in the Principal drug of concern.
Code 5 includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital.
Code 6 refers to situations where the service provider is aware of the client’s intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client’s best interest.

Code 7 refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.

Code 8 refers to situations where the client’s participation has been ceased by the service provider due to non-compliance with the rules or conditions of the program.

Code 9 refers to situations where the client has fulfilled their obligation to satisfy expiation requirements (e.g. participate in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with the treatment program.

Code 10 refers to situations where the client ceases participation by mutual agreement with the service provider even though the treatment plan has not been completed. This may include situations where the client has moved out of the area. To be used when codes 2, 3 or 4 is not applicable.

Code 11 applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.

Code 12 applies to clients who are imprisoned for reasons other than code 11.

**Verification rules:**

**Collection methods:** To be collected on cessation of a treatment episode

**Related metadata:**
relates to the data element concept Cessation of treatment episode for alcohol and other drugs vers 2
relates to the data element Date of cessation of treatment episode for alcohol and other drugs vers 2
supersedes previous data element Reason for cessation of treatment vers 1

**Administrative Attributes**

**Source document:**

**Source organisation:** Intergovernmental Committee on Drugs NMDS WG

**Information model link:**

NHIM Exit/leave from service event

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set Specifications:</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Alcohol and other drug treatment services</td>
<td>01/07/2001</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
Reason for removal from elective surgery waiting list

Identifying and Definitional Attributes

Knowledgebase ID: 000142

Version No: 4

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: The reason why a patient is removed from the waiting list.

Context: Elective surgery:

Routine admission for the awaited procedure is only one reason why patients are removed from the waiting list. Each reason for removal provides different information. These data are necessary to augment census and throughput data. For example, after an audit the numbers of patients on a list would be expected to reduce. If an audit were undertaken immediately prior to a census the numbers on the list may appear low and not in keeping with the number of additions to the list and patients admitted from the list.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Admitted as an elective patient for awaited procedure in this hospital or another hospital

2 Admitted as an emergency patient for awaited procedure in this hospital or another hospital

3 Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)

4 Treated elsewhere for awaited procedure, but not as a patient of this hospital’s waiting list

5 Surgery not required or declined

6 Transferred to another hospital’s waiting list

9 Not known

Guide for use: Patients undergoing the awaited procedure whilst admitted for another reason are to be coded as code 1.

Code 2 identifies patients who were admitted ahead of their normal position in the queue because the condition requiring treatment deteriorated whilst waiting. Admission as an emergency patient could also be due to other causes such as inappropriate urgency rating, delays in the system, or unpredicted biological variation.

Codes 3–5 provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated other than as a patient of the hospital’s waiting list. The awaited procedure may have been performed as an emergency or as an elective procedure.
Code 6 identifies patients who were transferred from one hospital’s elective surgery waiting list to that of another hospital. The waiting time on the waiting lists at the initial hospital and subsequent hospitals should be combined for national reporting.

Code 9 identifies patients removed from the waiting list for reasons unknown.

Verification rules:
Collection methods:
Related metadata: supersedes previous data element Reason for removal from elective surgery waiting list vers 3

Administrative Attributes
Source document:
Hospital Access Program Waiting Lists Working Group
Source organisation:
Waiting Times Working Group
National Health Data Committee

Information model link:
NHIM Exit/leave from service event

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

Comments:
Recoveries

Identifying and Definitional Attributes

**Knowledgebase ID:** 000295  
**Version No:** 1

**Metadata type:** Data Element  
**Admin. status:** Current  
01/07/89

**Definition:** All revenue received that is in the nature of a recovery of expenditure incurred. This would include:

- income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors

- income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital

- other recoveries such as those relating to inter-hospital services where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost.

Generally, gross revenues should be reported but, where inter-hospital payments for transfers of goods and services are made, offsetting practices are acceptable to avoid double counting. Where a range of inter-hospital transfers of goods and services is involved and it is not possible to allocate the offsetting revenue against particular expenditure categories, then it is acceptable to bring that revenue in through recoveries.

**Context:** Health expenditure:

Recoveries represent a significant source of income for many establishments and, as well as assisting in completing the picture in any health financing studies or analysis at the national level, are relevant in relation to the determination of net costs and output costs.

Relational and Representational Attributes

**Datatype:** Numeric  
**Representational form:** Currency  
**Representational layout:** $999,999,999  
**Minimum size:** 2  
**Maximum size:** 12

**Data domain:** Australian dollars to the nearest whole dollar.

**Guide for use:** Record as currency up to hundreds of millions of dollars. This data element relates to all revenue received by establishments except for general revenue payments received from State or Territory governments.

**Verification rules:**

**Collection methods:**

**Related metadata:** relates to the data element Establishment type vers 1
Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Financial resource item

Data Set Specifications: Start date End date
NMDS – Public hospital establishments 01/07/1989

Comments:

The Resources Working Party had considered splitting recoveries into staff meals and accommodation, and use of hospital facilities (private practice) and other recoveries.

Some States had felt that use of facilities was too sensitive as a separate identifiable item in a national minimum data set. Additionally, it was considered that total recoveries was an adequate category for health financing analysis purposes at the national level.
Referral to further care (psychiatric patients)

Identifying and Definitional Attributes

Knowledgebase ID: 000143  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/89
Definition: Referral to further care by health service agencies/facilities.

Context: Mental health care:
Many psychiatric inpatients have continuing needs for post-discharge care. Continuity of care across the hospital-community interface is a key policy theme emerging in the various States and Territories. Inclusion of this item allows the opportunity to monitor interagency linkages and is complementary to the data element Source of referral.

Relational and Representational Attributes

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

Data domain:
1 Not referred
2 Private psychiatrist
3 Other private medical practitioner
4 Mental health/alcohol and drug inpatient facility
5 Mental health/alcohol and drug non inpatient facility
6 Acute hospital
7 Other

Guide for use:
Verification rules:
Collection methods:
Related metadata:

Administrative Attributes

Source document:
Source organisation: National minimum data set working parties
Information model link:
NHIM  Exit/leave from service event
Data Set Specifications: Start date End date
NMDS – Admitted patient mental health care 01/07/1997

Comments:
Referred to ophthalmologist – diabetes mellitus

Identifying and Definitional Attributes

Knowledgebase ID: 000843 Version No: 1

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual was referred to an ophthalmologist within the last 12 months.

Context: Public health, health care and clinical settings:

Diabetes mellitus specific data element.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Yes, referred to an ophthalmologist

2 No, not referred to an ophthalmologist

9 Not stated/inadequately described

Guide for use: Record whether or not the individual was referred to an ophthalmologist during the last 12 months.

Verification rules:

Collection methods: Ask the individual if he/she was referred to an ophthalmologist during the last 12 months. 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 Blindness – diabetes complication vers 1

relates to the data element Cataract – history vers 1

relates to the data element Ophthalmological assessment – outcome vers 1

relates to the data element Ophthalmoscopy – performed vers 1

relates to the data element Visual acuity vers 1

Administrative Attributes


Source organisation: National Diabetes Data Working Group
**Information model link:**
NHIM  Request for/entry into service event

**Data Set Specifications:**
<table>
<thead>
<tr>
<th>Dataset</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS - Diabetes (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
An ophthalmologist is a physician specialising in diagnosing and prescribing treatment for defects, injuries and diseases of the eye, and who is skilled at delicate eye surgery.

Patients with diabetes have increased risk of developing several eye complications including retinopathy, cataract and glaucoma that may lead to loss of vision.

Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to detect abnormalities early and to avoid or postpone complications.

**References:**
Region code

Identifying and Definitional Attributes

Knowledgebase ID: 000378  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/97
Definition: An identifier for location of health services in a defined geographic or administrative area.

Context: All health services.

Relational and Representational Attributes

Datatype: Alphanumeric
Representational form: Code
Representational layout: AN
Minimum size: 1
Maximum size: 2

Data domain: Any valid region code created by a jurisdiction.

Guide for use: Domain values are specified by individual States/Territories. Regions may also be known as Areas or Districts.

Verification rules:
Collection methods:
Related metadata: is a composite part of Establishment identifier vers 4

Administrative Attributes

Source document:
Source organisation:
Information model link: NHIM Organisation characteristic

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

Comments:
Removal date

Identifying and Definitional Attributes

Knowledgebase ID: 000798  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/02
Definition: Date on which a patient is removed from an elective surgery waiting list.

Context: Elective surgery:
This data element is necessary for the calculation of the waiting time at removal from an elective surgery waiting list.

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: This date is recorded when a patient is removed from an elective surgery waiting list.
Verification rules: Right justified and zero filled.
Removal date >= date of birth
Removal date >= listing date for care

Collection methods:
Related metadata: 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 Exit/leave from service event
Data Set Specifications:
NMDS – Elective surgery waiting times 01/07/2002

Comments: Removal date will be the same as admission date for patients in ‘reason for removal from elective surgery waiting list’ categories 1 and 2.
Renal disease – end-stage, diabetes complication

Identifying and Definitional Attributes

Knowledgebase ID: 000844  
Version No: 1

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether an individual has end-stage renal disease as a complication of diabetes, and has required dialysis or has undergone a kidney transplant.

Context: Public health, health care and clinical settings: Diabetes mellitus specific data element.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1  End-stage renal disease – developed in the last 12 months
2  End-stage renal disease – developed prior to the last 12 months
3  No end-stage of renal disease
9  Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods: Ask the individual if he/she has required dialysis or has undergone a kidney (renal) transplant (due to diabetic nephropathy). Alternatively obtain the relevant 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 Creatinine serum – measured vers 1
relates to the data element Microalbumin/protein – measured vers 1

Administrative Attributes


Source organisation: National Diabetes Data Working Group

Information model link:

NHIM  Physical wellbeing
**Data Set Specifications:**

**DSS – Diabetes (clinical)**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

To determine chronic renal impairment:

- Glomerular filtration rate (GFR)
  - GFR > 90 ml/min: normal
  - GFR > 60–90 ml/min: mild renal impairment
  - GFR > 30–60 ml/min: moderate renal impairment
  - GFR 0–30 ml/min: severe renal impairment

For greater than 3 months.

In general, patients with GFR < 30 ml/min/1.73 m² are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure. Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required. Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (i.e. hypertensive, proteinuric (>1 g/24 hours), significant co-morbid illness) should be considered for referral to a nephrologist well before function declines to less than 30 ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation)

Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

End-stage renal disease is a recognised complication of Type 1 and Type 2 diabetes mellitus. Diabetes is the commonest cause for renal dialysis in Australia.

The term end-stage renal disease has become synonymous with the late stages of chronic renal failure. Diabetic nephropathy may be effectively prevented and treated by controlling glycemia and administering angiotensin-converting enzyme (ACE) inhibitors. J Am Soc Nephrol 2002 Jun; 13(6): 1615–1625].
Renal disease therapy

Identifying and Definitional Attributes

Knowledgebase ID: 000675
Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: The therapy the person is receiving for renal disease.

Context: Clinical settings:
Its main use is to enable categorisation of management regimes.

Relational and Representational Attributes

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

Data domain:
1 Drugs for modification of renal disease
2 Drugs for treatment of complications of renal disease
3 Peritoneal dialysis
4 Haemodialysis
5 Functioning renal transplant

Guide for use: More than one code can be selected.
Code 1 Drugs for modification of renal disease, includes drugs intended to slow progression of renal failure. Examples include antiproteinurics such as angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor antagonists (ATRA) and immunosuppressants
Code 2 Drugs for the treatment of the complications of renal disease. Examples include antihypertensive agents and drugs that are intended to correct biochemical imbalances caused by renal disease. (e.g. loop diuretics, ACEI, erythropoietin, calcitriol, etc.)
Code 3 Peritoneal dialysis, chronic peritoneal dialysis, delivered at home, at a dialysis satellite centre or in hospital.
Code 4 Haemodialysis, chronic haemodialysis delivered at home, at a dialysis satellite centre or in hospital.
Code 5 Functioning renal transplant, the presence of a functioning renal transplant.

Verification rules:
Collection methods: To be collected on commencement of treatment and regularly reviewed.
Related metadata: is used in conjunction with Service contact date vers 1
Administrative Attributes

Source document: CARI Guidelines. Australian Kidney Foundation

Source organisation: CV-Data Working Group

Information model link: NHIM Service provision event

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

Comments:
DSS – Cardiovascular disease (clinical):
Nephrotoxic agents (including radiocontrast) should be avoided where possible. Drugs that impair auto-regulation of glomerular filtration rate (GFR) (NSAIDs, COX-2, ACEI, ATRA) should be used with caution in renal impairment, particularly when patients are acutely unwell for other reasons (sepsis, peri-operative etc.).

Although combination ACEI and diuretic can be a very potent and efficacious means of reducing blood pressure (and thereby slowing progression), either drug should be introduced individually and carefully in a patient with underlying renal impairment. At the very least, diuretic therapy should be held or reduced when commencing an ACEI in a patient with renal impairment. Combination therapy with ACEI, diuretics and NSAIDs or COX-2 may be particularly harmful.

Drugs, which are primarily excreted by the kidney (e.g. metformin, sotalol, cisapride, etc.) need to be used with caution in patients with renal impairment. The calculated GFR needs to be determined and the dose reduced or the drug avoided as appropriate.
Repairs and maintenance

Identifying and Definitional Attributes

Knowledgebase ID: 000242

Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: The costs incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works. Expenditure of a capital nature should not be included here. Do not include salaries and wages of repair and maintenance staff. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Context: Health expenditure:

This is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.

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 as currency 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 minimum data set working parties

Information model link: 

NHIM Recurrent expenditure

Data Set Specifications: 

NMDS – Public hospital establishments

Start date End date

01/07/1989

Comments:
## Resuscitation of baby

### Identifying and Definitional Attributes

- **Knowledgebase ID:** 000145
- **Version No:** 2
- **Metadata type:** Data Element
- **Admin. status:** Current 01/07/01
- **Definition:**
  
  Active measures taken immediately after birth to establish independent respiration and heart beat, or to treat depressed respiratory effort and to correct metabolic disturbances.

- **Context:**
  - Perinatal:
  
  Required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

### Relational and Representational Attributes

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

<table>
<thead>
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<th>Data domain</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Suction only</td>
</tr>
<tr>
<td>3</td>
<td>Oxygen therapy only</td>
</tr>
<tr>
<td>4</td>
<td>Intermittent positive pressure respiration (IPPR) through bag and mask</td>
</tr>
<tr>
<td>5</td>
<td>Endotracheal intubation and IPPR</td>
</tr>
<tr>
<td>6</td>
<td>External cardiac massage and ventilation</td>
</tr>
<tr>
<td>9</td>
<td>Not stated</td>
</tr>
</tbody>
</table>

- **Guide for use:**
  
  This item does not include drug therapy. Code the most severe measure used. If oxygen is given by bag and mask without IPPR, code as ‘oxygen therapy’.

- **Verification rules:**

- **Collection methods:**

- **Related metadata:**
  
  - is used in conjunction with Apgar score vers 1
  - is used in conjunction with Apgar score at 5 minutes vers 1
  - supersedes previous data element Resuscitation of baby vers 1
  - is used in conjunction with Status of the baby vers 1

### Administrative Attributes

- **Source document:**

- **Source organisation:** National Perinatal Data Development Committee
Information model link:
NHIM  Birth event

Data Set Specifications:

Comments:
Salaries and wages

Identifying and Definitional Attributes

Knowledgebase ID: 000254
Version No: 1

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition:
Salary and wage payments for all employees of the establishment (including contract staff employed by an agency, provided staffing (ME) data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave for the following staffing categories (see below).

Generally, salary data by staffing categories should be broadly consistent with full-time equivalent staffing numbers. Where staff provide services to more than one hospital, their salaries should be apportioned between all hospitals to whom services are provided on the basis of hours worked in each hospital.

Salary payments for contract staff employed through an agency should be included under salaries for the appropriate staff category provided they are included in full-time equivalent staffing. If they are not salary, payments should be shown separately.

Context:
Health expenditure:
Salaries and wages invariably constitute the major component of recurrent and, indeed, total expenditure for the establishments forming part of this data set and are vital to any analysis of health expenditure at the national level. The categories correspond with those relating to full-time equivalent staffing which is a requirement for any proper analysis of average salary costs.

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 as currency up to hundreds of millions of dollars.
Figures should be supplied for each of the staffing categories:
C1.1 Salaried medical officers
C1.2 Registered nurses
C1.3 Enrolled nurses
C1.4 Student nurses
C1.5 Trainee/pupil nurses
C1.6 Other personal care staff
C1.7 Diagnostic and health professionals
C1.8 Administrative and clerical staff
C1.9 Domestic and other staff
Verification rules:

Collection methods: For contract staff, see comments under the data element Total full-time equivalent staff. Salary data for contract staff, provided the contract is for the supply of labour (e.g. nursing) rather than products (e.g. photocopier maintenance), should be shown under the appropriate staff salary category provided that corresponding staffing (full-time equivalent) data is available. If not, it should be shown separately.

Related metadata: relates to the data element Establishment type vers 1
relates to the data element Full-time equivalent staff vers 2

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM   Recurrent expenditure

Data Set Specifications:

<table>
<thead>
<tr>
<th>Data Set Specifications:</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Public hospital establishments</td>
<td>01/07/1989</td>
<td></td>
</tr>
<tr>
<td>NMDS – Community mental health establishments</td>
<td>01/07/1998</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
### Same-day patient

#### Identifying and Definitional Attributes

**Knowledgebase ID:** 000146  
**Version No:** 1  
**Metadata type:** Data Element Concept  
**Admin. status:** Current  
01/07/94  
**Definition:** A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth)

- that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

**Context:** Admitted patient care.

#### Relational and Representational Attributes

**Datatype:**  
**Representational form:**  
**Representational layout:**  
**Minimum size:**  
**Maximum size:**  
**Data domain:**

**Guide for use:** Same-day patients may be either intended to be separated on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient’s episode of care.

Data on same-day patients are derived by a review of admission and separation dates.

**Verification rules:**

**Collection methods:**

**Related metadata:** relates to the data element concept Admitted patient vers 3

#### Administrative Attributes

**Source document:**

**Source organisation:** National Health Data Committee
Information model link:
NHIM  Recipient role

Data Set Specifications:  

Comments:
Scheduled admission date

Identifying and Definitional Attributes

Knowledgebase ID: 000147  Version No: 2
Metadata type: Data Element
Admin. status: Current 01/01/95
Definition: The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.
Context: This item is required for the purposes of hospital management – allocation of beds, operating theatre time and other resources.

Relational and Representational Attributes

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

Data domain: Valid dates
Guide for use:
Verification rules:
Collection methods: is used in conjunction with Listing date for care vers 4
Related metadata: supersedes previous data element Scheduled admission date vers 1

Administrative Attributes

Source document:
Source organisation: National Health Data Committee
Information model link: NHIM Planning event
Data Set Specifications:

Comments: If this data element were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).
Separation

Identifying and Definitional Attributes

Knowledgebase ID: 000148  Version No: 3

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

Definition: Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical.

Formal separation:
The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

Statistical separation:
The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person’s home (for hospital-in-the-home patients).

Verification rules:

Collection methods:

Related metadata: relates to the data element concept Admission vers 3
relates to the data element concept Admitted patient vers 3
relates to the data element Care type vers 4
supersedes previous data element Separation vers 2
relates to the data element Separation date vers 5

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

Comments: While this concept is also applicable to non-Admitted patient care and welfare services, terminology different from ‘separation’ is often used in these other care settings.
Separation date

Identifying and Definitional Attributes

Knowledgebase ID: 000043  Version No: 5

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: Date on which an admitted patient completes an episode of care.

Context: Required to identify the period in which an admitted patient hospital stay or episode occurred, and for derivation of length of stay.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid dates

Guide for use:

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must:

− be <= last day of financial year
− be >= first day of financial year
− be >= Admission date.

Collection methods:

Related metadata: supersedes previous data element Discharge date vers 4 is used in the calculation of Length of stay (including leave days) vers 1 is used in the calculation of Length of stay (postnatal) vers 1

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  01/07/1999

NMDS – Admitted patient mental health care  01/07/1999

NMDS – Perinatal  01/07/1999

NMDS – Admitted patient palliative care  01/07/1999
Comments: There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical separation (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.
Separation time

Identifying and Definitional Attributes

Knowledgebase ID: 000644    Version No: 1
Metadata type: Data Element
Admin. status: Current
   01/07/01
Definition: Time at which an admitted patient completes an episode of care.
Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Time
Representational layout: HHMM
Minimum size: 4
Maximum size: 4

Data domain: 24-hour clock time at separation

Guide for use:
Verification rules:
Collection methods:
Related metadata:
   relates to the data element concept Admission vers 3
   relates to the data element Admission date vers 4
   relates to the data element Admission time vers 2
   relates to the data element concept Admitted patient vers 3
   relates to the data element Separation date vers 5

Administrative Attributes

Source document:
Source organisation:
Information model link:
   NHIM Exit/leave from service event
Data Set Specifications:
   Start date    End date

Comments: Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.
Separations

Identifying and Definitional Attributes

**Knowledgebase ID:** 000205  
**Version No:** 2  
**Metadata type:** Derived Data Element  
**Admin. status:** Current  
01/07/94  
**Definition:** The total number of separations occurring during the reference period. This includes both formal and statistical separations.

**Context:** Admitted patient care:  
Needed as the basic count of the number of separations from care for an establishment.

Relational and Representational Attributes

**Datatype:** Numeric  
**Representational form:** Quantitative value  
**Representational layout:** NNNNNN  
**Minimum size:** 1  
**Maximum size:** 6  
**Data domain:** A number, representing the number of completed episodes of care.

**Guide for use:** The sum of the number of separations where the Discharge date has a value:  
- \( \geq \) the beginning of the reference period (typically a financial year)  
- \( \leq \) the end of the reference period.  
This sum may be calculated at:  
- individual establishment level or  
- system (i.e. State/Territory) level, i.e. the sum of the number of establishments.

**Verification rules:**
**Collection methods:**
**Related metadata:** relates to the data element concept Separation vers 3  
is derived from Separation date vers 5  
supersedes previous derived data element Separations vers 1

Administrative Attributes

**Source document:**
**Source organisation:** National Health Data Committee  
**Information model link:** NHIM Performance indicator

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Community mental health establishments</td>
<td>01/07/1998</td>
<td></td>
</tr>
<tr>
<td>NMDS – Public hospital establishments</td>
<td>01/07/1994</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
Service contact

Identifying and Definitional Attributes

<table>
<thead>
<tr>
<th>Knowledgebase ID:</th>
<th>000401</th>
<th>Version No:</th>
<th>1</th>
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<tbody>
<tr>
<td>Metadata type:</td>
<td>Data Element Concept</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin. status:</td>
<td>Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>01/07/99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Definition:**
A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.

**Context:**
Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services).

A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (e.g. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient’s record.

Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

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 Number of service contact dates vers 2
relates to the data element Service contact date vers 1

Administrative Attributes

**Source document:**

**Source organisation:**

**Information model link:**

NHIM  Service provision event

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
</table>

**Comments:**
The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in admitted patient care) and hospital separations. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry.
being made in each individual participant’s patient/client record is not currently covered by this data element concept.
Service contact date

Identifying and Definitional Attributes

Knowledgebase ID: 000402 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/99
Definition: The date of each service contact between a health service provider and patient/client.

Context: Community-based mental health care and clinical settings:
The service contact is required for clinical audit and other quality assurance purposes.
NMDS – Community mental health care:
Collection of the date of each service contact with health service providers allows a description or profile of service utilisation by a person or persons during an episode of 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: Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person’s participation in the group activity results in a dated entry being made in the patient’s/client’s record.

Verification rules:

Collection methods: For collection from community-based (ambulatory and non-residential) agencies.

Related metadata: is used in the derivation of Number of service contact dates vers 2 relates to the data element concept Service contact vers 1

Administrative Attributes

Source document:
Source organisation:
Information model link:
NHIM Service provision event

Data Set Specifications:

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Community mental health care</td>
<td>01/07/2000</td>
<td></td>
</tr>
<tr>
<td>DSS – Cardiovascular disease (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>
Comments: NMDS – Community mental health care:
The National Health Data Committee acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant’s patient/client record is not obtained via this data element.
Service delivery outlet

Identifying and Definitional Attributes

Knowledgebase ID: 000845 Version No: 1

Metadata type: Data Element Concept

Admin. status: Current

01/07/03

Definition: A site from which an organisation, or sub-unit of an organisation, delivers a health/community service.

Context: Alcohol and other drug treatment services:

Required to identify the agency sites that conduct treatment episodes, as distinguished from administration centres. Identification of sites from which health care or community services are delivered facilitates assessment of the accessibility of services to the population.

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 Establishment identifier vers 4
relates to the data element Geographical location of service delivery outlet vers 1
relates to the data element Treatment delivery setting for alcohol and other drugs vers 1

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Service delivery setting

Data Set Specifications: Start date End date

Comments: An organisation may have one or more service delivery outlets. An organisation with a devolved structure for service delivery may or may not devolve all functions to the service delivery outlet level. It is common for administrative functions, including personnel management, to be retained at a higher or central level of an organisation. The service delivery outlet is the lowest level of an organisation at which, or from which, services are delivered. The site from which a service is delivered relates to the physical location of the service and is to be clearly differentiated from the service delivery setting which refers to the...
type of physical setting in which a service is actually provided to a client (e.g. client’s home, non-residential treatment facility etc.).

For example, where a service provider regularly delivers a service at a variety of clients’ homes (e.g. home visits every Monday, Wednesday and Friday) or a mobile service delivers a service to a variety of different locations, then the service delivery outlet should be recorded as the location of the clinic in which the service provider is based. However, where a mobile unit regularly (e.g. every Monday) delivers a service from the same geographical location then this location will be recorded as the service delivery outlet.
Identifying and Definitional Attributes

**Knowledgebase ID:** 000149  
**Version No:** 3

**Metadata type:** Data Element  
**Admin. status:** Current  
**Date:** 01/07/03

**Definition:** The sex of the person.

**Context:** Required for analyses of service utilisation, needs for services and epidemiological studies.

Relational and Representational Attributes

**Datatype:** Numeric  
**Representational form:** Code  
**Representational layout:** N

**Minimum size:** 1  
**Maximum size:** 1

**Data domain:**
1 Male  
2 Female  
3 Indeterminate  
9 Not stated/inadequately described

**Guide for use:** An indeterminate sex category may be necessary for situations such as the classification of perinatal statistics when it is not possible for the sex to be determined.

**Verification rules:** Code 3 Indeterminate should be queried for people aged 90 days (3 months) or greater.

For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnosis and procedure codes, for records grouped in Major diagnostic categories 12, 13 and 14, for valid grouping. For other Major diagnostic categories, sex conflicts should be queried.

**Collection methods:** Code 9 is not to be an allowable option when data is being collected ie it is not to be a tick box on any collection forms or computer screens. Systems are to take account of any null values that may occur on the primary collection form.

It is suggested that the following format be used for data collection:

What is your (the person’s) sex?  
___ Male ___ Female

The term ‘sex’ refers to the biological differences between males and females, while the term ‘gender’ refers to the socially expected/perceived dimensions of behaviour associated with males and females – masculinity and femininity.

The Australian Bureau of Statistics advises that the correct terminology for this data element is sex.

Information collection for transsexuals and people with transgender issues should be treated in the same manner.
To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission recorded.

**Related metadata:**
is used in the derivation of Diagnosis related group vers 1
supersedes previous data element Sex vers 2

**Administrative Attributes**

**Source document:**

**Source organisation:** National Health Data Committee

**Information model link:**

NHIM Demographic characteristic

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Admitted patient care</td>
<td>01/07/2003</td>
<td></td>
</tr>
<tr>
<td>NMDS – Admitted patient mental health care</td>
<td>01/07/2003</td>
<td></td>
</tr>
<tr>
<td>NMDS – Perinatal</td>
<td>01/07/2003</td>
<td></td>
</tr>
<tr>
<td>NMDS – Community mental health care</td>
<td>01/07/2003</td>
<td></td>
</tr>
<tr>
<td>NMDS – Admitted patient palliative care</td>
<td>01/07/2003</td>
<td></td>
</tr>
<tr>
<td>NMDS – Alcohol and other drug treatment services</td>
<td>01/07/2003</td>
<td></td>
</tr>
<tr>
<td>NMDS – Non-admitted patient emergency department care</td>
<td>01/07/2003</td>
<td></td>
</tr>
<tr>
<td>DSS – Cardiovascular disease (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
<tr>
<td>DSS – Diabetes (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
<tr>
<td>DSS – Health care client identification</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

This item enables standardisation of the collection of information relating to sex (to include indeterminate), gender, people with transgender issues and transsexuals.

In collection systems (ie on forms and computer screens) Male and Female may be mapped to M and F respectively for collection purposes; however, they should be stored within information systems as the codes 1 and 2 respectively.

DSS – Diabetes (clinical):

Referring to the National Diabetes Register Statistical profile (December 2000), the sex ratio varied with age. For ages less than 25 years, numbers of males and females were similar. At ages 25–44 years, females strongly outnumbered males, reflecting the effect of gestational diabetes in women from this group. For older age groups (45–74 years), males strongly outnumber females and in the group of 75 and over, the ratio of males to females was reversed, with a substantially lower proportion of males in the population in this age group due to the higher female life expectancy. (AIHW National Mortality Database 1997/98; National Diabetes Register; Statistical Profile, December 2000)
Source of referral to alcohol and other drug treatment service

Identifying and Definitional Attributes

Knowledgebase ID: 000444  Version No: 2

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The source from which the person was transferred or referred to the alcohol and other drug treatment service.

Context: Alcohol and other drug treatment services:
Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

10 Non-agency individual
11 Self
12 Family member/friend
13 General practitioner
18 Other individual
20 Agency
21 Hospital
22 Community mental health care service
23 Alcohol and other drug treatment service
24 Other community/health care service
25 Community-based correctional service
26 Police diversion
27 Court diversion
28 Other agency
99 Not stated/inadequately described

Guide for use:

Code 10 Non-agency/individual refers to a person such as a friend or a general practitioner.

Code 13 General practitioner includes vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.

Code 20 Agency refers to an organisation such as a hospital or a health care service.
Code 21  Includes public and private hospitals, hospitals specialising in
dental, ophthalmic aids and other specialised medical or surgical
care, satellite units managed and staffed by a hospital, emergency
departments of hospitals, and mothercraft hospitals.

Code 22–23  Includes both residential and non-residential services.

Code 24  Includes outpatient clinics.

Verification rules:
Collection methods:
Related metadata: supersedes previous data element Source of referral to alcohol and other drug
treatment service vers 1

Administrative Attributes
Source document:
Source organisation:
Information model link:
NHIM  Request for/entry into service event

Data Set Specifications:  
NMDS – Alcohol and other drug treatment services  
Start date  End date
01/07/2003

Comments:
Source of referral to public psychiatric hospital

Identifying and Definitional Attributes

Knowledgebase ID: 000150  Version No: 3
Metadata type: Data Element
Admin. status: Current 01/07/97
Definition: Source from which the person was transferred/referred to the public psychiatric hospital.
Context: To assist in analyses of intersectoral patient flow and health care planning.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain:
01 Private psychiatric practice
02 Other private medical practice
03 Other public psychiatric hospital
04 Other health care establishment
05 Other private hospital
06 Law enforcement agency
07 Other agency
08 Outpatient department
09 Other
10 Unknown

Guide for use:
Verification rules:
Collection methods:
Related metadata: supplements the data element Mode of separation vers 3
supersedes previous data element Source of referral vers 1

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  01/07/1997
NMDS – Admitted patient mental health care  01/07/2000

Comments:
Specialised service indicators

Identifying and Definitional Attributes

- Knowledgebase ID: 000321
- Version No: 1
- Metadata type: Data Element
- Admin. status: Current 01/07/89
- Definition: Specialised services provided in establishments.
- Context: Health services:
  Essential to provide a broad picture of the availability of these key specialised services by State and region and to assist with planning if services are over supplied in one region relative to another.

Relational and Representational Attributes

- Datatype: Numeric
- Representational form: Code
- Representational layout: AN.NN
- Minimum size: 1
- Maximum size: 5
- Data domain: 1 Yes 2 No
- Guide for use: Each of the following specialised services should be coded separately.
  - E4.1 Obstetric/maternity service:
    A specialised facility dedicated to the care of obstetric/maternity patients.
  - E4.2 Specialist paediatric service:
    A specialised facility dedicated to the care of children aged 14 or less.
  - E4.3 Psychiatric unit/ward:
    A specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders.
  - E4.4. Intensive care unit (level III):
    A specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services.
  - E4.5 Hospice care unit:
    A facility dedicated to the provision of palliative care to terminally ill patients.
  - E4.6 Nursing home care unit:
    A facility dedicated to the provision of nursing home care.
  - E4.7 Geriatric assessment unit:
    Facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial admission to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents.
  - E4.8 Domiciliary care service:
    A facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment.
  - E4.9 Alcohol and drug unit:
    A facility/service dedicated to the treatment of alcohol and drug dependence.
E4.10 Acute spinal cord injury unit (SS):
A specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister’s Advisory Council guidelines for service provision.

E4.11 Coronary care unit:
A specialised facility dedicated to acute care services for patients with cardiac diseases.

E4.12 Cardiac surgery unit (SS):
A specialised facility dedicated to operative and peri-operative care of patients with cardiac disease.

E4.13 Acute renal dialysis unit (SS):
A specialised facility dedicated to dialysis of renal failure patients requiring acute care.

E4.14 Maintenance renal dialysis centre (SS):
A specialised facility dedicated to maintenance dialysis of renal failure patients. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.

E4.15 Burns unit (level III) (SS):
A specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of patients body surface affected).

E4.16 Major plastic/reconstructive surgery unit (SS):
A specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery.

E4.17 Oncology (cancer treatment) unit (SS):
A specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients. Treatment services include surgery, chemotherapy and radiation.

E4.18 Neonatal intensive care unit (level III) (SS):
A specialised facility dedicated to the care of neonates requiring care and sophisticated technological support. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.

E4.19 In-vitro fertilisation unit:
A specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services.

E4.20 Comprehensive epilepsy centre (SS):
A specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy.

E4.21 Transplantation unit:
A specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient.

- bone marrow
- renal
- heart, including heart-lung
- liver
- pancreas.

E4.22 Clinical genetics unit (SS):
A specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of or anxious about genetic disorders.

E4.23 Sleep centre:
A specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders.
E4.24 Neuro surgical unit:
A specialised facility dedicated to the surgical treatment of neurological conditions.

E4.25 Infectious diseases unit:
A specialised facility dedicated to the treatment of infectious diseases.

E4.26 AIDS unit:
A specialised facility dedicated to the treatment of AIDS patients.

E4.27 Diabetes unit:
A specialised facility dedicated to the treatment of diabetics.

E4.28 Rehabilitation unit:
Dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see data element Care type).

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 Organisation characteristic

Data Set Specifications:

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Public hospital establishments</td>
<td>01/07/1989</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
State/Territory identifier

Identifying and Definitional Attributes

Knowledgebase ID: 000380  Version No: 3
Metadata type: Data Element
Admin. status: Current
01/07/03
Definition: An identifier for Australian State or Territory.
Context: Public health care.

Relational and Representational Attributes

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

Data domain:
1   New South Wales
2   Victoria
3   Queensland
4   South Australia
5   Western Australia
6   Tasmania
7   Northern Territory
8   Australian Capital Territory
9   Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Guide for use:
DSS – Health care client identification:
When used specifically in the collection of address information for a health care client, the following local implementation rules may be applied:
– NULL may be used to signify an unknown address State
– Code 0 may be used to signify an overseas address.

Verification rules:
Collection methods:

Related metadata:
relates to the data element Address type vers 1
relates to the data element Australian postcode vers 1
relates to the data element Postal delivery point identifier vers 1
is a composite part of Establishment identifier vers 4
supersedes previous data element State identifier vers 2
relates to the data element Suburb/town/locality vers 1
Administrative Attributes

Source document: Adapted from Australian Standard Geographic Classification, Australian Bureau of Statistics, Catalogue No. 1216.0

Source organisation: National Health Data Committee

Information model link: NHIM Address element

Data Set Specifications:

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS – Health care client identification</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
State/Territory of birth

Identifying and Definitional Attributes

Knowledgebase ID: 000155  
Version No: 1

Metadata type: Data Element

Admin. status: Current  
01/07/96

Definition: The State/Territory in which the birth occurred.

Context: NMDS – Perinatal:  
To enable analyses by State/Territory of delivery.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:
1 New South Wales
2 Victoria
3 Queensland
4 South Australia
5 Western Australia
6 Tasmania
7 Northern Territory
8 Australian Capital Territory
9 Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link: NHIM Other setting

Data Set Specifications:  
Start date  
End date

NMDS – Perinatal  
01/07/1997

DSS – Health care client identification  
01/01/2003

Comments:
Status of the baby

Identifying and Definitional Attributes

Knowledgebase ID: 000159  
Version No: 1

Metadata type: Data Element

Admin. status: Current  
01/07/96

Definition: Status of the baby at birth.

Context: Perinatal statistics:
Essential to analyse outcome of pregnancy.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:  
1  Live birth  
2  Stillbirth (foetal death)  
9  Not stated

Guide for use:
Live birth is the complete expulsion or extraction from its mother of a product of conception, 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 voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (World Health Organization (WHO) 1992 definition).

Stillbirth is a foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of foetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Verification rules:

Collection methods:

Related metadata:  
is qualified by Apgar score at 1 minute vers 1  
relates to the data element concept Live birth vers 1  
is used in conjunction with Resuscitation of baby vers 2  
relates to the data element concept Stillbirth (foetal death) vers 1
Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM  Physical wellbeing

Data Set Specifications:

NMDS – Perinatal  Start date  End date

01/07/1997

Comments:
Stillbirth (foetal death)

Identifying and Definitional Attributes

Knowledgebase ID: 000160  Version No: 1
Metadata type: Data Element Concept
Admin. status: Current
01/07/96

Definition: A foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight. The death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

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: 

Administrative Attributes

Source document: 
Source organisation: National Perinatal Data Development Committee
Information model link: NHIM Death event
Data Set Specifications: Start date End date

Comments: The World health Organization definition of live birth, and the legal definition used in Australian States and Territories, do not specify any lower limit for gestational age or birthweight. In practice, liveborn foetuses of less than 20 weeks’ gestation are infrequently registered as live births. In analysing data from the perinatal collections, it is recommended that the same criteria of gestational age and birthweight should be used for live births and stillbirths. Births for which gestational age and birthweight have not been recorded (usually occurring outside hospitals) should be included in the perinatal collections if it seems likely that the criteria have been met.

Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.
Suburb/town/locality

Identifying and Definitional Attributes

Knowledgebase ID: 000787  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: The full name of the general locality containing the specific address.
Context:

Relational and Representational Attributes

Datatype: Alphabetic
Representational form: Text
Representational layout: A(46)
Minimum size: 1
Maximum size: 46

Data domain: Valid name as per the Australian Postcode File
Guide for use:
Verification rules: This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory Health Authorities for Postcode files.
Collection methods:
Unknown person address:
Enter ‘Unknown’ in the Suburb/town/locality field.
No fixed address
Enter ‘Unknown’ in the Suburb/town/locality field.

Related metadata: relates to the data element Address type vers 1
relates to the data element Australian postcode vers 1
is used in the derivation of Postal delivery point identifier vers 1
relates to the data element State/Territory identifier vers 3

Administrative Attributes

Source document: AS5017 Health care client identification
Source organisation: Standards Australia
Information model link: NHIM Address element
Data Set Specifications:
DSS – Health care client identification 01/01/2003

Comments:
Superannuation employer contributions (including funding basis)

Identifying and Definitional Attributes

Knowledgebase ID: 000237  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/89

Definition: Contributions paid or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a State health authority, to a superannuation fund providing retirement and related benefits to establishment employees.

The following different funding bases are identified:
- paid by hospital to fully funded scheme
- paid by Commonwealth Government or State government to fully funded scheme
- unfunded or emerging costs schemes where employer component is not presently funded.

Fully funded schemes are those in which employer and employee contributions are paid into an invested fund. Benefits are paid from the fund. Most private sector schemes are fully funded.

Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable, i.e. there is no ongoing invested fund from which benefits are paid. The Commonwealth superannuation fund is an example of this type of scheme as employee benefits are paid out of general revenue.

Context: Health expenditure:
Superannuation employer contributions are a significant element of establishment expenditure and, as such, are required for health expenditure analysis at the national level. The funding basis is required for cost comparison purposes particularly in the case of unfunded or emerging cost schemes where no actual contribution is being presently made but ultimately employer liability will have to be funded.

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 as currency 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 minimum data set working parties

Information model link: 

NHIM  Recurrent expenditure

Data Set Specifications:  

NMDS – Public hospital establishments  

Start date  End date

01/07/1989

Comments: 

The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments. In private enterprise some superannuation schemes are partially funded but this is considered too complex a distinction for national minimum data sets. It is noted that the emergence of salary sacrifice schemes allows employees to forego salary for higher superannuation contributions. If these become significant, national minimum data sets may have to take them into account at a future stage.
Surgical specialty

Identifying and Definitional Attributes

Knowledgebase ID: 000161  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/95
Definition: The area of clinical expertise held by the doctor who will perform the elective surgery.

Context: Elective surgery:
Many hospitals manage their waiting lists on a specialty basis. Current data show that the total ready-for-care times waited and numbers of long-wait patients vary significantly between specialties. Furthermore, the hospital capacity to handle the demand for elective surgery varies with specialty.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain: 01 Cardio-thoracic surgery
02 Ear, nose and throat surgery
03 General surgery
04 Gynaecology
05 Neurosurgery
06 Ophthalmology
07 Orthopaedic surgery
08 Plastic surgery
09 Urology
10 Vascular surgery
11 Other

Guide for use:
Verification rules:
Collection methods:
Related metadata:

Administrative Attributes

Source document: Hospital Access Program Waiting Lists Working Group
Source organisation: National Health Data Committee
Waiting Times Working Group
Information model link:
NHIM  Labour characteristic

Data Set Specifications:
NMDS – Elective surgery waiting times

Start date  End date
01/01/1995

Comments: The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties – ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).
Teaching status

Identifying and Definitional Attributes

Knowledgebase ID: 000322  
Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: An indicator (yes/no) to identify the non-direct patient care activity of teaching for a particular establishment. This is where teaching (associated with a university) is a major program activity of the establishment. It is primarily intended to relate to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Context: Health services:
The non-direct care activity of teaching can involve the consumption of considerable resources. In comparisons of cost in relation to establishment output, it is important to be aware of particular establishments which are devoting substantial resources to activities not relating to output as measured in terms of either inpatient bed days or outpatient occasions of service. Teaching can be one of the variables in any regression analysis undertaken. In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain: 1 Yes
2 No
9 Unknown

Guide for use:

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 Organisation characteristic
**Data Set Specifications:**

NMDS – Public hospital establishments

**Start date** 01/07/1989

**End date**

---

**Comments:**

The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:

- teaching
- research
- group or community contacts
- public health activities
- mobile centre and/or part-time service.

However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant State health authority. If a teaching hospital is identified by a Yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).
Telephone number

Identifying and Definitional Attributes

Knowledgebase ID: 000791
Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: Person or organisation contact telephone number.

Context:

Relational and Representational Attributes

Datatype: Alphanumeric
Representational form: Text
Representational layout: N(40)
Minimum size: 0
Maximum size: 40

Data domain: Numbers and spaces only.

Guide for use:
More than one phone number may be recorded as required. Each phone number should have an appropriate Telephone number type code assigned.
Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).

Verification rules: Numbers and spaces only.

Collection methods:
Prefix plus telephone number:
Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix.
For example, 08 8226 6000 or 0417 123456.
Punctuation:
Do not record punctuation.
For example, (08) 8226 6000 or 08-8226 6000 would not be correct.
Unknown:
Leave the field blank.

Related metadata:
is qualified by Telephone number type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification
Source organisation: Standards Australia
Information model link: NHIM Address element
Data Set Specifications:
DSS – Health care client identification
Start date: 01/01/2003

Comments:
Telephone number type

Identifying and Definitional Attributes

<table>
<thead>
<tr>
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<th>000792</th>
<th>Version No:</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>Metadata type:</td>
<td>Data Element</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin. status:</td>
<td>Current</td>
<td>01/01/03</td>
<td></td>
</tr>
<tr>
<td>Definition:</td>
<td>A code representing a type of telephone number.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Context:</td>
<td>Primarily concerned with the clinical use of Health care client identification data. For use by health and health-related establishments that create, use or maintain records on health care clients. Establishments should use this Standard, where appropriate, for collecting data when registering health care clients or potential health care clients. The positive and unique identification of health care clients is a critical event in health service delivery, with direct implications for the safety and quality of health care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Relational and Representational Attributes

<table>
<thead>
<tr>
<th>Datatype:</th>
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</thead>
<tbody>
<tr>
<td>Representational form:</td>
<td>Code</td>
</tr>
<tr>
<td>Representational layout:</td>
<td>A</td>
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<tr>
<td>Minimum size:</td>
<td>0</td>
</tr>
<tr>
<td>Maximum size:</td>
<td>1</td>
</tr>
<tr>
<td>Data domain:</td>
<td>B  Business or work</td>
</tr>
<tr>
<td></td>
<td>H  Home</td>
</tr>
<tr>
<td></td>
<td>M  Personal mobile</td>
</tr>
<tr>
<td></td>
<td>N  Contact number (not own)</td>
</tr>
<tr>
<td></td>
<td>O  Business or work mobile</td>
</tr>
<tr>
<td></td>
<td>T  Temporary</td>
</tr>
<tr>
<td>Guide for use:</td>
<td>Where more than one telephone number has been recorded, then each telephone number should have the appropriate Telephone number type code assigned.</td>
</tr>
</tbody>
</table>

Verification rules:
Collection methods:
Related metadata:   is a qualifier of Telephone number vers 1

Administrative Attributes

<table>
<thead>
<tr>
<th>Source document:</th>
<th>AS5017 Health care client identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source organisation:</td>
<td>Standards Australia</td>
</tr>
<tr>
<td>Information model link:</td>
<td>NHIM  Address element</td>
</tr>
<tr>
<td>Data Set Specifications:</td>
<td>DSS – Health care client identification</td>
</tr>
<tr>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td>01/01/2003</td>
</tr>
</tbody>
</table>

Comments:
Time of commencement of service event

Identifying and Definitional Attributes

Knowledgebase ID: 000357  
Version No: 2

Metadata type: Data Element
Admin. status: Current
01/07/01

Definition: The time at which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client’s care.

Context: Community health care.  
Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Time
Representational layout: HHMM
Minimum size: 4
Maximum size: 4

Data domain: Valid time in 24-hour clock format.
Guide for use: 24-hour clock format.

Verification rules:
Collection methods:

Related metadata: relates to the data element Date of commencement of service event vers 2  
relates to the data element Date of triage vers 1  
relates to the data element Date patient presents vers 2  
relates to the data element Emergency department waiting time to admission vers 1  
relates to the data element Emergency department waiting time to service delivery vers 2  
relates to the data element concept Patient presentation at emergency department vers 1  
supersedes previous data element Time of service event vers 1  
relates to the data element Time of triage vers 1  
relates to the data element Time patient presents vers 1

Administrative Attributes

Source document: National Institution Based Ambulatory Model Reference Group
Source organisation: National Health Data Committee

Information model link: NHIM Service provision event
Data Set Specifications:  
NMDS – Emergency department waiting times  
01/07/2001

Comments:
Time of triage

Identifying and Definitional Attributes

Knowledgebase ID: 000354  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/98
Definition: The time at which the patient is triaged.
Context: Admitted patient care:
Required to identify the commencement of the service and calculation of waiting times.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Time
Representational layout: HHMM
Minimum size: 4
Maximum size: 4

Data domain: Valid time in 24-hour clock format.
Guide for use: 24-hour clock format.

Verification rules:
Collection methods:
Related metadata:
relates to the data element Admission date vers 4
relates to the data element Admission time vers 2
relates to the data element Date of service event vers 1
relates to the data element Date of triage vers 1
relates to the data element Date patient presents vers 2
relates to the data element Emergency department waiting time to admission vers 1
relates to the data element Emergency department waiting time to service delivery vers 2
relates to the data element concept Patient presentation at emergency department vers 1
relates to the data element Time of commencement of service event vers 2
relates to the data element Time patient presents vers 2
relates to the data element Triage category vers 1
relates to the data element Type of visit to emergency department vers 2
Administrative Attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group
National Health Data Committee

Information model link:

NHIM Assessment event

Data Set Specifications:  Start date  End date
NMDS – Emergency department waiting times  01/07/1999

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS – Emergency department waiting times.
Time patient presents

Identifying and Definitional Attributes

Knowledgebase ID: 000351     Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/01

Definition: The time at which the patient presents for the delivery of a service.

Context:
Admitted patient care.
Community health care.
Hospital non-admitted patient care:
Required to identify commencement of a visit and for calculation of waiting times.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Time
Representational layout: HHMM
Minimum size: 4
Maximum size: 4

Data domain: Time in 24-hour clock format.

Guide for use:
For community health care, outreach services and services provided via telephone or telehealth, this may be the time at which the service provider presents to the patient or the telephone/telehealth session commences.

The time of patient presentation at the emergency department is the earliest occasion of being registered clerically or triaged.

The time that the patient presents is not necessarily:

– the listing time for care (see Listing date for care data element concept for an analogous concept), nor
– the time at which care is scheduled to be provided, nor
– the time at which commencement of care actually occurs (for admitted patients see Admission time, for hospital non-admitted patient care and community health care see Time of commencement of service event).

Verification rules:

Collection methods:

Related metadata:
relates to the data element Admission time vers 2
relates to the data element Date of triage vers 1
relates to the data element Date patient presents vers 2
relates to the data element Emergency department waiting time to admission vers 1
relates to the data element Emergency department waiting time to service delivery vers 2
relates to the data element concept Patient presentation at emergency department vers 1
relates to the data element Time of triage vers 1
supersedes previous data element Time patient presents vers 1
relates to the data element Triage category vers 1

Administrative Attributes

Source document:  
Source organisation: National Institution Based Ambulatory Model Reference Group
National Health Data Committee

Information model link:
NHIM Request for/entry into service event

Data Set Specifications:  
Start date  End date
NMDS – Emergency department waiting times  01/07/2001
NMDS – Non-admitted patient emergency department care  01/07/2003

Comments: This data element is required to identify commencement of a visit and for calculation of waiting times. It supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS – Emergency department waiting times.
Tobacco smoking – consumption/quantity (cigarettes)

Identifying and Definitional Attributes

Knowledgebase ID: 000403  Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: The number of cigarettes (manufactured or roll-your-own) smoked per day by a person.

Context: Public health and health care: The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual. Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products. From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions)
- monitor health risk factors and progress towards National Health Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person’s exposure to tobacco smoke.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN

Minimum size: 1

Maximum size: 2

Data domain:

Count of the number of cigarettes smoked daily.

99 Not stated/inadequately described

Guide for use: This data element is relevant only for persons who currently smoke cigarettes daily or at least weekly. Daily consumption should be reported, rather than weekly consumption. Weekly consumption is converted to daily consumption by dividing by 7 and rounding to the nearest whole number. Quantities greater than 98 (extremely rare) should be coded 98.

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions. The questions cover persons aged 18 years and over.

Related metadata: is qualified by Date of birth vers 4
is qualified by Tobacco smoking – frequency vers 1
is qualified by Tobacco smoking – product vers 1
Administrative Attributes

**Source document:** Standard Questions on the Use of Tobacco Among Adults (1998)

**Source organisation:** Australian Institute of Health and Welfare

**Information model link:** NHIM  Lifestyle characteristic

**Data Set Specifications:**

- **DSS – Cardiovascular disease (clinical)**
  - **Start date:** 01/01/2003

**Comments:**

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
**Tobacco smoking – duration (daily smoking)**

### Identifying and Definitional Attributes

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<thead>
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<th>000404</th>
<th>Version No: 1</th>
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<tbody>
<tr>
<td>Metadata type:</td>
<td>Derived Data Element</td>
<td></td>
</tr>
<tr>
<td>Admin. status:</td>
<td>Current</td>
<td></td>
</tr>
<tr>
<td></td>
<td>01/07/99</td>
<td></td>
</tr>
<tr>
<td><strong>Definition:</strong></td>
<td>Duration (in years) of daily smoking for a person who is now a daily smoker or has been a daily smoker in the past.</td>
<td></td>
</tr>
<tr>
<td><strong>Context:</strong></td>
<td>Public health and health care: Duration of daily smoking is an indicator of exposure to increased risk to health. In this data element, duration is measured as the years elapsed from the time the person first started smoking daily and when they most recently quit smoking daily (or the present for those persons who still smoke daily). There may have been intervening periods when the person did not smoke daily. However, as the negative health effects of smoking accumulate over time, the information on duration of daily smoking, as measured in this data element, remains useful, despite any intervening periods of non-daily smoking.</td>
<td></td>
</tr>
</tbody>
</table>

### Relational and Representational Attributes

<table>
<thead>
<tr>
<th>Datatype:</th>
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<td>Representational form:</td>
<td>Quantitative value</td>
</tr>
<tr>
<td>Representational layout:</td>
<td>NN</td>
</tr>
<tr>
<td><strong>Minimum size:</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Maximum size:</strong></td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Data domain:</strong></th>
<th>Number of completed years or 99 Not stated/inadequately described</th>
</tr>
</thead>
</table>

| **Guide for use:** | In order to estimate duration of smoking the person’s date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person’s current age. If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age. Record duration of less than one year as 0. |

| **Verification rules:** | The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 1, 5, 6, 7) and self-administered (Question 1, 3, 3a, 4) versions. The questions cover persons aged 18 years of age and over. |

| **Collection methods:** | is qualified by Date of birth vers 4 is qualified by Tobacco smoking – ever daily use vers 1 is derived from Tobacco smoking – quit age (daily smoking) vers 1 is derived from Tobacco smoking – start age (daily smoking) vers 1 |


Administrative Attributes


Source organisation: Australian Institute of Health and Welfare

Information model link: NHIM  Lifestyle characteristic

Data Set Specifications:  

Comments: Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables. It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected. The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking – ever daily use

Identifying and Definitional Attributes

Knowledgebase ID: 000405  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/99
Definition: Whether a person has ever smoked tobacco in any form daily in his or her lifetime.

Context: Public health and health care. Whether a person has ever smoked on a daily basis can be used to assess an individual’s health risk from smoking and to monitor population trends in smoking behaviour. It can also be used to:
− evaluate health promotion and disease prevention programs (assessment of interventions)
− monitor health risk factors
− ascertain determinants and consequences of smoking.

Relational and Representational Attributes

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

Data domain: 1 Ever-daily
2 Never-daily

Guide for use: If a person reports that they now smoke cigarettes, cigars, pipes or any other tobacco products daily OR if they report that in the past they have been a daily smoker, they are coded to 1 (ever-daily)
If a person reports that they have never smoked cigarettes, cigars, pipes or any other tobacco products daily AND they have never in the past been a daily smoker then they are coded to 2 (never-daily)

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18 years and over.

Related metadata: is qualified by Date of birth vers 4
is qualified by Tobacco smoking – frequency vers 1
Administrative Attributes


Source organisation: Australian Institute of Health and Welfare

Information model link: NHIM  Lifestyle characteristic

Data Set Specifications: Start date  End date

Comments: Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking – frequency

Identifying and Definitional Attributes

Knowledgebase ID: 000406     Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/99
Definition: How often a person now smokes a tobacco product.

Context: Public health and health care: The frequency of smoking helps to assess a person’s exposure to tobacco smoke which is a known risk factor for cardiovascular disease and cancer. From a public health point of view, the level of consumption of tobacco as measured by frequency of smoking tobacco products is only relevant for regular smokers (persons who smoke daily or at least weekly).

Relational and Representational Attributes

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

Data domain:
1   Smokes daily
2   Smokes at least weekly, but not daily
3   Smokes less often than weekly
4   Does not smoke at all

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.

Verification rules:
Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 1) and self-administered (Question 1) versions. The questions relate to smoking of manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products and are designed to cover persons aged 18 years and over.

Related metadata: is qualified by Date of birth vers 4
is a qualifier of Tobacco smoking – consumption/quantity (cigarettes) vers 1
relates to the data element Tobacco smoking – duration (daily smoking) vers 1
relates to the data element Tobacco smoking – ever daily use vers 1
is used in conjunction with Tobacco smoking – product vers 1
relates to the data element Tobacco smoking – start age (daily smoking) vers 1
Administrative Attributes


Source organisation: Australian Institute of Health and Welfare

Information model link: NHIM   Lifestyle characteristic

Data Set Specifications: Start date   End date

Comments: Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking – product

Identifying and Definitional Attributes

Knowledgebase ID: 000407 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/99
Definition: The type of tobacco product smoked by a person.

Context: Public health and health care:
Tobacco smoking is a known risk factor for cardiovascular disease and cancer.
The type of tobacco product smoked by a person in conjunction with
information about the frequency of smoking assists with establishing a profile
of smoking behaviour at the individual or population level and with monitoring
shifts from cigarette smoking to other types of tobacco products and vice versa.

Relational and Representational Attributes

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

Data domain:
1 Cigarettes – manufactured
2 Cigarettes – roll-your-own
3 Cigars
4 Pipes
5 Other tobacco product
6 None

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and
frequency are needed. In such situations, repeat both fields as many times as
necessary, viz: product1, frequency1; product2, frequency2 etc.

Verification rules: The recommended standard for collecting information about smoking the
above tobacco products is the Standard Questions on the Use of Tobacco
Among Adults – interviewer or self-administered versions.

Collection methods: Related metadata:
is qualified by Date of birth vers 4
is a qualifier of Tobacco smoking – consumption/quantity (cigarettes) vers 1
is used in conjunction with Tobacco smoking – frequency vers 1
Administrative Attributes


*Source organisation:* Australian Institute of Health and Welfare

*Information model link:* NHIM  Lifestyle characteristic

*Data Set Specifications:*

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
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</thead>
</table>

*Comments:* It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking – quit age (daily smoking)

Identifying and Definitional Attributes

Knowledgebase ID: 000408
Metadata type: Data Element
Admin. status: Current
01/07/99
Definition: Age (in years) at which a person who has smoked daily in the past and is no longer a daily smoker most recently stopped smoking daily.

Context:
Public health and health care:
Quit-age and start-age provide information on the duration of daily smoking and exposure to increased risk to health.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain:
Age in completed years
99 Not stated/inadequately described

Guide for use:
In order to estimate quit-age, the person’s date of birth or current age should also be collected. Quit-age may be directly reported, or derived from the date the person quit smoking or the length of time since quitting, once the person’s date of birth (or current age) is known.
Quit-age is relevant only to persons who have been daily smokers in the past and are not current daily smokers.

Verification rules:

Collection methods:
The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 6) and self-administered (Question 3a) versions. The questions cover persons aged 18 years and over.
The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this data element refers to when the person most recently stopped smoking daily. However, in order to provide information on when the person most recently stopped smoking daily, the most appropriate question to ask at the time of collecting the information is when the person finally stopped smoking daily.

Related metadata:
is qualified by Date of birth vers 4
is used in the derivation of Tobacco smoking – duration (daily smoking) vers 1
is used in conjunction with Tobacco smoking – start age (daily smoking) vers 1
is used in the derivation of Tobacco smoking – time since quitting (daily smoking) vers 1
is qualified by Tobacco smoking status vers 1

Administrative Attributes


*Source organisation:* Australian Institute of Health and Welfare

*Information model link:* NHIM Lifestyle characteristic

*Data Set Specifications:*  

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
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</thead>
</table>

*Comments:* Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking – start age (daily smoking)

Identifying and Definitional Attributes

Knowledgebase ID: 000409  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/99

Definition: Age (in years) at which a person who has ever been a daily smoker first started to smoke daily.

Context: Public health and health care:
Start-age may be used to derive duration of smoking, which is a much stronger predictor of the risks associated with smoking than is the total amount of tobacco smoked over time.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain: Age in completed years
99 Not stated/inadequately described

Guide for use: This information is relevant only if a person currently smokes daily or has smoked daily in the past.

Verification rules: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18 years and over.

Related metadata: is qualified by Date of birth vers 4
is used in the derivation of Tobacco smoking – duration (daily smoking) vers 1
is qualified by Tobacco smoking – ever daily use vers 1
is used in conjunction with Tobacco smoking – quit age (daily smoking) vers 1

Administrative Attributes

Source organisation: Australian Institute of Health and Welfare
Information model link: NHIM Lifestyle characteristic
Data Set Specifications:  

Comments: Where the information is collected by survey and the sample permits, population estimates should be presented by sex and age groups. The recommended age groups are: < 10, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20–24, 25–29 and 30. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking – time since quitting (daily smoking)

Identifying and Definitional Attributes

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<td>01/07/99</td>
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</table>

**Definition:**
Time since a person most recently quit daily smoking.

**Context:**
Public health and health care:
Time since quitting daily smoking may give an indication of improvement in the health risk profile of a person. It is also useful in evaluating health promotion campaigns.

Relational and Representational Attributes

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<tr>
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<td>Maximum size:</td>
<td>2</td>
</tr>
</tbody>
</table>

**Data domain:**

- 01 12 months (1 year)
- 02 2 years etc. to 78
- 79 79+ years
- 80 Less than 1 month
- 81 1 month
- 82 2 months
- 83 3 months
- 84 4 months
- 85 5 months
- 86 6 months
- 87 7 months
- 88 8 months
- 89 9 months
- 90 10 months
- 91 11 months
- 92 months, not specified
- 93 years, not specified
- 99 not stated

**Guide for use:**
In order to estimate time since quitting for all respondents, the person’s date of birth or current age should also be collected.

For optimal flexibility of use, the time since quitting is coded as months or years. However, people may report the time that they quit smoking in various ways (e.g. age, a date, or a number of days or weeks ago). When the information is reported in weeks and is less than 4, or in days and is less than 28, then use code 80.
When the person reports the time since quitting as weeks ago, convert into months by dividing by 4 (rounded down to the nearest month).

If days reported are between 28 and 59, then use code 81.

Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

**Verification rules:**

**Collection methods:** The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 6) and self-administered (Question 3) versions.

**Related metadata:** is qualified by Date of birth vers 4

is qualified by Tobacco smoking – ever daily use vers 1

is derived from Tobacco smoking – quit age (daily smoking) vers 1

**Administrative Attributes**

**Source document:** Standard Questions on the Use of Tobacco Among Adults (1998)

**Source organisation:** Australian Institute of Health and Welfare

**Information model link:** NHIM  Lifestyle characteristic

**Data Set Specifications:**

**Start date**  **End date**

**Comments:** Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking status

Identifying and Definitional Attributes

Knowledgebase ID: 000410  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/99

Definition: A person’s current and past smoking behaviour.

Context: Public health, health care and clinical settings:
Smoker type is used to define sub-populations of adults (age 18 years and over) based on their smoking behaviour. Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity. This data element can be used to estimate smoking prevalence.

Other uses are to:
- evaluate health promotion and disease prevention programs (assessment of interventions)
- monitor health risk factors and progress towards National Health Goals and Targets

Relational and Representational Attributes

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

Data domain:

1  Daily smoker
2  Weekly smoker
3  Irregular smoker
4  Ex-smoker
5  Never smoked

Guide for use: The above grouping subdivides a population into five mutually exclusive categories.
- Daily smoker: A person who smokes daily
- Weekly smoker: A person who smokes at least weekly but not daily
- Irregular smoker: A person who smokes less than weekly
- Ex-smoker: A person who does not smoke at all now, but has smoked at least 100 cigarettes or a similar amount of other tobacco products in his/her lifetime.
- Never-smoker: A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.
Verification rules:
Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18.

Related metadata: is qualified by Date of birth vers 4
relates to the data element Behaviour-related risk factor intervention vers 1
relates to the data element Behaviour-related risk factor intervention – purpose vers 1

Administrative Attributes

Source organisation: Australian Institute of Health and Welfare

Information model link: NHIM  Lifestyle characteristic

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

Comments: There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. ‘Regular’ smokers is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of ‘occasional’ smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers. Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.
Tobacco smoking status – diabetes mellitus

Identifying and Definitional Attributes

Knowledgebase ID: 000846  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: Whether an individual has been a regular smoker (daily or weekly) of any tobacco material over the previous 3 months.

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:
1 Yes, has smoked daily or weekly over the previous 3 months
2 No, has not smoked daily or weekly over the previous 3 months
9 Not stated/inadequately described

Guide for use: Record whether or not regular smoking (daily or weekly) of any tobacco material has occurred over the past 3 months. Record as no if the person has not smoked at all over the past 3 months or has been an irregular smoker (i.e. not daily or weekly).

Verification rules: Ask the individual if he/she has regularly smoked (daily or weekly) any tobacco material over the past 3 months.

Collection methods: relates to the data element Tobacco smoking – consumption/quantity (cigarettes) vers 1
relates to the data element Tobacco smoking – duration (daily smoking) vers 1
relates to the data element Tobacco smoking – ever daily use vers 1
relates to the data element Tobacco smoking – frequency vers 1
relates to the data element Tobacco smoking – product vers 1
relates to the data element Tobacco smoking – quit age (daily smoking) vers 1
relates to the data element Tobacco smoking – start age (daily smoking) vers 1
relates to the data element Tobacco smoking – time since quitting (daily smoking) vers 1
relates to the data element Tobacco smoking 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   Lifestyle characteristic

**Data Set Specifications:**

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<thead>
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</thead>
<tbody>
<tr>
<td>DSS – Diabetes (clinical)</td>
<td>01/01/2003</td>
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</tbody>
</table>

**Comments:**

Smoking is the act of drawing into the mouth and puffing out the smoke of tobacco contained in a cigarette, cigar or pipe. Tobacco smoke contains a number of harmful substances including poisons, various irritant and carcinogenic compounds. For people with diabetes smoking is one of the most powerful treatable risk factors. Associated with hypertension, diabetes and hypercholesterolemia, smoking is a definite health hazard for coronary heart disease.
Total contract patient days

Identifying and Definitional Attributes

Knowledgebase ID: 000429  Version No: 1

Metadata type: Derived Data Element

Admin. status: Current

01/07/00

Definition: Sum of the number of contract patient days (Contracted care completion date minus Contracted care commencement date) for all periods within the hospital 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: Calculated sum of contract patient days.

Guide for use: A day is measured from midnight to 2359 hours.

Contract patient days are included in the total count of patient days. If necessary, contract patient days can be distinguished from other patient days by using the following rules:

The day the contract commences is counted as a contract patient day.

If the patient is on contract from midnight to 2359 count as a contract patient day.

The day a contract is completed is not counted as a contract patient day.

If the patient is admitted and commences a contract on the same day, this is not counted as a contract patient day.

If a contract is completed and the patient is separated on the same day, the day should not be counted as a contract or other patient day.

Verification rules:

Collection methods:

Related metadata:

relates to the data element Contract establishment identifier vers 1
relates to the data element Contract procedure flag vers 1
relates to the data element Contract role vers 1
relates to the data element Contract type vers 1
relates to the data element Contracted care commencement date vers 1
relates to the data element Contracted care completion date vers 1
relates to the data element Contracted hospital care vers 1
relates to the data element Patient days vers 3
Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Performance indicator

Data Set Specifications:  

<table>
<thead>
<tr>
<th>Start date</th>
<th>End date</th>
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</table>

Comments:
Total hours worked by a medical practitioner

Identifying and Definitional Attributes

Knowledgebase ID: 000394  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/07/97

Definition: The total hours worked in a week in a job by a medical practitioner, including any on-call hours actually worked (includes patient care and administration).

Context: Health labour force:
Used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN
Minimum size: 3
Maximum size: 3

Data domain: Total hours, expressed as 000, 001 etc.
999 Not stated/inadequately described

Guide for use: Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked in all.

Verification rules: Value must be less than 169 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related metadata: relates to the data element Hours on-call (not worked) by medical practitioner vers 2
supersedes previous data element Hours worked vers 1
relates to the data element Hours worked by medical practitioner in direct patient care vers 2
Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:
NHIM   Labour characteristic

Data Set Specifications:          Start date   End date
NMDS – Health labour force       01/07/1997   

Comments: It is often argued that health professionals contribute a considerable amount of
time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.
Total leave days

Identifying and Definitional Attributes

Knowledgebase ID: 000163
Version No: 3

Metadata type: Data Element
Admin. status: Current
01/07/96

Definition: Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

Context: Recording of leave days allows for exclusion of these from the calculation of patient days. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN
Minimum size: 1
Maximum size: 3

Data domain: Count in number of days.

Guide for use: A day is measured from midnight to midnight. The following rules apply in the calculation of leave days for both overnight and same-day patients:

- the day the patient goes on leave is counted as a leave day
- the day the patient is on leave is counted as a leave day
- the day the patient returns from leave is counted as a patient day
- if the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day
- if the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day
- if the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies:
(Date of separation minus Date of admission) minus Total leave days must be >= 0 days.

Collection methods:

Related metadata: supersedes previous data element Total leave days vers 2

Administrative Attributes

Source document:
Source organisation: National Health Data Committee

Information model link:
NHIM  Exit/leave from service event

Data Set Specifications:
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<td>NMDS – Admitted patient care</td>
<td>01/07/1996</td>
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</tr>
<tr>
<td>NMDS – Admitted patient mental health care</td>
<td>01/07/1997</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Commonwealth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994). This item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.
Total psychiatric care days

Identifying and Definitional Attributes

Knowledgebase ID: 000164  Version No: 2
Metadata type: Derived Data Element
Admin. status: Current
01/07/98

Definition: The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.

Context: Admitted patient and residential mental health care:
This data element is required to identify the characteristics of patients treated in specialist psychiatric units located within acute care hospitals or 24-hour staffed Community-based residential services and to analyse the activities of these units and services.

Community mental health care:
This data element is required to identify the characteristics of patients treated in specialist psychiatric 24-hour staffed Community-based residential services and to analyse the activities of these units. The data element is necessary to describe and evaluate the progress of mainstreaming of mental health services.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNNNN
Minimum size: 1
Maximum size: 5

Data domain:
Guide for use: Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in Community-based residences.

Public acute care hospitals:
Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals:
Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals:
Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.
Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the *Health Insurance Act 1973* (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed Community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as Community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour Community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element Care type). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element Care type). Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by State or Territory health authorities. Several mechanisms exist for this data field to be implemented.

- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant State/Territory health authority.
- Acute care hospitals in most States and Territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital’s ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed Community-based residential services should be identified separately at the level of the establishment.
**Verification rules:**
Total days in psychiatric care must be:
>= zero; and
<= length of stay

**Collection methods:**

**Related metadata:**
is derived from Admission date vers 4
is derived from Establishment type vers 1
is derived from Separation date vers 5
is derived from Total leave days vers 3
supersedes previous data element Total psychiatric care days vers 1
is derived from Care type vers 4

**Administrative Attributes**

**Source document:**

**Source organisation:** National Mental Health Information Strategy Committee

**Information model link:**

**Data Set Specifications:**

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<tr>
<td>NMDS - Admitted patient mental health care</td>
<td>01/07/1998</td>
<td></td>
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<tr>
<td>NMDS - Community mental health care</td>
<td>01/07/2000</td>
<td></td>
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</table>

**Comments:**
This data element was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the Community-based residential care sector. The data element is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.
Treatment delivery setting for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: 000646 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/01
Definition: The setting in which the main treatment is provided.
Context: Alcohol and other drug treatment services:
Required to identify the settings in which treatment is occurring, allowing for trends in treatment patterns to be monitored.

Relational and Representational Attributes

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

Data domain:
1 Non-residential treatment facility
2 Residential treatment facility
3 Home
4 Outreach setting
8 Other

Guide for use: Code 1 refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.
Code 2 refers to Community-based settings in which clients reside either temporarily or long-term in a facility that is not their home or usual place of residence, to receive alcohol and other drug treatment. This does not include ambulatory situations.
Code 3 refers to the client’s own home or usual place of residence.
Code 4 refers to an outreach environment, excluding a client’s home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by codes 1–3. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Verification rules: Only one code to be selected.
Collection methods:
Related metadata: relates to the data element Main 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 delivery setting

Data Set Specifications:  

<table>
<thead>
<tr>
<th>NMDS – Alcohol and other drug treatment services</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/07/2001</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
Treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

**Knowledgebase ID:** 000647  
**Version No:** 1

**Metadata type:** Data Element Concept  
**Admin. status:** Current  
01/07/01

**Definition:** The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers that occurs in one setting and in which there is no change in the main treatment type or principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.

**Context:** Alcohol and drug treatment services:  
This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.

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 concept Cessation of treatment episode for alcohol and other drugs vers 2
- relates to the data element concept Commencement of treatment episode for alcohol and other drugs vers 2
- relates to the data element Date of cessation of treatment episode for alcohol and other drugs vers 2
- relates to the data element Date of commencement of treatment episode for alcohol and other drugs vers 2
- relates to the data element Main treatment type for alcohol and other drugs vers 1
- relates to the data element Treatment delivery setting for alcohol and other drugs vers 1

Administrative Attributes

**Source document:**  
**Source organisation:**  
**Information model link:** NHIM Service provision event

**Data Set Specifications:**

**Comments:**
Triage category

Identifying and Definitional Attributes

Knowledgebase ID: 000355  
Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: The urgency of the patient’s need for medical and nursing care.

Context: Emergency department care:

Required to provide data for analysis of emergency department processes.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1  Resuscitation: immediate (within seconds)
2  Emergency: within 10 minutes
3  Urgent: within 30 minutes
4  Semi-urgent: within 60 minutes
5  Non-urgent: within 120 minutes

Guide for use:

This triage classification is to be used in the emergency departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur’s response to the question: ‘This patient should wait for medical care no longer than ...?’.

The triage category is allocated by an experienced registered nurse or medical practitioner. If the triage category changes, record the more urgent category.

Verification rules:

Collection methods:

Related metadata:

relates to the data element Admission date vers 4
relates to the data element Admission time vers 2
relates to the data element Date of service event vers 1
relates to the data element Date of triage vers 1
relates to the data element Date patient presents vers 2
relates to the data element Emergency department departure status vers 2
relates to the data element Emergency department waiting time to admission vers 1
relates to the data element Emergency department waiting time to service delivery vers 2
relates to the data element Non-admitted patient vers 1
relates to the data element concept Patient presentation at emergency department vers 1
relates to the data element Time of commencement of service event vers 2
relates to the data element Time of triage vers 1
relates to the data element Time patient presents vers 2
relates to the data element Type of visit to emergency department vers 2

Administrative Attributes

Source document: National Triage Scale, Australasian College for Emergency Medicine
Source organisation: Information model link: NHIM Assessment event

Data Set Specifications: | Start date | End date |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NMDS – Emergency department waiting times</td>
<td>01/07/1999</td>
<td></td>
</tr>
<tr>
<td>NMDS – Non-admitted patient emergency department care</td>
<td>01/07/2003</td>
<td></td>
</tr>
</tbody>
</table>

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS – Emergency department waiting times.
Triglycerides – measured

Identifying and Definitional Attributes

Knowledgebase ID: 000658  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: A person’s measured triglycerides.
Context: Public health, health care and clinical setting.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NN.N
Minimum size: 3
Maximum size: 4

Data domain: Measurement in mmol/L to 1 decimal place
99.9 Not stated/inadequately described

Guide for use: Record the absolute result of the total triglyceride measurement.

Verification rules: Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Note that to calculate the low-density lipoprotein – cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al. 1972):

− a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein – cholesterol (HDL-C) is required
− the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L and
− that while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 6 weeks after an event.


Related metadata: relates to the data element Cholesterol-total – measured vers 1
relates to the data element Cholesterol-HDL – measured vers 1
is used in the calculation of Cholesterol-LDL calculated vers 1
relates to the data element Dyslipidaemia – treatment vers 1
is used in conjunction with Fasting status vers 1
is used in conjunction with Service contact date vers 1
relates to the data element Waist circumference – measured vers 2
Administrative Attributes

Source document: National Health Data Dictionary

Source organisation: CV-Data Working Group

Information model link: NHIM Assessment event

Data Set Specifications:

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS – Cardiovascular disease (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
<tr>
<td>DSS – Diabetes (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

DSS – Cardiovascular disease (clinical):
A relationship between triglyceride and HDL-C and chronic heart disease (CHD) event rates has been shown. This view is supported by the observation that the remnants of triglyceride-rich lipoproteins are the particles that occur in dysbetalipoproteinaemia, a condition associated with a very high risk of premature atherosclerotic vascular disease. There have been two comprehensive reviews of the relationship between plasma triglyceride and CHD (see Criqui et al. 1993 and Austin et al. 1991). Criqui concludes that triglyceride is not an independent predictor of CHD and is probably not causally related to the disease, while Austin provides a compelling case for a causal role of (at least) some triglyceride-rich lipoproteins. Conclusions drawn from population studies of the relationship between plasma triglyceride and the risk of CHD include the following:

- an elevated concentration of plasma triglyceride (> 2.0 mmol/L) is predictive of CHD when associated with either an increased concentration of LDL-C or a decreased concentration of HDL-C
- the relationship between CHD risk and plasma triglyceride is not continuous, with evidence that the risk is greatest in people with triglyceride levels between 2 and 6 mmol/L. (Lipid Management Guidelines – 2001, MJA 2001; 175: S57–S88. National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand.)

It is likely that the positive relationship between plasma triglyceride and CHD, as observed in many population studies, is because an elevated level of plasma triglyceride in some people is a reflection of an accumulation of the atherogenic remnants of chylomicrons and very low density lipoprotein. These particles are rich in both triglyceride and cholesterol and appear to be at least as atherogenic as LDL.

DSS – Diabetes (clinical):
Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, the targets for lipids management is:

- to reduce total cholesterol to less than 5.5 mmol/L
- to reduce triglyceride level to less than 2.0 mmol/L
- to increase HDL-C to more than or equal to 1.0 mmol/L.

Alterations in fat transport, often resulting in hyper-triglyceridaemia, are well-recognised concomitants of diabetes mellitus.

Elevated plasma triglyceride levels are present in about one third of diabetic patients. It seems that triglycerides are related to the critical role of insulin in the production and removal from plasma of triglyceride-rich lipoproteins.

Lifestyle modifications, including weight loss and reduction of excess alcohol intake, are particularly effective for reducing triglyceride and increasing HDL-C.

References:

Hypertriglyceridaemia; Australian Medicines Handbook.
Tumour size at diagnosis – solid tumours

Identifying and Definitional Attributes

Knowledgebase ID: 000778

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: The largest dimension of a solid tumour, measured in millimetres.

Context: This is used to measure the diameter of the largest dimension of breast cancers and other solid neoplasms for patient management, population cancer statistics and research.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 3

Maximum size: 3

Data domain: Size in millimetres with valid values 001 to 997

999 Unknown

Guide for use: The reporting standard for the size of solid tumours is:

Breast cancer or other solid neoplasms – the largest tumour dimension, measured to a precision of 1 mm.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Request for/entry into service event

Data Set Specifications: Start date End date

Comments:
Tumour thickness at diagnosis – melanoma

Identifying and Definitional Attributes

Knowledgebase ID: 000779

Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: The measured thickness of a melanoma in millimetres.

Context: Patient management, population cancer statistics and research.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN.NN

Minimum size: 6

Maximum size: 6

Data domain: Size in millimetres – valid values are: 000.01 to 997.99

999.99 Unknown

Guide for use: The reporting standard for the thickness of melanoma is:

Primary cutaneous melanoma – the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01 mm.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Request for/entry into service event

Data Set Specifications: Start date End date

Comments:
Type and sector of employment establishment

Identifying and Definitional Attributes

Knowledgebase ID: 000166

Metadata type: Data Element

Admin. status: Current

01/07/95

Definition:
For each health profession, type of employment establishment is a self-reporting, condensed industry of employment classification that can be cross-referenced to the Australian and New Zealand Standard Industrial Classification.

Sector of employment establishment is government (public) or non-government (private), according to whether or not the employer is a Commonwealth, State or local government agency.

Context:
Health labour force:
To analyse distribution of service providers by setting (defined by industry of employer and sector), cross-classified with main type of work and/or specialty area.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01 Private medical practitioner rooms/surgery (including 24-hour medical clinics)
02 Other public non-residential health care facility (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
03 Other private non-residential health care (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
04 Hospital – acute care (including psychiatric or specialist hospital) hospital (public)
05 Hospital – acute care (including psychiatric or specialist hospital) hospital (private)
06 Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (public)
07 Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (private)
08 Tertiary education institution (public)
09 Tertiary education institution (private)
10 Defence forces
11 Government department or agency (e.g. laboratory, research organisation etc.)
12 Private industry/private enterprise (e.g. insurance, pathology, bank)
13 Other (specified) public
14 Other (specified) private
99 Unknown/inadequately described/not stated

**Guide for use:** Establishments are coded into self reporting groupings in the public and private sectors. This can be seen in the code list for medical practitioners. Minor variations in ordering of sequence and disaggregation of the principal categories will be profession-specific as appropriate; where a more detailed set of codes is used, the essential criterion is that there should not be an overlap of the detailed codes across the Australian and New Zealand Standard Industrial Classification category definitions.

**Note:**
Public psychiatric hospitals are non-acute care facilities, whereas private psychiatric hospitals are acute care facilities. To minimise the possibility of respondent confusion and misreporting, public psychiatric hospitals are included in the grouping for acute care public hospitals.

Day surgery centres, outpatient clinics and medical centres approved as hospitals under the *Health Insurance Act 1973* (Commonwealth) have emerged as a new category for investigation. These will be included in a review of the National Health Labour Force Collection questions and coding frames.

**Verification rules:**
**Collection methods:**
**Related metadata:**

**Administrative Attributes**

**Source document:**

**Source organisation:** National Health Labour Force Data Working Group

**Information model link:**

NHIM Organisational setting

**Data Set Specifications:**

<table>
<thead>
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<th>End date</th>
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</thead>
<tbody>
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<td>01/07/1995</td>
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</table>

**Comments:**
**Type of accommodation**

**Identifying and Definitional Attributes**

<table>
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<th>Knowledgebase ID:</th>
<th>000173</th>
<th>Version No: 2</th>
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<tr>
<td>Metadata type:</td>
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<td></td>
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<tr>
<td>Admin. status:</td>
<td>Current 01/07/99</td>
<td></td>
</tr>
</tbody>
</table>

**Definition:**
The type of accommodation setting in which the person usually lives/lived.

**Context:**
Admitted patient mental health care:
Permits analysis of the usual residential accommodation type of people prior to admission to institutional health care. The setting in which the person usually lives can have a bearing on the types of treatment and support required by the person and the outcomes that result from their treatment.

**Relational and Representational Attributes**

<table>
<thead>
<tr>
<th>Datatype:</th>
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<tbody>
<tr>
<td>Representational form:</td>
<td>Code</td>
</tr>
<tr>
<td>Representational layout:</td>
<td>N(N)</td>
</tr>
<tr>
<td>Minimum size:</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size:</td>
<td>2</td>
</tr>
</tbody>
</table>

**Data domain:**

1. Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes
2. Psychiatric hospital
3. Residential aged care service
4. Specialised alcohol/other drug treatment residence
5. Specialised mental health Community-based residential support service
6. Domestic-scale supported living facility (e.g. group home for people with disabilities)
7. Boarding/rooming house/hostel or hostel type accommodation, not including aged persons’ hostel
8. Homeless persons’ shelter
9. Shelter/refuge (not including homeless persons’ shelter)
10. Other supported accommodation
11. Prison/remand centre/youth training centre
12. Public place (homeless)
13. Other accommodation, not elsewhere classified
14. Unknown/unable to determine

**Guide for use:**
‘Usual’ is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person’s type of usual accommodation. In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the person
perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

3 – Includes nursing home beds in acute care hospitals.

4 – Includes alcohol/other drug treatment units in psychiatric hospitals.

5 – Specialised mental health Community-based residential support services are defined as Community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

6 – Domestic-scale supported living facilities include group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

10 – Includes other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Verification rules:
Collection methods:
Related metadata: is an alternative to Type of usual accommodation vers 1

Administrative Attributes

Source document:
Source organisation: National Health Data Committee

Information model link:
NHIM Accommodation characteristic

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

Comments: The changes made to this data element are in accordance with the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. HACC Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).
## Type of augmentation of labour

### Identifying and Definitional Attributes

- **Knowledgebase ID:** 000167
- **Version No:** 2
- **Metadata type:** Data Element
- **Admin. status:** Current
  - 01/07/00
- **Definition:** Methods used to assist progress of labour.
- **Context:**
  - Perinatal care:
  
  Type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

### Relational and Representational Attributes

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

- **Data domain:**
  - 0 None
  - 1 Oxytocin
  - 2 Prostaglandins
  - 3 Artificial rupture of membranes
  - 4 Other
  - 5 Not stated

- **Guide for use:** More than one method of augmentation can be recorded, except where 0=none applies.

- **Verification rules:** Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.

- **Collection methods:**
  - Related metadata: is used in conjunction with Method of birth vers 1
  - is used in conjunction with Onset of labour vers 2
  - supersedes previous data element Type of augmentation of labour vers 1
  - is used in conjunction with Type of labour induction vers 1

### Administrative Attributes

- **Source document:**
- **Source organisation:** National Perinatal Data Development Committee
Information model link:
NHIM  Birth event

Data Set Specifications:  

Comments:  Prostaglandin is listed as a method of augmentation in the data domain. Advice from Royal Australia and New Zealand College of Obstetricians and Gynaecologists and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.
Type of labour induction

Identifying and Definitional Attributes

Knowledgebase ID: 000171  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/96
Definition: Methods used to induce labour.

Context: Perinatal statistics:
Type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and Representational Attributes

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

Data domain:
0 None
1 Oxytocin
2 Prostaglandins
3 Artificial rupture of membranes
4 Other

Guide for use: More than one method of induction can be recorded, except where 0=none applies.

Verification rules:
Collection methods:
Related metadata: is used in conjunction with Onset of labour vers 2
is used in conjunction with Type of augmentation of labour vers 2

Administrative Attributes

Source document:
Source organisation: National Perinatal Data Development Committee
Information model link: NHIM Birth event
Data Set Specifications: Start date   End date

Comments:
Type of non-admitted patient care

Identifying and Definitional Attributes

Knowledgebase ID: 000231 Version No: 1
Metadata type: Derived Data Element
Admin. status: Current
01/07/94

Definition: This data element identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

Context: Required to describe the broad types of services provided to non-admitted patients, community patients and outreach clients.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNNNNNN
Minimum size: 1
Maximum size: 7

Data domain: Count of number of non-admitted patient occasions of service.

Guide for use: A count is required for each of the following categories (definitions of each are given below):

Emergency department and emergency services:
   A9.1 Emergency services

Outpatient services:
   A9.2 Dialysis
   A9.3 Pathology
   A9.4 Radiology and organ imaging
   A9.5 Endoscopy and related procedures
   A9.6 Other medical/surgical/diagnostic
   A9.7 Mental health
   A9.8 Drug and alcohol
   A9.9 Dental
   A9.10 Pharmacy
   A9.11 Allied health services

Other non-admitted services:
   A9.12 Community health services
   A9.13 District nursing services
   A9.14 Other outreach services
Definitions:

A9.1 Emergency services:
Services to patients who are not admitted and who receive treatment that was either unplanned or carried out in designated emergency departments within a hospital. Unplanned patients are patients who have not been booked into the hospital before receiving treatment. In general it would be expected that most patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided in emergency departments these are to be included. The exceptions are for dialysis and endoscopy and related procedures which have been recommended for separate counting.

A9.2 Dialysis:
This represents all non-admitted patients receiving dialysis within the establishment. Where patients receive treatment in a ward or clinic classified elsewhere (for example, an emergency department), those patients are to be counted as dialysis patients and to be excluded from the other category. All forms of dialysis which are undertaken as a treatment necessary for renal failure are to be included.

A9.3 Pathology:
This includes all occasions of service to non-admitted patients from designated pathology laboratories. Occasions of service to all patients from other establishments should be counted separately.

A9.4 Radiology and organ imaging:
This includes all occasions of service to non-admitted patients undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography and magnetic resonance imaging.

A9.5 Endoscopy and related procedures:
This should include all occasions of service to non-admitted patients for endoscopy including:
- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy.

Where one of these procedures is carried out in a ward or clinic classified elsewhere, for example in the emergency department, the occasion is to be included under endoscopy and related procedures, and to be excluded from the other category. Care must be taken to ensure procedures or admitted patients are excluded from this category.

A9.6 Other medical/surgical/diagnostic:
Any occasion of service to a non-admitted patient given at a designated unit primarily responsible for the provision of medical/surgical or diagnostic services which has not been covered in the above. These include ECG, obstetrics, nuclear medicine, general medicine, general surgery, fertility and so on.

A9.7 Mental health:
All occasions of service to non-admitted patients attending designated psychiatric or mental health units within hospitals.

A9.8 Alcohol and drug:
All occasions of service to non-admitted patients attending designated drug and alcohol units within hospitals.
A9.9 Dental:
All occasions of service to non-admitted patients attending designated dental units within hospitals.

A9.10 Pharmacy:
This item includes all occasions of service to non-admitted patients from pharmacy departments. Those drugs dispensed/administered in other departments such as the emergency department, or outpatient departments, are to be counted by the respective departments.

A9.11 Allied health services:
This includes all occasions of service to non-admitted patients where services are provided at units/clinics providing treatment/counselling to patients. These include units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy and so on.

A9.12 Community health services:
Occasions of service to non-admitted patients provided by designated community health units within the establishment. Community health units include:
- baby clinics
- immunisation units
- aged care assessment teams
- other.

A9.13 District nursing service: Occasions of service to non-admitted patients which:
- are for medical/surgical/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider*
- are not provided by staff from a unit classified in the community health category above.

A9.14 Other outreach services: Occasions of service to non-admitted patients which:
- involve travel by the service provider*
- are not classified in allied health or community health services above.

* Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

It is intended that these activities should represent non-medical/surgical/psychiatric services. Activities such as home cleaning, meals on wheels, home maintenance and so on should be included.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Verification rules:
Collection methods:
The list of categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.
Related metadata:

Administrative Attributes

Source document: 
Source organisation: National minimum data set working parties
Information model link: NHIM  Performance indicator
Data Set Specifications: NMDS - Public hospital establishments

Comments: Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.
Type of non-admitted patient care (public psychiatric, alcohol and drug)

Identifying and Definitional Attributes

Knowledgebase ID: 000233  Version No: 1
Metadata type: Derived Data Element
Admin. status: Current 01/07/89

Definition: Emergency patients and outpatients are persons who receive non-admitted care. Non-admitted care is care provided to a person who receives direct care within the emergency department or other designated clinics within the hospital and who is not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.
For outreach/community patients, care delivered by hospital employees to the patient in the home, place of work or other non-hospital site.
A group is defined as two or more patients receiving a service together, where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Context: Required to adequately describe the services provided to non-admitted patients in public psychiatric hospitals and alcohol and drug hospitals.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNNNNNN
Minimum size: 1
Maximum size: 7

Data domain: Count occasions of service for each of the categories.

Guide for use: A count is required for each of the following categories:
Emergency and outpatient occasions of service:
1 Individual patients
2 Groups
Outreach/community occasions of service:
3 Individual patients
4 Groups

Verification rules:

Collection methods: The working party discussed the need to distinguish different types of psychiatric outpatient services in psychiatric hospitals. South Australia outlined its categories of psychiatric outpatients:
- day patients (not admitted but are day program patients)
- outpatients (typically 20 minutes consultation)
- community/outreach (outreach services provided by staff off the hospital site, including community health service provided off-site and domiciliary care)
− casualty patients (designated casualty area, mirroring usual hospital set up).

These categories also applied to mental health clinics in South Australia. The working party agreed that the South Australian categories were useful, but that outpatient and casualty categories should be collapsed as there was a boundary problem between these two categories.

The working party initially recommended the following categories for activity data for outpatient services at establishment level:
− day program patients
− emergency and other outpatients
− outreach/community.

The first two of the above categories cover all outpatients treated on the hospital site, the latter covers outreach services provided by the staff off the hospital site. It includes community health services provided by hospital staff off-site.

The working party then discussed the unit of counting for activity data. The Psychiatric Working Party reviewed the recommendation of the Inpatient/Non-inpatient Working Party that occasions of service should be the appropriate unit of counting. The following points were raised:

• The method of counting the number of group sessions in a psychiatric setting was difficult because a day patient is always a group patient. Also, groups would have a mixture of inpatients and outpatients.

• Counting occasions of service for a day patient was difficult because a patient could have up to eight treatment encounters in one day.

• From a client perspective, groups should be ignored and information should be collected on every individual.

• Queensland counted the number of days on which contact is made, irrespective of intensity of service.

• It was suggested that occasions of service (or individuals) be counted but that the information should be divided into one-on-one sessions or group sessions, for resource implications.

• Some members thought that, in terms of resources, groups of staff and type of provider were more important than number of clients.

• Victoria proposed a bare-bones approach, and recommended that only occasions of service be counted. All the other points raised were important dimensions, but Victoria felt that to do justice to them, it would be necessary to include community services, phone consultations and so on, which was not feasible at this stage.

• The Psychiatric Working Party foreshadowed the need to categorise outpatients further into child, adult and other. It was generally agreed that while this aspect would be worthwhile flagging in a policy statement, it was not necessary to consider it at this stage.

• The Psychiatric Working Party also agreed that occasions of service was the preferred counting unit for non-admitted patient activity data. It was noted that the acute sector had opted for this unit.

• The Psychiatric Working Party recommended that a family was to be counted as one occasion of service (individual session) not as a group, and that a family unit was to be determined as a group of people which identified themselves as such.

The Psychiatric Working Party agreed that the unit of counting of services should be as follows:
− day program attendances
− other outpatient occasions of service
− outreach occasions of service.

Day program patients should be counted as number of attendances to a day program (patient days). Day program patient occasions of service with other staff should be counted separately as other outpatient occasions of service.
Related metadata:

Administrative Attributes

Source document:
Source organisation: National minimum data set working parties
Information model link: NHIM Performance indicator
Data Set Specifications: NMDS - Public hospital establishments Start date End date
01/07/1989

Comments: In general, establishments other than acute hospitals provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore, disaggregation by type of non-admitted patient care is not relevant to psychiatric and alcohol/drug hospitals.
Type of non-admitted patient care (residential aged care services)

Identifying and Definitional Attributes

Knowledgebase ID: 000234  
Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the residential aged care service.

For outreach/community patients, care is delivered by residential aged care service employees to the patient in the home, place of work or other non-establishment site.

Context: Non-admitted patient care:

Required to adequately describe the services provided to non-admitted patients.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count of occasions of service.

Guide for use: Count to be recorded for each of the following categories:

A11.1 Service to outpatients

A11.2 Service to outreach/community patients

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link: NHIM Performance indicator

Data Set Specifications: 

Start date 

End date

Comments: Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.
Type of usual accommodation

Identifying and Definitional Attributes

Knowledgebase ID: 000173  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/89
Definition: The type of physical accommodation the person lived in prior to admission.
Context: Admitted patient mental health care:
Permits analysis of the prior residential accommodation type of people admitted to residential aged care services or other institutional care.

Relational and Representational Attributes

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

Data domain:
1 House or flat
2 Independent unit as part of retirement village or similar
3 Hostel or hostel type accommodation
4 Psychiatric hospital
5 Acute hospital
6 Other accommodation
7 No usual residence

Guide for use:
Verification rules:
Collection methods: The above classifications have been based on Question 16 of Form NH5. This item is not available for New South Wales State nursing homes. As this data item includes only details of physical accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate data element (see data element Mode of admission). The Commonwealth Department of Health and Ageing has introduced a new Aged Care Application and Approval form which replaces the NH5.

Related metadata: is an alternative to Type of accommodation vers 2

Administrative Attributes

Source document:
Source organisation: National minimum data set working parties
Information model link:
NHIM Accommodation characteristic
Data Set Specifications: Start date  End date
NMDS – Admitted patient mental health care 01/07/1997
Comments:
Type of visit to emergency department

Identifying and Definitional Attributes

Knowledgebase ID: 000352
Version No: 2

Metadata type: Data Element
Admin. status: Current
01/07/01

Definition: The reason the patient presents to the emergency department.

Context: Hospital non-admitted patient care:
Required for analysis of emergency department services.

Relational and Representational Attributes

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

Data domain:
1 Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.
2 Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.
3 Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.
4 Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.
5 Dead on arrival: a patient who is dead on arrival at the emergency department.

Guide for use:
Verification rules:
Collection methods:
Related metadata: relates to the data element Emergency department waiting time to admission vers 1
relates to the data element Emergency department waiting time to service delivery vers 2
relates to the data element concept Patient presentation at emergency department vers 1
relates to the data element Triage category vers 1
supersedes previous data element Type of visit vers 1

Administrative Attributes

Source document:
Source organisation:
National Institution Based Ambulatory Model Reference Group
National Health Data Committee


Information model link:
NHIM Request for/entry into service event

Data Set Specifications:

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<th>Data Set</th>
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<td>01/07/2001</td>
<td></td>
</tr>
<tr>
<td>NMDS - Non-admitted patient emergency department care</td>
<td>01/07/2003</td>
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</tr>
</tbody>
</table>

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS - Emergency department waiting times.
Urgency of admission

Identifying and Definitional Attributes

Knowledgebase ID: 000425          Version No: 1
Metadata type: Data Element
Admin. status: Current
01/07/00

Definition:
Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis.

An emergency admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.

An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours. Admissions for which an urgency status is usually not assigned are:

− admissions for normal delivery (obstetric)
− admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient
− statistical admissions
− planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: N(.N)
Minimum size: 1
Maximum size: 3

Data domain:
1  Urgency status assigned – emergency
2  Urgency status assigned – elective
3  Urgency status not assigned
9  Not known/not reported

Guide for use:
Emergency admission:
The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.
Such a patient would be:
− at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation or
− suffering from suspected acute organ or system failure or
− suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened or
− suffering from a drug overdose, toxic substance or toxin effect or
− experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk or
− suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened or
− suffering acute significant haemorrhage and requiring urgent assessment and treatment or
− suffering gynaecological or obstetric complications or
− suffering an acute condition which represents a significant threat to the patient’s physical or psychological wellbeing or
− suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

Elective admissions:
If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions:
A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists:
Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an Urgency of admission category, which may or may not be elective.

• Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see data domain value 1 in data element Reason for removal) will be assigned an Urgency of admission code of 2. In that case, their Clinical urgency category could be regarded as further detail on how urgent their admission was.

• Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see data domain value 2 in data element Reason for removal), will be assigned an Urgency of admission code of 1.

Admissions for which an urgency status is usually not assigned:
An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

Use of code 9.
The not known/not reported category is to be used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.
Verification rules:
Collection methods:
Related metadata: relates to the data element Clinical urgency vers 2
relates to the data element concept Elective care vers 1

Administrative Attributes

Source document:

Source organisation: Emergency Definition Working Party
National Health Data Committee

Information model link: NHIM Assessment event

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

Comments:
Vascular history

Identifying and Definitional Attributes

Knowledgebase ID: 000676 Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: Describes the vascular history of the person.

Context: Public health, health care and clinical settings:
The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s).
It may be used to map vascular conditions, assist in risk stratification and link to best practice management.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain:
01 Myocardial infarction
02 Unstable angina pectoris
03 Angina
04 Heart failure
05 Atrial fibrillation
06 Other dysrhythmia or conductive disorder
07 Rheumatic heart disease
08 Non-rheumatic valvular heart disease
09 Left ventricular hypertrophy
10 Stroke
11 Transient ischaemic attack
12 Hypertension
13 Peripheral vascular disease (includes abdominal aortic aneurism)
14 Deep vein thrombosis
15 Other atherosclerotic disease
16 Carotid stenosis
17 Vascular renal disease
18 Vascular retinopathy (hypertensive)
19 Vascular retinopathy (diabetic)
97 Other vascular
98 No vascular history
99 Unknown/not stated/not specified
Guide for use: More than one code can be recorded.

Verification rules: Ideally, vascular history information is derived from and substantiated by clinical documentation.

Collection methods: is used in conjunction with Date of diagnosis vers 1 relates to the data element Service contact date vers 1

Related metadata: Administrative Attributes


Source organisation: CV-Data Working Group
National Centre for Classification in Health
National Data Standards for Injury Surveillance Advisory Group

Information model link: NHIM Physical wellbeing

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

Comments: Further work needs to be undertaken to ensure that the values in the data domain can be mapped to the current version of ICD-10-AM.
Vascular procedures

Identifying and Definitional Attributes

Knowledgebase ID: 000677  Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: Describes the vascular procedures the person has undergone.

Context: Public health and health care:
This data element is important for tracking cardiovascular patient management against appropriate practice for cardiovascular presentation(s) and risk factor(s) the person may exhibit.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 1
Maximum size: 2

Data domain:
01 Amputation for arterial vascular insufficiency
02 Carotid endarterectomy
03 Carotid angioplasty/stenting
04 Coronary angioplasty/stenting
05 Coronary artery bypass grafting
06 Renal artery angioplasty/stenting
07 Heart transplant
08 Heart valve surgery
09 Abdominal aortic aneurism repair/bypass graft/stenting
10 Cerebral circulation angioplasty/stenting
11 Femoral/popliteal bypass/graft/stenting
12 Congenital heart and blood vessel defect surgery
13 Permanent pacemaker implantation
14 Implantable cardiac defibrillator
98 Other
99 Unknown/not recorded

Guide for use:

Verification rules:
Collection methods: Ideally, Vascular procedure information is derived from and substantiated by clinical documentation.

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


**Source organisation:** CV-Data Working Group

**Information model link:**
NHIM  Physical wellbeing

**Data Set Specifications:**

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<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
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</thead>
<tbody>
<tr>
<td>DSS - Cardiovascular disease (clinical)</td>
<td>01/01/2003</td>
<td></td>
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</table>

**Comments:** In settings where the monitoring of a person’s health is ongoing and where a history can change over time (such as general practice), the Service contact date should be recorded.
Visual acuity

Identifying and Definitional Attributes

Knowledgebase ID: 000847     Version No: 1
Metadata type: Data Element
Admin. status: Current
01/01/03

Definition: The visual acuity test measures the smallest letters that a person can read on a standardised chart at a distance of 6 metres (20 feet) wearing glasses if needed.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Code
Representational layout: NN
Minimum size: 2
Maximum size: 2

Data domain:
01 6/5
02 6/6
03 6/9
04 6/12
05 6/18
06 6/24
07 6/36
08 6/60
09 CF (count fingers)
10 HM (hand movement)
11 PL (perceive light)
12 BL (blind)
13 6/7.5
99 Not stated/inadequately described

Guide for use: Test wearing distance glasses if prescribed. Use pinhole if vision less than 6/6. Record actual result for both right and left eyes (this is a repeating field):
- 1st field: right eye
- 2nd field: left eye.

Verification rules:

One of the most often utilised tests for visual acuity uses the Snellen chart.
- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.
- Both eyes are to be opened and then cover one eye with the ocular occluder.
• The observer has to read out the smallest line of letters that he/she can see from the chart.
• This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

− within five years of diagnosis and then every 1–2 years for patients whose diabetes onset was at age under 30 years
− at diagnosis and then every 1–2 years for patients whose diabetes onset was at age 30 years or more.

**Related metadata:**
relates to the data element Health professionals attended – diabetes mellitus vers 1
relates to the data element Blindness – diabetes complication vers 1
relates to the data element Cataract – history vers 1
relates to the data element Ophthalmological assessment – outcome vers 1
relates to the data element Ophthalmoscopy – performed vers 1
relates to the data element Referred to ophthalmologist – diabetes mellitus 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:**

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<tr>
<td>DSS – Diabetes (clinical)</td>
<td>01/01/2003</td>
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</tbody>
</table>

**Comments:**

Patients with diabetes have an increased risk of developing several eye complications including retinopathy, cataract and glaucoma that can lead to loss of vision. Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications. Assessment by an ophthalmologist is essential:

− at initial examination if the corrected visual acuity is less than 6/6 in either eye
− if at subsequent examinations declining visual acuity is detected
− if any retinal abnormality is detected
− if clear view of retina is not obtained.

References:

Vision Australia, No 2, 1997/8; University of Melbourne
World Health Organization
US National Library of Medicine
Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993
Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus
Waist circumference – measured

Identifying and Definitional Attributes

Knowledgebase ID: 000372
Version No: 2

Metadata type: Data Element
Admin. status: Current
01/01/03

Definition: A person’s waist circumference measured half way between the inferior margin of the last rib and the crest of the ilium in the mid-axillary plane. In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.

Context: Public health, health care and clinical settings:
Originally used in the calculation of Waist-to-hip ratio which requires the measurement of hip circumference and waist circumference as a predictor of obesity-related morbidity and mortality. More recently it has been used in it’s own right as an indicator of risk associated with excess abdominal fat.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN.N
Minimum size: 4
Maximum size: 5

Data domain: Distance in centimetres, measured to the nearest 0.1cm.
999.9 Not collected

Guide for use: If measured waist circumference is not able to be collected, code 999.9
The measurement is recorded as a continuous variable measured to the nearest 0.1 cm.

Verification rules: The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity, and without drawing attention to an individual’s weight.

Collection methods: The measurement of waist circumference requires a narrow (< 7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.

The subject should remove any belts and heavy outer clothing. Measurement of waist circumference should be taken over at most one layer of light clothing. Ideally the measure is made directly over the skin.

The subject stands comfortably with weight evenly distributed on both feet, and the feet separated about 25–30 cm. The arms should hang loosely at the sides. Posture can affect waist circumference. The measurement is taken midway between the inferior margin of the last rib and the crest of the ilium, in
the mid-axillary plane. Each landmark should be palpated and marked, and
the midpoint determined with a tape measure and marked.

The circumference is measured with an inelastic tape maintained in a
horizontal plane, at the end of normal expiration. The tape is snug, but does
not compress underlying soft tissues. The measurer is positioned by the side of
the subject to read the tape. To ensure contiguity of the two parts of the tape
from which the circumference is to be determined, the cross-handed technique
of measurement, as described by Norton et al. (1996), should be used. Ideally
an assistant will check the position of the tape on the opposite side of the
subject’s body.

The measurement is recorded at the end of a normal expiration to the nearest
0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the
two measurements disagree by more than 1 cm, take a third measurement. All
raw measurements should be recorded on the data collection form. If practical,
it is preferable to enter the raw data into the database as this enables
intra-observer and, where relevant, inter-observer errors to be assessed. The
subject’s measured waist circumference is subsequently calculated as the mean
of the two observations, or the mean of the two closest measurements if a third
is taken, and recorded on the form. If only a mean value is entered into the
database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so,
rounding should be to the nearest even digit to reduce systematic
over-reporting (Armitage & Berry 1994). For example, a mean value of 72.25 cm
would be rounded to 72.2 cm, while a mean value of 72.35 cm would be
rounded to 72.4 cm.

Validation and quality control measures:
Steel tapes should be checked against a 1 metre engineer’s rule every
12 months. If tapes other than steel are used they should be checked daily
against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They
can be assessed by the same (within-) or different (between-) observers
repeating the measurement, on the same subjects, under standard conditions
after a short time interval. The standard deviation of replicate measurements
(technical error of measurement (Pederson & Gore 1996)) between observers
should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured
waist circumference should be checked both during data collection and after
data entry. Individuals should not be excluded on the basis of true biological
difference.

Last-digit preference, and preference or avoidance of certain values, should be
analysed in the total sample and (if relevant) by observer, survey site and over
time if the survey period is long.

**Related metadata:** supersedes previous data element Adult abdominal circumference – measured vers 1
is used in the calculation of Waist-to-hip ratio vers 2

**Administrative Attributes**

**Source document:** The measurement protocol described below is that recommended by the World
Health Organization (WHO Expert Committee 1995) which was adapted from
Lohman et al. (1988) and the International Society for the Advancement of
Kinanthropometry as described by Norton et al. (1996).

**Source organisation:** World Health Organization (see also Comments) and the International Society
for the Advancement of Kinanthropometry.
**Information model link:**

NHIM  Physical characteristic

**Data Set Specifications:**  

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<td>DSS – Cardiovascular disease (clinical)</td>
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</table>

**Comments:**  

This data element applies to persons of all ages. It is recommended for use in population surveys and health care settings.

There is evidence that waist circumference alone might be used to identify people at health risk both from being overweight and from having a central fat distribution (Lean et al. 1995; Han et al. 1995; Pouliot et al. 1994; Seidell et al. 1992). It has been suggested that waist circumference as an index of truncal adiposity in adults may have certain advantages over other measurements of adiposity in predicting obesity related diseases. However, among children and adolescents, waist circumference measures should only be used as a measure of variation in an individual. As yet, no age appropriate cut-off points indicative of risk factors have been developed for use among children and adolescents.

It is recommended that, in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

**Presentation of data:**

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For reporting purposes, it may be desirable to present waist circumference in categories. It is recommended that 5-cm groupings are used for this purpose. Waist circumference should not be rounded before categorisation. The following categories may be appropriate for describing the waist circumferences of Australian men, women children and adolescents, although the range will depend on the population.

- Waist < 35 cm
- 35 cm = Waist < 40 cm
- 40 cm = Waist < 45 cm
- ... in 5 cm categories
- 105 cm = Waist < 110 cm
- Waist => 110 cm
Waist circumference risk indicator – adults

Identifying and Definitional Attributes

Knowledgebase ID: 000851  
Version No: 1

Metadata type: Derived Data Element

Admin. status: Current  
01/07/03

Definition: The sex specific category of risk of metabolic complications associated with excess abdominal adiposity in adult caucasians.

Context: Public health and health care:

Sex specific waist circumference risk indicator is used as an indicator of risk of metabolic complications associated with overweight and obesity including dyslipidaemia, glucose intolerance and hypertension. On a population basis there is a strong association between abdominal obesity and health risk. Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure. Waist circumference as an indicator of risk can be used:

- to indicate the prevalence of abdominal obesity and its sociodemographic distribution (problem identification)
- to evaluate health promotion and disease prevention programs (assessment of interventions)
- to monitor progress towards national public health policy
- to ascertain determinants and consequences of abdominal obesity
- in nutrition and physical activity surveillance and long-term planning.

Waist circumference is a convenient and simple measurement that is unrelated to height, correlates closely with body mass index (BMI) and waist-to-hip ratio (WHR) and is an approximate index of intra-abdominal fat mass and total body fat. Changes in waist circumference can reflect changes in risk factors for cardiovascular disease and other forms of chronic disease, even though the risks seem to vary in different populations.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:  
1 Not at risk (male waist circumference < 94 cm, female waist circumference < 80 cm)  
2 Increased (male waist circumference >= 94 cm, female waist circumference >= 80 cm)  
3 Substantially increased (male waist circumference >= 102 cm, female waist circumference >= 88 cm)  
9 Not stated/inadequately described
Guide for use: Waist circumference risk indicator – adults cannot be determined if Waist circumference measured has not been collected (i.e. is coded to 999.9) and/or sex is not stated (i.e. coded to 9).

Verification rules:

Collection methods: Waist circumference risk indicator should be derived after the data entry of waist circumference measured. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.

Related metadata: is used in conjunction with Sex vers 3
is used in conjunction with Waist circumference – measured vers 2

Administrative Attributes


Source organisation: World Health Organization

Information model link: NHIM Surveillance/monitoring event

Data Set Specifications: Start date End date

Comments: This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Recent evidence suggests that waist circumference may provide a more practical correlate of abdominal fat distribution and associated ill health.

The identification of risk using waist circumference is population-specific and will depend on levels of obesity and other risk factors for cardiovascular disease and non-insulin dependant diabetes mellitus.

Populations differ in the level of risk associated with a particular waist circumference, so that globally applicable cut-off points cannot be developed. For example, complications associated with abdominal fat in black women and those of South Asian descent are markedly higher for a given level of BMI than in Europeans. Also, although women have almost the same absolute risk of coronary heart disease as men at the same Waist-to-hip ratio, they show increases in relative risk of coronary heart disease at lower waist circumferences than men. Thus, there is a need to develop sex-specific waist circumference cut-off points appropriate for different populations. Hence, the cut-off points used for this element are associated with obesity in caucasians. This issue is being investigated further.

Cut-off points for children and adolescents are also being developed. Research shows that a high childhood BMI and high trunk skin fold values are predictive of abdominal obesity as an adult and waist circumference measures in childhood track well into adulthood.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth and Indigenous status and smoking. Data elements are being developed for physical activity.
Waist-to-hip ratio

Identifying and Definitional Attributes

Knowledgebase ID: 000373
Version No: 2

Metadata type: Derived Data Element

Admin. status: Current
01/07/03

Definition: A ratio calculated by dividing the waist circumference of an adult person by the hip circumference of that same person.

Context: Public health and health care:
Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure.

Waist-to-hip ratio (WHR) can be used:
- to indicate the prevalence of abdominal obesity and its sociodemographic distribution (problem identification)
- to evaluate health promotion and disease prevention programs (assessment of interventions)
- to monitor progress towards national public health policy
- to ascertain determinants and consequences of abdominal obesity
- in nutrition and physical activity surveillance and long-term planning.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: N.NN

Minimum size: 4
Maximum size: 4

Data domain
Calculated value to two decimal places

Guide for use: Formula:
WHR = Waist circumference (cm) divided by hip circumference (cm).

Adult waist-to-hip ratio is a continuous variable. Adult waist-to-hip ratio cannot be calculated if either component necessary for its calculation (i.e. abdominal circumference or hip circumference) has not been collected (i.e. is coded to 999.9).

Adult cut-off points for waist-to-hip ratio, that may define increased risk of cardiovascular disease and all cause mortality, range from 0.9 to 1.0 for men and 0.8 to 0.9 for women (Croft et al. 1995, Bray 1987, Bjorntorp 1985). These values are based primarily on evidence of increased risk of death in European populations, and may not be appropriate for all age and ethnic groups.

In Australia and New Zealand, the cutoffs of > 0.9 for males and > 0.8 for females were used in the Australian Bureau of Statistics’ 1995 National Nutrition Survey.

As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to calculate this item for those aged under 18 years.
Verification rules:

Collection methods: WHR should be derived after the data entry of waist circumference and hip circumference. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.

Related metadata: supersedes previous derived data element Adult abdomen to hip ratio vers 1 is calculated using Hip circumference – measured vers 2 is calculated using Waist circumference – measured vers 2

Administrative Attributes

Source document: National Health Data Committee

Source organisation: National Centre for Monitoring Cardiovascular Disease
Australian Institute of Health and Welfare

Information model link: NHIM Physical characteristic

Data Set Specifications: Start date End date

Comments: This data element applies to persons aged 18 years or older as no cut off points have been developed for children and adolescents. It is recommended for use in population surveys and health care settings.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in waist-to-hip ratio measurements. Waist-to-hip ratio is therefore no longer a commonly used measure.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.
Waiting list category

Identifying and Definitional Attributes

Knowledgebase ID: 000176 Version No: 3
Metadata type: Data Element
Admin. status: Current
01/01/95
Definition: The type of elective hospital care that a patient requires.

Context: Admitted patients:
Hospitals maintain waiting lists which may include patients awaiting hospital care other than elective surgery – for example, dental surgery and oncology treatments. This item is necessary to distinguish patients awaiting elective surgery (code 1) from those awaiting other types of elective hospital care (code 2). The waiting period for patients awaiting transplant or obstetric procedures is largely independent of system resource factors.

Relational and Representational Attributes

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

Data domain: 1 Elective surgery
2 Other

Guide for use: Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.
Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.
Patients awaiting the following procedures should be classified as Code 2 – other:
• organ or tissue transplant procedures
• procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
• cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
• biopsy of:
  - kidney (needle only)
  - lung (needle only)
  - liver and gall bladder (needle only)
• bronchoscopy (including fibre-optic bronchoscopy)
• peritoneal renal dialysis
• haemodialysis
• colonoscopy
• endoscopic retrograde cholangio
• panreatography (ERCP)
- endoscopy of:
  - biliary tract
  - oesophagus
  - small intestine
  - stomach
- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the ICD-10-AM (International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition, 2002) National Centre for Classification in Health, Sydney) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care. All other elective surgery should be included in waiting list Code 1 – elective surgery.

Verification rules:

Collection methods:

Related metadata:
relates to the data element concept Elective care vers 1
is supplemented by the data element Indicator procedure vers 3
is used in conjunction with Patient listing status vers 3
supersedes previous data element Waiting list category – ICD-9-CM code vers 2

Administrative Attributes


Source organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group
National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications: NMDS – Elective surgery waiting times

Start date 01/07/1999

End date

Comments:
The table of ICD-10-AM procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians.

A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use above, to facilitate more readily the identification of the exclusions when the list of codes is not used.
ICD-10-AM CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant:
- 13706-07 [802] 13706-09 [802] 30375-21 [817] 90317-00 [954]

Procedures associated with obstetrics:
- 16511-00 [1274] Obstetric Blocks [1330] to [1345] and [1347]

Biopsy (needle) of:
- kidney: 36561-00 [1047]
- lung: 38412-00 [550]
- liver and gall bladder: 30409-00 [953] 30412-00 [953] 90319-01 [951]
- 30094-04 [964]

Bronchoscopy:
- 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Peritoneal renal dialysis:
- 13100-06 [1061] 13100-07 [1061] 13100-08 [1061] 13100-00 [1060]

Endoscopy of biliary tract:
- 30451-00 [959] 30452-02 [959] 90349-00 [975]

Endoscopy of oesophagus:
- 30478-18 [1008]

Endoscopy of large intestine, rectum and anus:
- 32084-01 [911] 32087-00 [911] 30479-01 [931] 90315-00 [933]

Miscellaneous cardiac:
- 35324-00 [740] 35315-00 [758] 35315-01 [758]

Endovascular interventional:

Urethroscopy:
- 35527-00 [1116] 37318-04 [1117]
Dental:
Blocks [450] to [490]

Other diagnostic and non-surgical:
13921-00 [1780] 13927-00 [1780] 13939-00 [1780] 13942-00 [1780]
90768-00 [1780] Blocks [1820] to 1939], [1940] to [2016]
Waiting time at a census date

Identifying and Definitional Attributes

Knowledgebase ID: 000412  
Version No: 2  
Metadata type: Derived Data Element  
Admin. status: Current  
01/07/02  
Definition: The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list to a designated census date.

Context: Elective surgery:  
This is a critical elective surgery waiting times data element. It is used to determine whether patients are overdue, or had extended waits at a census date. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Relational and Representational Attributes

Datatype: Numeric  
Representational form: Quantitative value  
Representational layout: NNNN  
Minimum size: 1  
Maximum size: 4  
Data domain: Count in number of days  
Guide for use: The number of days is calculated by subtracting the Listing date for care from the Census date, minus any days when the patient was ‘not ready for care’, and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at the Census date.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as ‘not ready for care’ from the date(s) the person was subsequently recorded as again being ‘ready for care’.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at the Census date, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at Census date) the number of days at the less urgent clinical urgency category should be calculated by subtracting the Listing date for care from the Category reassignment date. If the patient’s clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at the Census date should be calculated by subtracting one Category reassignment date from the subsequent Category reassignment date, and then added together.

When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.

Therefore at the Census date the patient’s waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.
Verification rules:
Collection methods:
Related metadata:
- is calculated using Category reassignment date vers 2
- is calculated using Census date vers 2
- is qualified by Clinical urgency vers 2
- is used in the derivation of Extended wait patient vers 1
- is calculated using Listing date for care vers 4
- is used in the derivation of Overdue patient vers 3
- is calculated using Patient listing status vers 3
- supersedes previous derived data element Waiting time at a census date vers 1

Administrative Attributes
Source document: Australian Institute of Health and Welfare
Source organisation: National Health Data Committee
Information model link: NHIM Performance indicator
Data Set Specifications: Start date End date
Comments:
Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This data element is used to measure waiting times at a designated census date whereas the data element Waiting time at removal from elective surgery waiting list measures waiting times at removal.

The calculation of waiting times for patients who are transferred from an elective surgery waiting list managed by one public acute hospital to another will be investigated in the future. In this case, the amount of time waited on previous lists should follow the patient to the next. Therefore at the Census date, their waiting time includes the total number of days on all lists (less days not ready for care and days in lower urgency categories).
Waiting time at removal from elective surgery waiting list

Identifying and Definitional Attributes

Knowledgebase ID: 000413  Version No: 2
Metadata type: Derived Data Element
Admin. status: Current
01/07/02
Definition: The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list.

Context: Elective surgery:
This is a critical elective surgery waiting times data element. It is used to determine whether patients were overdue, or had extended waits when they were removed from the waiting list. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNNN
Minimum size: 1
Maximum size: 4

Data domain: Count in number of days.

Guide for use: The number of days is calculated by subtracting the Listing date for care from the Removal date, minus any days when the patient was ‘not ready for care’, and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.
Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as ‘not ready for care’ from the date(s) the person was subsequently recorded as again being ‘ready for care’.
If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited. In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the Listing date for care from the Category reassignment date. If the patient’s clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one Category reassignment date from the subsequent Category reassignment date, and then adding the days together.
When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore at the removal date the patient’s waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.
Verification rules:
Collection methods:
Related metadata:
is calculated using Category reassignment date vers 2
is qualified by Clinical urgency vers 2
is used in the derivation of Extended wait patient vers 1
is calculated using Listing date for care vers 4
is used in the derivation of Overdue patient vers 3
is qualified by Patient listing status vers 3
is calculated using Removal date vers 1
supersedes previous derived data element Waiting time at admission vers 1

Administrative Attributes
Source document:
Source organisation: Australian Institute of Health and Welfare
National Health Data Committee
Information model link: NHIM Performance indicator
Data Set Specifications: Start date End date
NMDS – Elective surgery waiting time 01/07/2002

Comments: Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This data element is used to measure waiting times at removal whereas the data element Waiting time at Census Date measures waiting times at a designated census date. The calculation of waiting times for patients, who are transferred from an elective surgery waiting list managed by one public acute hospital to another, will be investigated in the future. In this case, the amount of time waited on previous lists would follow the patient to the next. Therefore when the patient is removed from the waiting list (for admission or other reason), their waiting time would include the total number of days on all lists (less days not ready for care and days in lower urgency categories).
Weight – measured

Identifying and Definitional Attributes

Knowledgebase ID: 000365  
Metadata type: Data Element  
Admin. status: Current  
01/01/03  
Definition: A person’s measured weight (body mass).  
In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.

Context: Public health, health care and clinical settings:  
Weight is an overall measure of body size that does not distinguish between fat and muscle. Weight is an indicator of nutritional and health status. Low pre-pregnancy weight is an indicator of poorer gestational outcome in women (Kramer 1988). Low weight is also associated with osteoporosis. In general, change in weight in adults is of interest because it is an indicator of changing health status, and in children as it indicates changing health status and growth and development. It enables the calculation of body mass index (BMI) which requires the measurement of height and weight for adults as well as sex and date of birth for children and adolescents.

Relational and Representational Attributes

Datatype: Numeric  
Representational form: Quantitative value  
Representational layout: NNN.N  
Minimum size: 4  
Maximum size: 5  
Data domain: Measurement of weight in kilograms to one decimal place  
999.9 Not able to be collected  
Guide for use:  
Verification rules:  
Collection methods: The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity and without drawing attention to an individual's weight.  
Measurement protocol:  
Weight – measured is a continuous variable measured to the nearest 0.1 kg.  
Equipment used should be described and reported. Scales should have a resolution of at least 0.1 kg and should have the capacity to weigh up to at least 200 kg. Measurement intervals and labels should be clearly readable under all conditions of use of the instrument. Scales should be capable of being calibrated across the entire range of measurements. Precision error should be no more than 0.1 kg. Scales should be calibrated on each day of use. Manufacturers’ guidelines should be followed with regard to the transportation of the scales.
Adults and children who can stand:

The subject stands over the centre of the weighing instrument, with the body weight evenly distributed between both feet.

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater. Any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form.

Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

If the subject has had one or more limbs amputated, record this on the data collection form and weigh them as they are. If they are wearing an artificial limb, record this on the data collection form but do not ask them to remove it. Similarly, if they are not wearing the limb, record this but do not ask them to put it on.

The measurement is recorded to the nearest 0.1 kg. If the scales do not have a digital readout, take a repeat measurement. If the two measurements disagree by more than 0.5 kg, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject’s measured weight is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 kg. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage & Berry 1994). For example, a mean value of 72.25 kg would be rounded to 72.2 kg, while a mean value of 72.35 kg would be rounded to 72.4 kg.

Infants:

Birth weight and gender should be recorded with gestational age. During infancy a levelled pan scale with a bean and movable weights or digital scales capable of measuring to two decimal places of a kilogram are acceptable. Birth weight should be determined within 12 hours of birth. The infant, with or without a nappy or diaper is placed on the scales so that the weight is distributed equally about the centre of the pan. When the infant is lying or suspended quietly, weight is recorded to the nearest 10 grams. If the nappy or diaper is worn, its weight is subtracted from the observed weight, i.e. reference data for infants are based on nude weights.

Validation and quality control measures:

If practical, equipment should be checked daily using one or more objects of known weight in the range to be measured. It is recommended that the scale be calibrated at the extremes and in the mid range of the expected weight of the population being studied.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement of weight, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement) between observers should not exceed 0.5 kg and be less than 0.5 kg within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.
**Related metadata:**

- supersedes previous data element Adult weight – measured vers 1
- is used in the calculation of Body mass index vers 2
- is used in conjunction with Creatinine serum – measured vers 1

**Administrative Attributes**

**Source document:**
The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995).

**Source organisation:**
World Health Organization

**Information model link:**
NHIM Physical characteristic

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set Specifications</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS – Cardiovascular disease (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
<tr>
<td>DSS – Diabetes (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

This data element applies to persons of all ages. It is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men, women, children and adolescents, although the range will depend on the population.

- Wt< 10 kg
- 10 kg = Wt <15 kg
- 15 kg = Wt < 20 kg
- ... in 5 kg categories
- 135 kg = Wt < 140 kg
- Wt => 140 kg

**Source organisation:**

WHO and the consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing.
DSS – Diabetes (clinical):
Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, BMI should be below 27 kg/m² for men and women. For adults who suffer from diabetes, the recommendation is to measure weight and calculate BMI on the initial visit and then measure weight every 3 months. If the patient is on a weight reduction program, weight is to be measured more frequently.

Strong evidence exists that weight loss reduces blood pressure in both overweight hypertensive and non-hypertensive individuals; reduces serum triglycerides and increases high-density lipoprotein (HDL)-cholesterol; and generally produces some reduction in total serum cholesterol and low-density lipoprotein (LDL)-cholesterol.

The risk of developing diabetes rises continuously with increasing obesity (DHAC & AIHW 1999:13). An increased central distribution of body fat (when fatness is concentrated in the abdomen) also appears to be associated more often with Type 2 diabetes (Bishop et al. 1998:430-1).

Weight loss reduces blood glucose levels in overweight and obese persons with and without diabetes; and weight loss also reduces blood glucose levels and HbA1c in some patients with type 2 diabetes. Although there have been no prospective trials to show changes in mortality with weight loss in obese patients, reductions in risk factors would suggest that development of type 2 diabetes and CVD would be reduced with weight loss.

References:
Chronic Diseases and Associated Risk Factors in Australia 2001 (AIHW).
Weight – self-reported

Identifying and Definitional Attributes

Knowledgebase ID: 000366  Version No: 2
Metadata type: Data Element
Admin. status: Current
01/01/03
Definition: A person’s self-reported weight (body mass).

Context: Public health and health care:
Weight is an overall measure of body size that does not distinguish between fat
and muscle. Weight is an indicator of nutrition status and health status. Low
pre-pregnancy weight is an indicator of poorer gestational outcome in women
(Kramer 1988). Low weight is also associated with osteoporosis. In general,
change in weight is of interest in adults because it is an indicator of changing
health status. Self reported or parentally reported weight for children and
adolescents should be used cautiously if at all. It enables the calculation of body
mass index which requires the measurement of height and weight (body mass)
for adults.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Quantitative value
Representational layout: NNN
Minimum size: 2
Maximum size: 3

Data domain: Recorded in kilograms.
888 Unknown
999 Not stated

Guide for use:
Verification rules:
Collection methods:
The method of data collection, e.g. face to face interview, telephone interview
or self-completion questionnaire, can affect survey estimates and should be
reported.
The data collection form should include a question asking the respondent what
their weight is. For example, the Australian Bureau of Statistics National
Health Survey 1989–90 included the question 'How much do you weigh
without clothes and shoes?'. The data collection form should allow for both
metric (to the nearest 1 kg) and imperial (to the nearest 1 lb) units to be
recorded.
If practical, it is preferable to enter the raw data into the data base before
conversion of measures in imperial units to metric. However, if this is not
possible, weight reported in imperial units can be converted to metric prior to
data entry using a conversion factor of 0.454 kg to the lb.
Rounding to the nearest 1 kg will be required for measures converted to metric
prior to data entry, and may be required for data reported in metric units to a
greater level of precision than the nearest 1 kg. The following rounding
conventions are desirable to reduce systematic over reporting (Armitage &
Berry 1994):
nnn.x where x < 5 – round down, e.g. 72.2 kg would be rounded to 72 kg.
nnn.x where x > 5 – round up, e.g. 72.7 kg would be rounded to 73 kg.
nnn.x where x = 5 – round to the nearest even number, e.g. 72.5 kg would be
rounded to 72 kg, while 73.5 kg would be rounded to 74 kg.

Related metadata:
supersedes previous data element Adult weight – self-reported vers 1
is used in the calculation of Body mass index vers 2

Administrative Attributes

Source document: National Health Data Committee
Source organisation: National Centre for Monitoring Cardiovascular Disease
Australian Institute of Health and Welfare

Information model link:
NHIM  Physical characteristic

Data SetSpecifications:  Start date  End date

Comments:
This data element is recommended for persons aged 18 years or older. It is
recommended for use in population surveys when it is not possible to measure
weight.
It is recommended that in population surveys, sociodemographic data
including ethnicity should be collected, as well as other risk factors including
physiological status (e.g. pregnancy), physical activity, smoking and alcohol
cconsumption. Summary statistics may need to be adjusted for these variables.
National health data elements currently exist for Sex, Date of birth, Country of
birth, Indigenous status and smoking. Data elements are being developed for
physical activity.
Presentation of data:
Means and 95% confidence intervals, medians and centiles should be reported
to one decimal place. Where the sample permits, population estimates should
be presented by sex and 5-year age groups. Estimates based on sample surveys
may need to take into account sampling weights.
For consistency with conventional practice, and for current comparability with
international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and
95. To estimate the 5th and 95th centiles, a sample size of at least 200 is
recommended for each group for which the centiles are being specified.
For some reporting purposes, it may be desirable to present weight data in
categories. It is recommended that 5 kg groupings are used for this purpose.
Weight data should not be rounded before categorisation. The following
categories may be appropriate for describing the weights of Australian men and
women, although the range will depend on the population. The World Health
Organization’s range for weight is 30–140 kg.
Wt < 30 kg
30 kg = Wt < 35 kg
35 kg = Wt < 40 kg
... in 5 kg categories
135 kg = Wt < 140 kg
Wt = >140 kg
On average, body mass (weight) tends to be underestimated when self-reported
by respondents. Data for men and women aged 20–69 years in 1989 indicated
that men underestimated by an average of 0.2 kg (sem of 0.05 kg) and women
by an average of 0.4 kg (sem of 0.04 kg) (Waters 1993). The extent of
underestimation varied with age.
Year insulin started

Identifying and Definitional Attributes

Knowledgebase ID: 000848
Version No: 1

Metadata type: Data Element
Admin. status: Current
01/01/03

Definition: The year the patient started insulin injections.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric
Representational form: Date
Representational layout: YYYY
Minimum size: 4
Maximum size: 4

Data domain: Actual year insulin was started.
9999 Not stated/inadequately described

Guide for use: Record the year that insulin injections were started.
This data element has to be completed for all patients who use insulin. It is used
to cross check diabetes type assignment.

Verification rules:

Collection methods: Ask the individual the year when he/she started to use insulin. Alternatively
obtain this information from appropriate documentation, if available.

Related metadata:
relates to the data element Date of birth vers 4
relates to the data element Diabetes status vers 1
relates to the data element Diabetes therapy type vers 1
relates to the data element Year of diagnosis of diabetes mellitus 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 Request for/entry into service event

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

Comments: This data element provides information about the duration of diabetes in
individual patients.
Insulin is a regulating hormone secreted into the blood in response to a rise in concentration of blood glucose or amino acids. It is a double-chain protein hormone formed from proinsulin in the beta cells of the pancreatic islets of Langerhans. Insulin promotes the storage of glucose and the uptake of amino acids, increases protein and lipid synthesis, and inhibits lipolysis and gluconeogenesis.

Commercially prepared insulin is available in various types, which differ in the speed they act and in the duration of their effectiveness.
# Year of diagnosis of diabetes mellitus

## Identifying and Definitional Attributes

<table>
<thead>
<tr>
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<th>000849</th>
<th>Version No: 1</th>
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<td></td>
</tr>
<tr>
<td><strong>Admin. status:</strong></td>
<td>Current</td>
<td>01/01/03</td>
</tr>
<tr>
<td><strong>Definition:</strong></td>
<td>The year a patient was first diagnosed as having diabetes.</td>
<td></td>
</tr>
<tr>
<td><strong>Context:</strong></td>
<td>Public health, health care and clinical settings.</td>
<td></td>
</tr>
</tbody>
</table>

## Relational and Representational Attributes

<table>
<thead>
<tr>
<th><strong>Datatype:</strong></th>
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<tbody>
<tr>
<td><strong>Representational form:</strong></td>
<td>Date</td>
</tr>
<tr>
<td><strong>Representational layout:</strong></td>
<td>YYYY</td>
</tr>
<tr>
<td><strong>Minimum size:</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Maximum size:</strong></td>
<td>4</td>
</tr>
</tbody>
</table>

**Data domain:**

- Actual year of diagnosis of diabetes mellitus
- 9999 Not stated/inadequately described

**Guide for use:**

Record the year that the patient was first diagnosed as having diabetes.

**Verification rules:**

Ask the individual the year when he/she was diagnosed with diabetes. Alternatively obtain this information from appropriate documentation, if available.

**Related metadata:**

- relates to the data element Date of birth vers 4
- relates to the data element Year insulin started 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 Request for/entry into service event

**Data Set Specifications:**

<table>
<thead>
<tr>
<th>Data Set Specifications:</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS – Diabetes (clinical)</td>
<td>01/01/2003</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

Long-term complications of diabetes mellitus affect the eyes, kidneys, nerves, and blood vessels.
Data Set Specifications

The Dictionary contains some metadata items that are grouped together to form a metadata set for the purposes of collection of a set of data. There are currently two endorsed types of metadata sets in the Dictionary, the National Minimum Data Set (NMDS) and the Data Set Specification (DSS).

Other metadata items in the Dictionary, while not being part of an endorsed metadata set, are endorsed as appropriate national standards. That is they have been subjected to the same rigorous process as for an NMDS or DSS.

National Minimum Data Sets

A National Minimum Data Set is a core set of data elements agreed by the National Health Information Management Group for mandatory collection and reporting at a national level. One National Minimum Data Set may include data elements that are also included in another National Minimum Data Set. A National Minimum Data Set is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

The *National Health Data Dictionary* contains definitions of data elements that are included in National Minimum Data Set collections in the health sector, including data elements used to derive some of the performance indicators required under Australian Health Care Agreements (bilaterial agreements between the Commonwealth and State/Territory governments about funding and delivery of health services).

The National Health Data Dictionary, Version 12, identifies metadata items for the following National minimum data sets:

1. Admitted patient care NMDS
2. Admitted patient mental health care NMDS
3. Admitted patient palliative care NMDS
4. Alcohol and other drug treatment services NMDS  
   (modified in NHDD version 12 from 1/07/2002)
5. Community mental health care NMDS
6. Community mental health establishments NMDS
7. Elective surgery waiting times NMDS
8. Emergency department waiting times NMDS
9. Health labourforce NMDS
10. Injury surveillance NMDS
11. Non-admitted patient emergency department care  
    (NEW in NHDD version 12 from 1/07/2003)
12. Perinatal NMDS
13. Public hospital establishments NMDS

Full descriptions of the NMDS are found on the following pages.
## Admitted patient care NMDS

**Admin. status:** CURRENT 1/07/2001  Version number: 2

**Metadata type:** NATIONAL MINIMUM DATA SET

**Start date:** 1 July 1989

**Scope:** Episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia’s off-shore Territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

**Statistical units:** Episodes of care for admitted patients.

**Collection methodology:** Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant State or Territory health authority on a regular basis (e.g. monthly).

**National reporting arrangements:** State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

**Periods for which data are collected and nationally collated:** Financial years ending 30 June each year.

**Data elements included:**

- Activity when injured, version 2
- Additional diagnosis, version 4
- Admission date, version 4
- Admitted patient election status, version 1
- Area of usual residence, version 3
- Care type, version 4
- Country of birth, version 3
- Date of birth, version 4
- Diagnosis-related group, version 1
- Establishment identifier, version 4
- External cause – admitted patient, version 4
- Funding source for hospital patient, version 1
- Hospital insurance status, version 3
- Indigenous status, version 4
- Infant weight – neonate, stillborn, version 3
- Intended length of hospital stay, version 2
- Inter-hospital contracted patient, version 2
- Mental health legal status, version 5
- Major diagnostic category, version 1
- Mode of admission, version 4

* new in NMDS this version  
∇ modified this version
### Data elements included (continued):

- Mode of separation, version 3
- Number of days of hospital-in-the-home care, version 1
- Number of leave periods, version 3
- Number of qualified days for newborns, version 2
- Person identifier, version 1<br>
∇
- Place of occurrence of external cause of injury, version 5
- Principal diagnosis, version 3
- Procedure, version 5
- Region code, version 2
- Separation date, version 5
- Sex, version 3<br>
∇
- Source of referral to public psychiatric hospital, version 3
- Total leave days, version 3
- Total psychiatric care days, version 2
- Urgency of admission, version 1

### Supporting data elements and data element concepts:

- Acute care episode for admitted patients, version 1
- Admission, version 3
- Admitted patient, version 3
- Diagnosis, version 1
- Episode of care, version 1
- Establishment number, version 4
- Establishment sector, version 3
- Hospital boarder, version 1
- Hospital in-the-home care, version 1
- Hospital, version 1
- Live birth, version 1
- Neonate, version 1
- Newborn qualification status, version 2
- Patient, version 1
- Region code, version 2
- Same-day patient, version 1
- Separation, version 3
- State/Territory identifier, version 3

### Data elements in common with other NMDSs:

- See Appendix D
**Scope links with other NMDSs:**
Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- Admitted patient mental health care NMDS, version 2.

Episodes of care for admitted patients where care type is palliative care:

- Admitted patient palliative care NMDS, version 2.

**Source organisation:**
National Health Information Management Group

**Comments:**
Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
### Admitted patient mental health care NMDS

**Admin. status:** CURRENT 1/07/2001 Version number: 2

**Metadata type:** NATIONAL MINIMUM DATA SET

**Start date:** 1 July 1997

**Scope:** The scope of this minimum data set is restricted to admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

**Statistical units:** Episodes of care for admitted patients.

**Collection methodology:** Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant State or Territory health authority on a regular basis (e.g. monthly).

**National reporting arrangements:** State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

**Periods for which data are collected and nationally collated:** Financial years ending 30 June each year.

**Data elements included:**
- Additional diagnosis, version 4
- Admission date, version 4
- Area of usual residence, version 3
- Care type, version 4
- Country of birth, version 3
- Date of birth, version 4
- Diagnosis related group, version 1
- Employment status – acute hospital and private psychiatric hospital admissions, version 2
- Employment status – public psychiatric hospital admissions, version 2
- Establishment identifier, version 4
- Indigenous status, version 4
- Major diagnostic category, version 1
- Marital status, version 3
- Mental health legal status, version 5
- Mode of separation, version 3
- Person identifier, version 1
- Previous specialised treatment, version 3
- Principal diagnosis, version 3
- Referral to further care (psychiatric patients), version 1
- Separation date, version 5

♦ new in NMDS this version  
∇ modified this version
**Data elements included (continued):**
- Sex, version 3
- Source of referral to public psychiatric hospital, version 3
- Total leave days, version 3
- Total psychiatric care days, version 2
- Type of accommodation, version 2
- Type of usual accommodation, version 1

**Supporting data elements and data element concepts:**
- Acute care episode for admitted patients, version 1
- Admission, version 3
- Admitted patient, version 3
- Diagnosis, version 1
- Episode of care, version 1
- Establishment number, version 4
- Establishment sector, version 3
- Hospital, version 1
- Patient, version 1
- Region code, version 2
- Separation, version 3
- State/Territory identifier, version 3

**Data elements in common with other NMDSs:**
- See Appendix D

**Scope links with other NMDSs:**
- Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:
  - Admitted patient care NMDS, version 2,
  - Admitted patient palliative care NMDS, version 2.

**Source organisation:**
- National Health Information Management Group

**Comments:**
- Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.
- Number of days of hospital-in-the-home care data will be collected from all States and Territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.
### Admitted patient palliative care NMDS

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<tr>
<td>Start date:</td>
<td>1 July 2000</td>
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<tr>
<td>Scope:</td>
<td>The scope of this data set is admitted patients receiving palliative care in all public and private acute hospitals, and free standing day-hospital facilities. Hospitals operated by the Australian Defence Force, correctional authorities and Australia’s external Territories are not currently included. Palliative care patients are identified by the data element Care type.</td>
<td></td>
</tr>
<tr>
<td>Statistical units:</td>
<td>Episodes of care for admitted patients.</td>
<td></td>
</tr>
<tr>
<td>Collection methodology:</td>
<td>State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.</td>
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<tr>
<td>Periods for which data are collected and nationally collated:</td>
<td>Financial years ending 30 June each year</td>
<td></td>
</tr>
<tr>
<td>Data elements included:</td>
<td>Additional diagnosis, version 4</td>
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<tr>
<td></td>
<td>Admission date, version 4</td>
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<tr>
<td></td>
<td>Area of usual residence, version 3</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Country of birth, version 3&lt;sup&gt;v&lt;/sup&gt;</td>
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<td></td>
<td>Date of birth, version 4&lt;sup&gt;v&lt;/sup&gt;</td>
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<td>Establishment identifier, version 4&lt;sup&gt;v&lt;/sup&gt;</td>
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<td></td>
<td>Funding source for hospital patient, version 1</td>
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<tr>
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<td>Indigenous status, version 4&lt;sup&gt;v&lt;/sup&gt;</td>
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<td></td>
<td>Mode of admission, version 4</td>
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<tr>
<td></td>
<td>Mode of separation, version 3</td>
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<td>Number of days of hospital-in-the-home care, version 1</td>
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<td>Person identifier, version 1&lt;sup&gt;v&lt;/sup&gt;</td>
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<td>Previous specialised treatment, version 3</td>
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<td></td>
<td>Principal diagnosis, version 3</td>
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<tr>
<td></td>
<td>Separation date, version 5</td>
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<td></td>
<td>Sex, version 3&lt;sup&gt;v&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>Supporting data elements and data element concepts:</td>
<td>Admission, version 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admitted patient, version 3</td>
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<tr>
<td></td>
<td>Diagnosis, version 1</td>
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<tr>
<td></td>
<td>Episode of care, version 1</td>
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</table>

* new in NMDS this version  
<sup>v</sup> modified this version
Supporting data elements and data element concepts: (continued)

Establishment number, version 4
Establishment sector, version 3
Hospital, version 1
Hospital-in-the-home care, version 1
Patient, version 1
Region code, version 2
Separation, version 3
State/Territory identifier, version 3

Supporting data element concepts (continued):

Data elements in common with other NMDSs:

See Appendix D

Scope links with other NMDSs:

Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:
Admitted patient care NMDS, version 2,
Admitted patient mental health care NMDS, version 2.

Source organisation:

National Health Information Management Group

Comments:

Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.
Number of days of hospital in-the-home care data will be collected from all States and Territories except Western Australia from 1 July 2001.
Western Australia will begin to collect data from a later date.
## Alcohol and other drug treatment services NMDS

**Admin. status:** CURRENT 1/07/2003 Version number: 4

**Metadata type:** NATIONAL MINIMUM DATA SET

**Start date:** 1 July 2000

**Scope:**
This metadata set is nationally mandated for collection and reporting. Publicly funded government and non-government agencies providing alcohol and/or drug treatment services. Including community-based ambulatory services and outpatient services.

The following services are currently not included in the coverage:
- services based in prisons and other correctional institutions
- agencies that provide primarily accommodation or overnight stays such as ‘sobering-up shelters’ and ‘halfway houses’
- agencies that provide services concerned primarily with health promotion
- needle and syringe programs
- agencies whose sole function is to provide prescribing and/or dosing of methadone
- acute care and psychiatric hospitals, or alcohol and drug treatment units that report to the admitted patient care NMDS and do not provide treatment to non-admitted patients.

Clients who are on a methadone maintenance program may be included in the collection where they also receive other types of treatment.

**Statistical units:**
Completed treatment episodes for clients who participate in a treatment type as specified in the data element Main treatment type for alcohol and other drugs.

**Collection methodology:**
Data to be reported in each agency on completed treatment episode and then forwarded to State/Territory authorities for collation.

**National reporting arrangements:**
State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

**Periods for which data are collected and nationally collected:**
Financial years ending 30 June each year.

**Data elements included:**
- Client type – alcohol and other drug treatment services, version 3
- Country of birth, version 3
- Date of birth, version 4
- Date of cessation of treatment episode for alcohol and other drugs, version 2
- Date of commencement of treatment episode for alcohol and other drugs, version 1
- Establishment identifier, version 4
- Geographical location of service delivery outlet, version 1

* new in NMDS this version
V modified this version
Data elements included (continued):

Indigenous status, version 4
Injecting drug use status, version 2
Main treatment type for alcohol and other drugs, version 1
Method of use for principal drug of concern, version 1
Number of service contacts within a treatment episode for alcohol and other drugs, version 2
Other drug of concern, version 2
Other treatment type for alcohol and other drugs, version 1
Person identifier, version 1
Preferred language, version 2
Principal drug of concern, version 2
Reason for cessation of treatment episode for alcohol and other drugs, version 2
Sex, version 3
Source of referral to alcohol and other drug treatment service, version 2
Treatment delivery setting for alcohol and other drugs, version 1

Supporting data elements and data element concepts:

Cessation of treatment episode for alcohol and other drugs, version 2
Commencement of treatment episode for alcohol and other drugs, version 2
Establishment number, version 4
Establishment sector, version 3
Region code, version 2
Service contact, version 1
Service delivery outlet, version 1
State/Territory identifier, version 3
Treatment episode for alcohol and other drugs, version 1

Data elements in common with other Metadata sets:

See Appendix D

Source organisation:
National Health Information Management Group

Comments:
Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
# Community mental health care NMDS

**Admin. status:** CURRENT 1/07/2001  
**Version number:** 2

**Metadata type:** NATIONAL MINIMUM DATA SET

**Start date:** 1 July 2000

**End date:**

**Latest evaluation date:**

**Scope:** Patient-level data: Data required for reporting by specialised psychiatric services that deliver ambulatory services, in both institutional and community settings. It does not extend to services provided to patients who are in general (non-specialised) care who may be receiving treatment or rehabilitation for psychiatric conditions.

The data provided through the Community mental health care NMDS supplements that reported for psychiatric and acute care hospitals through the Admitted patient mental health care NMDS.

**Statistical units:** Service contact dates

**Collection methodology:** State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

**Periods for which data are collected and nationally collated:** Financial years ending 30 June each year

**Data elements included:**
- Area of usual residence, version 3
- Country of birth, version 3\(^v\)
- Date of birth, version 4\(^v\)
- Establishment identifier, version 4\(^v\)
- Indigenous status, version 4\(^v\)
- Marital status, version 3
- Mental health legal status, version 5
- Person identifier, version 1\(^v\)
- Principal diagnosis, version 3
- Service contact date, version 1\(^v\)
- Sex, version 3\(^v\)

**Supporting data elements and data element concepts:**
- Diagnosis, version 1
- Establishment number, version 4
- Establishment sector, version 3
- Region code, version 2
- Service contact, version 1
- State/Territory identifier, version 3

\(^v\) modified this version

\(^v\) new in NMDS this version
Data elements in common with other NMDSs:
See Appendix D

Scope links with other NMDSs:

Source organisation: National Health Information Management Group

Comments: Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published
# Community mental health establishments NMDS

**Admin. status:** CURRENT 1/07/2000  
**Version number:** 1

**Metadata type:** NATIONAL MINIMUM DATA SET

**Start date:** 1 July 1998

**End date:**

**Latest evaluation date:**

**Scope:** Data required for reporting by specialised psychiatric services that deliver ambulatory services, in both institutional and community settings, and/or community-based residential care. It does not extend to services provided to patients who are in general (non-specialised) care who may be receiving treatment or rehabilitation for psychiatric conditions.

The data provided through the NMDS – Community mental health establishments supplements that reported for psychiatric and acute care hospitals through the NMDS – Admitted patient mental health care.

**Statistical units:** Establishment-level data.

**Collection methodology:**

**National reporting arrangements:** State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

**Periods for which data are collected and nationally collated:** Financial years ending 30 June each year

**Data elements included:** Establishment identifier, version 4  
Full time equivalent staff, version 2  
Geographical location of establishment, version 2  
Non-salary operating costs, version 1  
Number of available beds for admitted patients, version 2  
Salaries and wages, version 1  
Separations, version 2

**Supporting data elements and data element concepts:** Administrative expenses vers 1  
Depreciation vers 1  
Domestic services vers 1  
Drug supplies vers 1  
Establishment number, version 4  
Establishment sector, version 3  
Food supplies vers 1  
Interest payments vers 1  
Medical and surgical supplies vers 1

* new in NMDS this version  
∇ modified this version
### Supporting data elements and data element concepts (continued):

- Other recurrent expenditure vers 1
- Patient transport vers 1
- Patient, version 2
- Payments to visiting medical officers vers 1
- Region code, version 2
- Repairs and maintenance vers 1
- Separation, version 3
- State/Territory identifier, version 3
- Superannuation employer contributions (including funding basis) vers 1

### Data elements in common with other NMDSs:

See Appendix D

### Scope links with other NMDSs:

### Source organisation:

National Health Information Management Group

### Comments:

Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
Elective surgery waiting times NMDS

Admin. status: CURRENT 1/07/2001 Version number: 3

Metadata type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1994

End date:

Latest evaluation date:

Scope: The scope of this minimum data set is patients on, or removed from, waiting lists for elective surgery (as defined in the Waiting list category data element) which are managed by public acute hospitals. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals.

Hospitals may also collect information for other care (as defined in the Waiting list category data element), but this is not part of the NMDS for elective surgery waiting times.

Patients on, or removed from, waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia’s external Territories are not currently included.

There are two different types of data collected for this minimum data set (census data and removals data) and the scope and list of data elements associated with each is different.

Census data:

Data are collected for patients on elective surgery waiting lists who are yet to be admitted to hospital or removed for another reason. The scope is patients on elective surgery waiting lists on a census date who are ‘ready for care’ as defined in the Patient listing status data element.

Removals data:

Data are collected for patients who have been removed from an elective surgery waiting list (for admission or another reason). Patients who were ‘ready for care’ and patients who were ‘not ready for care’ at the time of removal are included.

Statistical units: Patients on waiting lists on census dates; patients removed from waiting lists (for admission or other reason) during each financial year.

Collection methodology: Category reassignment date is required for reporting to the NMDS, but is necessary for the derivation of Waiting time at census date and Waiting time at removal from elective surgery waiting list. Waiting list category and Patient listing status are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to State and Territory health authorities as required.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year for removals data

Census dates are 30 September, 31 December, 31 March and 30 June
**Data elements included:**

**Census data**
- Census date, version 2
- Clinical urgency, version 2
- Extended wait patient, version 1
- Establishment identifier, version 4
- Indicator procedure, version 3
- Listing date for care, version 4
- Overdue patient, version 3
- Surgical specialty, version 1
- Waiting time at a census date, version 2

**Removals data**
- Clinical urgency, version 2
- Extended wait patient, version 1
- Establishment identifier, version 4
- Indicator procedure, version 3
- Listing date for care, version 4
- Overdue patient, version 3
- Reason for removal from elective surgery waiting list, version 4
- Surgical specialty, version 1
- Waiting time at removal from elective surgery waiting list, version 2
- Removal date, version 1

**Supporting data elements and data element concepts:**
- Category reassignment date, version 2
- Clinical review, version 1
- Elective care, version 1
- Elective surgery, version 1
- Establishment number, version 4
- Establishment sector, version 3
- Hospital census, version 1
- Hospital waiting list, version 2
- Non-elective care, version 1
- Patient listing status, version 3
- Region code, version 2
- State/Territory identifier, version 3
- Waiting list category, version 3

**Data elements in common with other NMDSs:**
See Appendix D

**Scope links with other NMDSs:**

**Source organisation:**
National Health Information Management Group

♦ new in NMDS this version  □ modified this version
Comments:

For the purposes of this NMDS, public hospitals include hospitals which are set up to provide services for public patients (as public hospitals do), but which are managed privately.

Category reassignment date is not required for reporting to the NMDS, but is necessary for the derivation of Waiting time at census date and Waiting time at removal from elective surgery waiting list. Waiting list category and Patient listing status are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to State and Territory health authorities as required.

The inclusion of public patients on, or removed from, elective surgery waiting lists managed by private hospitals will be investigated in the future.

Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.
Emergency department waiting times NMDS

Admin. status: CURRENT 1/07/2000 Version number: 1

Metadata type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1999

End date:

Latest evaluation date:

Scope: The scope of this data set is to be negotiated between Commonwealth and State/Territory Government health authorities. It is likely that data will only be required for reporting by metropolitan hospitals and larger rural/regional hospitals.

Statistical units:

Collection methodology:

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Date of commencement of service event, version 2
Date of triage, version 1
Date patient presents, version 2
Emergency department departure status, version 2
Emergency department waiting time to service delivery, version 2
Establishment number, version 4
Time of commencement of service event, version 2
Time of triage, version 1
Time patient presents, version 2
Triage category, version 1
Type of visit to emergency department, version 2

Supporting data elements and data element concepts:

Establishment number, version 4
Establishment sector, version 3
Patient presentation at emergency department, version 1
Patient, version 1
Region code, version 2
State/Territory identifier, version 3
Data elements in common with other NMDSs: See Appendix D

Scope links with other NMDSs:

Source organisation: National Health Information Management Group

Comments: Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
Health labour force NMDS

Admin. status: CURRENT 1/07/2000

Version number: 1

Metadata type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1989

End date:

Latest evaluation date:

Scope: The scope of this set of data elements is all health occupations. National collections using this data set have been undertaken for the professions of medicine, nursing, dentistry, pharmacy, physiotherapy and podiatry, using labour force questionnaires in the annual renewal of registration to practice.

Statistical units:

Collection methodology:

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included: Classification of health labour force job, version 1
Date of birth, version 4
Hours on-call (not worked) by medical practitioner, version 2
Hours worked by health professional, version 2
Hours worked by medical practitioner in direct patient care, version 2
Principal area of clinical practice, version 1
Principal role of health professional, version 1
Profession labour force status of health professional, version 1
Total hours worked by medical practitioner, version 2
Type and sector of employment establishment, version 1

Supporting data elements and data element concepts: Health labour force, version 1

Data elements in common with other NMDSs: See Appendix D

Scope links with other NMDSs:

new in NMDS this version
modified this version
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<thead>
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<th>National Health Information Management Group</th>
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<td><strong>Comments:</strong></td>
<td>Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.</td>
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</table>
## Injury surveillance NMDS

<table>
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<tr>
<td>Start date:</td>
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<td></td>
</tr>
<tr>
<td>End date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latest evaluation date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Scope:
The scope of this minimum data set is patient-level data from selected emergency departments of hospitals and other settings.

### Statistical units:

### Collection methodology:

### National reporting arrangements:
State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

### Periods for which data are collected and nationally collated:
Financial years ending 30 June each year

### Data elements included:
- Activity when injured, version 2
- Bodily location of main injury, version 1
- External cause – admitted patient, version 4
- External cause – human intent, version 4
- Narrative description of injury event, version 1
- Nature of main injury – non-admitted patient, version 1
- Place of occurrence of external cause of injury, version 5

### Supporting data elements and data element concepts:
- Admitted patient, version 3
- Non-admitted patient, version 1

### Data elements in common with other NMDSs:
See Appendix D

### Scope links with other NMDSs:

### Source organisation:
National Health Information Management Group

### Comments:
Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.

* new in NMDS this version  
∇ modified this version
Non-admitted patient emergency department care NMDS

**Admin. status:** 01/07/2003  Version number: 1

**Metadata type:** NATIONAL MINIMUM DATA SET

**Start Date:** 1 July 2003

**Scope:** This metadata set is nationally mandated for collection and reporting. The scope of this NMDS is non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare’s *Australian Hospital Statistics* publication from the preceding financial year.

The care provided to patients in emergency departments is, in most instances, recognised as being provided to ‘non-admitted’ patients. Patients being treated in emergency departments may subsequently become ‘admitted’. The care provided to non-admitted patients who are treated in the emergency department prior to being admitted is included in this NMDS.

Care provided to patients who are being treated in an emergency department site as an admitted patient (e.g. in an observation unit, short-stay unit, ‘Emergency department ward’ or awaiting a bed in an admitted patient ward of the hospital) are excluded from the emergency department care NMDS since the recording of the care provided to these patients is part of the scope of the Admitted patient care NMDS.

**Statistical units:** Non-admitted patient emergency department service episodes.

**National reporting arrangements:** State and Territory health authorities provide the NMDS data to the Australian Institute of Health and Welfare for national collation, on an annual basis, within 3 months of the end of a reporting period.

The Institute and the Commonwealth Department of Health and Ageing will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health and Ageing. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request.

**Periods for which data are collected and nationally collated:** Financial years, ending 30 June each year. Extraction of data for a financial year should be based on the date of the end of the non-admitted emergency department service episode.

**Data elements included:**

- Area of usual residence, version 3
- Compensable status, version 3
- Country of birth, version 3
- Date of birth, version 4
- Date patient presents, version 2
- Department of Veterans’ Affairs patient, version 1
- Emergency department arrival mode – transport, version 1
- Emergency department departure status, version 2

* new in NMDS this version  ▼ modified this version
Data elements included (continued):

- Emergency department waiting time to service delivery, version 2*
- Establishment identifier, version 4*
- Indigenous status, version 4*
- Length of non-admitted patient emergency department service episode, version 1*
- Person identifier, version 1*
- Sex, version 3*
- Time patient presents, version 2*
- Triage category, version 1*
- Type of visit to emergency department, version 2*

Supporting data elements and data element concepts:

- Emergency department – public hospital, version 1
- Establishment number, version 4
- Establishment sector, version 3
- Non-admitted patient emergency department service episode, version 1
- Patient presentation at emergency department, version 1
- Region code, version 2
- State/Territory identifier, version 3

Data elements in common with other Metadata sets:

See Appendix D

Scope links with other Metadata sets:

- Episodes of care for admitted patients are reported through the Admitted patient care NMDS

Source organisation:

National Health Information Management Group

Comments:
## Perinatal NMDS

<table>
<thead>
<tr>
<th>Admin. status:</th>
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<th>Version number: 1</th>
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<td></td>
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<tr>
<td>Start date:</td>
<td>1 July 1997</td>
<td></td>
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<tr>
<td>End date:</td>
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<td>Latest evaluation date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope:</td>
<td>The scope of this minimum data set is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400 g birth-weight.</td>
<td></td>
</tr>
<tr>
<td>Statistical units:</td>
<td></td>
<td></td>
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<tr>
<td>Collection methodology:</td>
<td>State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.</td>
<td></td>
</tr>
<tr>
<td>National reporting arrangements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periods for which data are collected and nationally collated:</td>
<td>Financial years ending 30 June each year</td>
<td></td>
</tr>
</tbody>
</table>
| Data elements included: | Actual place of birth, version 1
Birth order, version 2
Birth plurality, version 1
Country of birth, version 3
Date of birth, version 4
Establishment identifier, version 4
First day of last menstrual period, version 1
Gestational age, version 1
Indigenous status, version 4
Infant weight – neonate, stillborn, version 3
Method of birth, version 1
Onset of labour, version 2
Person identifier, version 1
Separation date, version 5
Sex, version 3
Status of the baby, version 1 |
| Supporting data elements and data element concepts: | Birthweight, version 1
Establishment number, version 4
Establishment sector, version 3 |

* new in NMDS this version

V modified this version
Supporting data elements and data element concepts:
- Establishment number, version 4
- Establishment sector, version 3
- Gestational age, version 1
- Live birth, version 1
- Neonatal death, version 1
- Neonate, version 1
- Perinatal period, version 1
- Region code, version 2
- State/Territory identifier, version 3
- Stillbirth (foetal death), version 1

Data elements in common with other NMDSs:
See Appendix D

Scope links with other NMDSs:

Source organisation:
National Health Information Management Group

Comments:
Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
Public hospital establishments NMDS

Admin. status: CURRENT 1/07/2000 Version number: 1

Metadata type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1989

Recent evaluation date:

Scope: The scope of this data set is establishment-level data for public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans’ Affairs, and alcohol and drug treatment centres.

From version 9, patient-level data remain in the new NMDS called Admitted patient care. These new NMDS replace the version 8 NMDS called Institutional health care.

Similar data for private hospitals and freestanding day-hospital facilities is collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia’s external Territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Statistical units: Public hospital establishments

Collection methodology: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant State or Territory health authority on a regular basis (e.g. monthly).

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included: Administrative expenses, version 1
Capital expenditure — gross (accrual accounting), version 2
Capital expenditure — net (accrual accounting), version 2
Depreciation, version 1
Domestic services, version 1
Drug supplies, version 1
Establishment identifier, version 4
Establishment type, version 1
Food supplies, version 1
Full-time equivalent staff, version 2

♦ new in NMDS this version  
∇ modified this version
### Data elements included (continued):

- Geographical location of establishment, version 2
- Group sessions, version 1
- Indirect health care expenditure, version 1
- Individual/group session, version 1
- Interest payments, version 1
- Medical and surgical supplies, version 1
- Number of available beds for admitted patients, version 2
- Occasions of service, version 1
- Other recurrent expenditure, version 1
- Other revenues, version 1
- Patient revenue, version 1
- Patient transport, version 1
- Payments to visiting medical officers, version 1
- Recoveries, version 1
- Repairs and maintenance, version 1
- Salaries and wages, version 1
- Specialised service indicators, version 1
- Superannuation employer contributions (including funding basis), version 1
- Teaching status, version 1
- Type of non-admitted patient care, version 1
- Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1

### Supporting data elements and data element concepts:

- Establishment number, version 4
- Establishment sector, version 3
- Hospital boarder, version 1
- Hospital, version 1
- Non-admitted patient, version 1
- Overnight-stay patient, version 3
- Patient, version 2
- Region code, version 2
- Same-day patient, version 1
- Separation, version 3
- State/Territory identifier, version 3

### Data elements in common with other NMDs:

See Appendix D
**Scope links with other NMDSs:**

Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- Admitted patient care NMDS, version 2
- Admitted patient mental health care NMDS, version 2
- Admitted patient palliative care NMDS, version 2.

**Source organisation:**

National Health Information Management Group

**Comments:**

Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
Other Data Set Specifications

Data Set Specifications are metadata sets that are not mandated for collection but are recommended as best practice. It is recommended that, if collecting data for the purposes of primary patient care, planning or analysis, the entire DSS be collected.

The *National Health Data Dictionary, Version 12*, identifies metadata items for the following Data Set Specifications:

1. Cardiovascular disease (clinical)
2. Diabetes (clinical)
3. Health care client identification

Full descriptions of the DSS are found on the following pages.
Cardiovascular disease (clinical) DSS

Admin. status: CURRENT 1/01/2003 Version number: 1

Metadata type: DATA SET SPECIFICATION

Start date: 01/01/2003

Scope: The collection of cardiovascular data (CV-data) in this metadata set is voluntary.

The definitions used in CV-Data are designed to underpin the data collected by health professionals in their day-to-day practice. They relate to the realities of a clinical consultation and the ongoing nature of care and relationships that are formed between doctors and patients in clinical practice.

The data elements specified in this metadata set provide a framework for:

- promoting the delivery of high quality cardiovascular disease preventive and management care to patients;
- facilitating ongoing improvement in the quality of cardiovascular and chronic disease care predominantly in primary care and other community settings in Australia; and
- supporting general practice and other primary care services as they develop information systems to complement the above.

This is particularly important as general practice is the setting in which chronic disease prevention and management predominantly takes place. Having a nationally recognised set of definitions in relation to defining a patient’s cardiovascular behavioural, social and biological risk factors, and their prevention and management status for use in these clinical settings, is a prerequisite to achieving these aims.

Many of the data elements in this metadata set are also used in the collection of diabetes clinical information.

Where appropriate, it may be useful if the data definitions in this metadata set were used to address data definition needs for use in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from, clinical settings (i.e. using application of CV-Data), with that collected through other means (e.g. public health surveys).

Collection methodology: This metadata set is primarily concerned with the clinical use of CV-data. It could also be used by a wider range of health and health-related establishments that create, use or maintain, records on health care clients.

Data elements included: Alcohol consumption frequency – self report, version 1
Alcohol consumption in standard drinks per day – self report, version 1
Australian postcode, version 1
Behaviour-related risk factor intervention, version 1
Behaviour-related risk factor intervention – purpose, version 1
Blood pressure – diastolic measured, version 1

♦ new in NMDS this version  ▼ modified this version
**Data elements included (continued):**

- Blood pressure – systolic measured, version 1°
- Carer availability, version 3°
- Cholesterol-HDL – measured, version 1°
- Cholesterol-LDL – calculated, version 1°
- Cholesterol-total – measured, version 1°
- Country of birth, version 3°
- Creatinine serum – measured, version 1°
- CVD drug therapy – purpose, version 1°
- Date of birth, version 4°
- Date of diagnosis, version 1°
- Date of referral to rehabilitation, version 1°
- Diabetes status, version 1°
- Diabetes therapy type, version 1°
- Division of general practice number, version 1°
- Fasting status, version 1°
- Formal community support access status, version 1°
- Height – measured, version 2°
- Indigenous status, version 4°
- Labour force status, version 1°
- Living arrangement, version 1°
- Person identifier, version 1°
- Physical activity sufficiency – status, version 1°
- Preferred language, version 2°
- Premature cardiovascular disease family history status, version 1°
- Proteinuria – status, version 1°
- Renal disease therapy, version 1°
- Service contact date, version 1°
- Sex, version 3°
- Tobacco smoking consumption/quantity (cigarettes), version 1°
- Tobacco smoking status, version 1°
- Triglycerides measured, version 1°
- Vascular history, version 1°
- Vascular procedures, version 1°
- Waist circumference – measured, version 2°
- Weight measured, version 2°

**Supporting data elements and data element concepts:**

- Alcohol consumption – concept, version 1°
- Blood pressure – concept, version 1°
- Service contact, version 1°

---

° new in NMDS this version

V modified this version
<table>
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<tr>
<th><strong>Diabetes (clinical) DSS</strong></th>
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<tr>
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<tr>
<td><strong>Metadata type:</strong> DATA SET SPECIFICATIONS</td>
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<tr>
<td><strong>Start date:</strong> 1 July 2002</td>
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</table>

**Scope:**

The use of this standard is voluntary.
However, if data is to be collected the Diabetes (clinical) DSS aims to ensure national consistency in relation to defining, monitoring and recording information on patients diagnosed with diabetes.

The Diabetes (clinical) DSS relates to the clinical status of, the provision of services for, and the quality of care delivered to individuals with diabetes, across all health care settings including:

- General practitioners
- Divisions of General Practice
- Diabetes centres
- Specialists in private practice
- Community health nurses and Diabetes educators.

The Diabetes (clinical) DSS:

- provides concise, unambiguous definitions for items/conditions related to diabetes quality care
- aims to ensure standardised methodology of data collection in Australia.

The expectation is that collection of this data set facilitates good quality of care, contributes to preventive care and has the potential to enhance self-management by patients with diabetes.

The underlying goal is improvement of the length and quality of life of patients with diabetes, and prevention or delay in the development of diabetes-related complications.

**Collection methodology:**

This metadata set is primarily concerned with the clinical use of diabetes data. It could/should be used by health and health-related establishments that create, use or maintain, records on health care clients.

Data are collected over a 1-month period of all diabetes patients presenting at sites participating in the collection. The information is de-identified to protect the privacy of individuals. The participation is voluntary. An individual benchmarking report is provided. The results provide a snapshot of care of people with diabetes.

**Data elements included:**

- Blindness – diabetes complication, version 1
- Blood pressure – diastolic measured, version 1
- Blood pressure – systolic measured, version 1
- Cardiovascular medication – current, version 1
- Cataract – history, version 1
- Cerebral stroke due to vascular disease – history, version 1
- Cholesterol-HDL – measured, version 1

* new in NMDS this version  V modified this version

683
Data elements included (continued):

- Cholesterol-total – measured, version 1
- Coronary artery disease – history of intervention or procedure, version 1
- Creatinine serum – measured, version 1
- Date of birth, version 4
- Diabetes status, version 1
- Diabetes therapy type, version 1
- Dyslipidaemia – treatment, version 1
- Erectile dysfunction, version 1
- Fasting status, version 1
- Foot deformity, version 1
- Foot lesion – active, version 1
- Foot ulcer – current, version 1
- Foot ulcer – history, version 1
- Glycosylated Haemoglobin (HbA1c) – measured, version 1
- Glycosylated Haemoglobin (HbA1c) – upper limit of normal range, version 1
- Health professionals attended – diabetes mellitus, version 1
- Height – measured, version 2
- Hypertension – treatment, version 1
- Hypoglycaemia – severe, version 1
- Indigenous status, version 4
- Initial visit – diabetes mellitus, version 1
- Lower limb amputation due to vascular disease, version 1
- Microalbumin – units, version 1
- Microalbumin – upper limit of normal range, version 1
- Microalbumin/protein – measured, version 1
- Myocardial infarction – history, version 1
- Ophthalmological assessment – outcome, version 1
- Ophthalmoscopy – performed, version 1
- Peripheral neuropathy – status, version 1
- Peripheral vascular disease in feet – status, version 1
- Pregnancy – current status, version 1
- Referred to ophthalmologist – diabetes mellitus, version 1
- Renal disease – end stage, diabetes complication, version 1
- Service contact date, version 1
- Sex, version 3
- Tobacco smoking status – diabetes mellitus, version 1
- Triglycerides – measured, version
- Visual acuity, version 1
- Weight – measured, version 2
- Year insulin started, version 1
- Year of diagnosis of diabetes mellitus, version 1

* new in NMDS this version
∇ modified this version
Supporting data elements and data element concepts:
- Blood pressure, version 1*
- Service contact, version 1*

Scope links with other Metadata sets:
- Cardiovascular disease (clinical) DSS

Source organisation:
National Diabetes Data Working Group

Comments:
Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.
Health care client identification DSS

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<td>DATA SET SPECIFICATIONS</td>
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Scope:
The collection of data based on this metadata set is voluntary.
The data elements specified in this metadata set provide a framework for improving the positive identification of persons in health care organisations.
This metadata set applies in respect of all potential or actual clients of the Australian health care system. It defines demographic and other identifying data elements suited to capture and use for person identification in health care settings.
The objectives in collecting the data elements in this metadata set are to promote uniformly good practice in:
- identifying individuals
- recording identifying data so as to ensure that each individual's health records will be associated with that individual and no other.

The process of positively identifying people within a health care service delivery context entails matching data supplied by those individuals against data the service provider holds about them.
The positive and unique identification of health care clients is a critical event in health service delivery, with direct implications for the safety and quality of health care.

There are many barriers to successfully identifying individuals in health care settings, including variable data quality; differing data capture requirements and mechanisms; and varying data matching methods.
These definitions provide a base for improving the confidence of health service providers and clients alike that the data being associated with any given individual, and upon which clinical decisions are made, is appropriately associated.

Collection methodology:
This metadata set is primarily concerned with the clinical use of Health care client identification data. It should be used by health and health-related establishments that create, use or maintain, records on health care clients. Establishments should use this metadata set, where appropriate, for collecting data when registering health care clients or potential health care clients.

National reporting arrangements:
Collectors of this metadata set should refer to relevant privacy legislation, codes of fair information practice and other guidelines so as not to breach personal privacy in their collection, use, storage and disclosure of health care client information. There is no comprehensive privacy legislation covering both the public and private sectors across Australia so users need to consider their particular set of circumstances (i.e. location and sector) and whether privacy legislation covers those circumstances. A Commonwealth legislative scheme applies to the private sector. Users may refer to the Federal Privacy Commissioner’s web site for assistance in complying with their privacy obligations. In the public sector, in instances where no legislation, code of fair information practice or other guidelines covers the particular
National reporting arrangements (continued):

circumstances, users should refer to AS 4400 Personal privacy protection in health care information systems.
Public sector agencies should refer to relevant legislation and regulations pertaining to State and Territory records so as not to breach their obligations regarding the creation and retention of public records.

Data elements included:

- Address type, version 1
- Australian postcode, version 1
- Birth order, version 2
- Birth plurality, version 1
- Centrelink customer reference number, version 1
- Country of birth, version 3
- Date of birth, version 4
- Establishment identifier, version 4
- Establishment number, version 4
- Establishment sector, version 3
- Estimated date flag, version 1
- Family name, version 1
- Given name(s), version 1
- Medicare card number, version 1
- Mother’s original family name, version 1
- Name context flag, version 1
- Name suffix, version 1
- Name title, version 1
- Name type, version 1
- Person identifier, version 1
- Person identifier type – health care, version 1
- Postal delivery point identifier, version 1
- Region code, version 2
- Sex, version 3
- State/Territory identifier, version 3
- State/Territory of birth, version 1
- Suburb/town/locality, version 1
- Telephone number, version 1
- Telephone number type, version 1

Supporting data elements and data element concepts:

- Address, version 1
- Name, version 1

Scope links with other metadata sets:

Collection of information in national minimum data sets.

Source organisation:

Standards Australia Inc.

Comments:

Data element Address line, version 1, is in DRAFT status. This data element may be viewed on the Knowledgebase.
# Appendix A: National Health Data Committee membership

<table>
<thead>
<tr>
<th>Member organisation</th>
<th>Representative</th>
<th>Address</th>
<th>Contact details</th>
</tr>
</thead>
</table>
| **Chair** | Mr Ching Choi | Head, Health Division  
Australian Institute of Health and Welfare  
GPO Box 570  
CANBERRA ACT 2601 | Telephone (02) 6244 1168  
Facsimile (02) 6244 1166  
E-mail ching.choi@aihw.gov.au |
| **Australian Bureau of Statistics** | Mr David Hunter | Director, Classifications & Data Standards  
PO Box 10  
BELCONNEN ACT 2616 | Telephone (02) 6252 6300  
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Facsimile (02) 6291 4466  
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| **Commonwealth Department of Health and Ageing** | Ms Jo Bothroyd | Director, Costing and Ambulatory Classification Section  
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| **National Centre for Classification in Health** | Ms Sue Walker | Associate Director, National Centre for Classification in Health  
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Facsimile (07) 3864 5515  
E-mail s.walker@qut.edu.au |
<table>
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<tr>
<th>Member organisation</th>
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<th>Contact details</th>
</tr>
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<tr>
<td>New South Wales</td>
<td>Mr Graham Pegler</td>
<td>Manager Information Architecture Information Management &amp; Clinical Systems Branch NSW Health Department Locked Mail Bag 961 NORTH SYDNEY NSW 2059</td>
<td>Telephone (02) 9391 9741 Facsimile (02) 9391 9762 E-mail <a href="mailto:gpeg@doh.health.nsw.gov.au">gpeg@doh.health.nsw.gov.au</a></td>
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<tr>
<td>Northern Territory</td>
<td>Ms Kristine Luke</td>
<td>Hospital Information Systems Unit Business Information Management Branch Territory Health Services PO Box 4056 CASUARINA NT 0811</td>
<td>Telephone (08) 8999 2718 Facsimile (08) 8999 2618 E-mail <a href="mailto:kristine.luke@nt.gov.au">kristine.luke@nt.gov.au</a></td>
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<td>Private Health Insurance industry</td>
<td>Mr Michael Bassingthwaighte</td>
<td>(Private Health Insurance industry representative) Lysaght Hospital &amp; Medical Club PO Box 77 PORT KEMBLA NSW 2505</td>
<td>Telephone (02) 9460 3897 Facsimile (02) 9460 3897 E-mail <a href="mailto:michaelbass@ozemail.com.au">michaelbass@ozemail.com.au</a></td>
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<tr>
<td>Queensland</td>
<td>Ms Sue Cornes</td>
<td>D/Manager, Health Information Centre Information and Business Management Branch Queensland Department of Health GPO Box 48 BRISBANE QLD 4001</td>
<td>Telephone (07) 3234 0899 Facsimile (07) 3234 1529 E-mail <a href="mailto:suzanne_cornes@health.qld.gov.au">suzanne_cornes@health.qld.gov.au</a></td>
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<tr>
<td>South Australia</td>
<td>Mr Paul Basso</td>
<td>Manager, Enterprise Information Services Information Management Services Department of Human Services (SA) PO Box 287, Rundle Mall ADELAIDE SA 5001</td>
<td>Telephone (08) 8226 7329 Facsimile (08) 8226 7341 E-mail <a href="mailto:paul.basso@dhs.sa.gov.au">paul.basso@dhs.sa.gov.au</a></td>
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<tr>
<td>Tasmania</td>
<td>Ms Karen Hinton</td>
<td>Manager, Clinical Data Services Divisional Support Unit Hospitals and Ambulance Services GPO Box 125B HOBART TAS 7001</td>
<td>Telephone (03) 6233 4016 Facsimile (03) 6233 3550 E-mail <a href="mailto:karen.hinton@dchs.tas.gov.au">karen.hinton@dchs.tas.gov.au</a></td>
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<tr>
<td>Victoria</td>
<td>Mr Mark Gill</td>
<td>Manager, Health Data Standards and Systems Unit Acute Health Division Department of Human Services GPO Box 4057 MELBOURNE VIC 3001</td>
<td>Telephone (03) 9616 7456 Facsimile (03) 9616 8523 E-mail <a href="mailto:mark.gill@dhs.vic.gov.au">mark.gill@dhs.vic.gov.au</a></td>
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<tr>
<td>Western Australia</td>
<td>Ms Sam Green</td>
<td>Acting Manager, Health Information Planning Unit Health Department of Western Australia PO Box 8172, Stirling Street PERTH WA 6849</td>
<td>Telephone (08) 9222 2410 Facsimile (08) 9222 4236 E-mail <a href="mailto:sam.green@health.wa.gov.au">sam.green@health.wa.gov.au</a></td>
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Appendix B: Format for data element definitions

All data element definitions included in the National Health Data Dictionary are presented in a format based on ISO/IEC International Standard 11179-3:2002 (Information Technology – Metadata Registries – Part 3: Registry metamodel and basic attributes). This is the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. Collectively, the format describes a set of attributes for data definitions.

Metadata

Metadata is information about the attributes of any man-made concept, construct, resource, physical measurement or attribute. This includes:

- concepts such as ‘service’, ‘agency’, ‘service delivery setting’, ‘Medicare eligibility’, ‘doctor’
- constructs such as ‘Medicare card’, ‘hospital’, ‘emergency department’
- resources such as ‘skills’, ‘labour force’, ‘income’
- measurements such as ‘blood pressure’, ‘height’, ‘length of stay’
- social information such as ‘name’, ‘Indigenous status’, ‘preferred language’
- demographic information such as ‘sex’, ‘address’, ‘country of birth’;
- management and planning concepts such as ‘service recipient’, ‘service provider’, ‘expenditure’, ‘date of service’.

All of these refer to some sort of data that would be collected or provide assistance in defining data be collected. There are also other types of metadata:

- actual data collections or sets of data that are recommended for collection where comparability, consistency and quality of the data are important
- data domain values and codesets that may be common across many sectors
- classification schemes and terminologies.

As such, there is a wide range of types of metadata that could be included in the National Health Data Dictionary. Version 12, however, does not currently concern itself about metadata about data domain values, code sets, classification schemes or terminologies.

All metadata items in this dictionary have a common set of attributes used to define national standards in Health. Attributes are divided into three major sections:

- identifying and definitional attributes
- relational and representational attributes
- administrative attributes.

Not all metadata items in the National Health Data Dictionary contain information about each of the attributes listed below.
### Identifying and definitional attributes

#### Name:
A single or multi-word designation assigned to a data element. This appears in the heading for each unique data definition in the Dictionary.

#### Knowledgebase ID:
A 6-digit number used to identify the data element on the Knowledgebase.

This number does not change even if there is a change in the name of the data element. In the Knowledgebase, this number is preceded by an acronym that identifies the Registration Authority for each data element. The National Health Information Management Group is the Registration Authority for all data elements included in the Dictionary. The combination of Registration Authority, Knowledgebase (or NHIK) ID and Version Number (see below) uniquely identifies each data element in the Knowledgebase. The Knowledgebase ID can be used to view the history of particular item even where the name of the item may have changed.

#### Version number:
A version number for each data element, beginning with 1 for the initial version of the data element, and 2, 3 etc. for each subsequent revision. This meets the ISO/IEC Standard 11179 requirement for ‘identification of a data element specification in a series of evolving data element specifications within a registration authority’. A new version number is allocated to a data element/concept when changes have been made to one or more of the following attributes of the definition:
- name
- definition
- data domain.

Other changes that significantly affect the meaning of the data element may also require the allocation of a new version number.

#### Metadata type:
Defines the type of metadata.
- A concept which can be represented in the form of data, described independently of any particular representation or value, is called a **DATA ELEMENT CONCEPT**. For example, hospital ‘admission’ is a process which does not have any particular representation of its own, except through data such as ‘admission date’, ‘mode of admission’, etc.
- A unit of data for which the definition, identification, representation and permissible values are specified by means of a set of attributes is called a **DATA ELEMENT**. For example, a hospital ‘admission date’ is a unit of data for which the definition, identification, representation and permissible values are specified.
- A unit of data that is created from the values of other DATA ELEMENTS is called a **DERIVED DATA ELEMENT**. They are derived by:
- use of some form of simple or complex calculation

  example 1: the data element Length of stay is calculated from Admission date to Separation date less any Total leave days

  example 2: the data element Age-standardised rate uses a more complex equation

- by conversion from one coding system to another

  example: Geographic location is derived by converting postcode to Statistical Local Area using the tables in the Australian bureau of Statistics Australian Standard Geographical Classification.

- A unit of data that is created from the values of two or more of the above DATA ELEMENTS using a simple combination of values is called a COMPOSITE DATA ELEMENT. For example, the data element Establishment identifier is a concatenation of the data elements State identifier, Establishment type, Region and Establishment number in that order.

- A collection of any of these data items is called a DATA SET SPECIFICATION. There are two types of data set specification:

  - National Minimum Data Set (NMDS) – an endorsed set of data items that are mandated for collection on a national basis for the purposes of national reporting. This is usually mandated under a national agreement between the involved agencies.

  - Other Data Set Specification (DSS) – an endorsed set of data items that are recommended for use where data is collected. The DSS is published to ensure quality of data and standardisation across organisations.

Admin. status:

The status given to an item in the registry that indicates its availability for use and the level of precedence given to it. The following is a descriptive list in descending order of precedence.

CURRENT

The Registration Authority confirms that the item is available for use as a national standard.

SUPERSEDED

The Registration Authority has confirmed that the item has been superseded by a newer version of the item.

This item is available on the Knowledgebase only.

RETIRED

The Registration Authority has confirmed that the item is no longer designated as a standard.

This item is available on the Knowledgebase only for historical purposes.
All mandatory metadata attributes have been completed. It has been proposed for progression to CURRENT but has not yet met all requirements for endorsement as a national standard. This item is available on the Knowledgebase only.

**Effective date:** The date an administered item became/becomes available to registry users i.e. the date it becomes a standard. This should not be confused with the date that the item was first included in a data collection.

**Definition:** A statement that expresses the essential nature of a data element and its differentiation from all other data elements.

**Context:** A designation or description of the application environment or discipline in which a name is applied or from which it originates. For example, the context for Admission date is Admitted patients, while the context for Capital expenditure—gross is Health expenditure. For the Dictionary this attribute may also include the justification for collecting the items and uses of the information.

### Relational and representational attributes

**Data type:** The type of symbol, character or other designation used to represent a data element. Examples include alphabetic, integer, numeric, alphanumeric etc. For example, the data type for data element ‘Intended place of birth’ is a numeric drawn from a domain or codeset in which numeric characters such as 1 = hospital, 4 = home are used to denote a data domain value (see Data domain below).

**Minimum size:** The minimum and maximum number, respectively, of storage units (of the corresponding datatype) to represent the data element value. For example, a data element value expressed in dollars may require a minimum field size of one character (1) up to a maximum field size of nine characters (999, 999, 999).

**Representational class:** The class of representation for the metadata item. Some examples of class are CODE, CURRENCY, DATE, IDENTIFICATION NUMBER, QUALITATIVE VALUE, QUANTITATIVE VALUE, TIME, TEXT. For example, representational class for the data element ‘Country of birth’ is CODE because the form of representation is individual numbers that each represent a different country.

**Representational format:** The layout of characters in a data element values expressed by a character string representation. Examples include ‘DDMMYYYY’ for calendar date, ‘N’ for a 1-digit numeric field, and ‘$999,999,999’ for data elements about currency.
Data domain: The set of representations of permissible instances of the data element, according to the representation form, layout, data type and maximum size specified in the corresponding attributes. The set can be specified by:

- enumeration of the representation of the instances (for example, for ‘Sex’ values are 1=Male 2=Female 3=Indeterminate 9=Not stated)
- reference to a source (such as the Australian Bureau of Statistics Directory of concepts and standards for social, labour and demographic statistics, 1995), or
- names of data elements involved in a calculation and the type of process that occurs to derive the domain value (e.g. is calculated by value1 subtracted from value2… or, is a concatenation of value1 and value2…). Include any formula in Guide for use.

Guide for use: Additional comments or advice on the interpretation or application of the attribute ‘data domain’ (this attribute has no direct counterpart in the ISO/IEC Standard 11179 but has been included to assist in clarification of issues relating to the classification of data elements).

Verification rules: The rules and/or instructions applied for validating and/or verifying elements occurring in actual communication and/or databases, in addition to the formal screening based on the requirements laid down in the basic attributes.

Collection methods: Comments and advice concerning the actual capture of data for the particular data element, including guidelines on the design of questions for use in collecting information, and treatment of ‘not stated’ or non-response (this attribute is not specified in the ISO/IEC Standard 11179 but has been added to cover important issues about the actual collection of data).

Related metadata: A reference to the relationship between the metadata item and any other related metadata item in the registry. This includes the type of relationship and version number.

Examples include: ‘is superseded by the data element… etc,’ ‘supersedes previous data element… etc,’ ‘is derived from the data elements… etc’.

Administrative attributes

Source document: The document from which definitional or representational attributes originate.


All new metadata items in following versions of the National Health Data Dictionary may need a Source organisation that is
willing to undertake an ongoing role in the maintenance of the metadata items. The Source organisation is not necessarily the organisation that undertook the initial data development.

**Information Model link:** The relationship of the metadata item to the National Health Information Model

**Data Set Specifications:** This is a reference to the inclusion of the metadata item in an endorsed data set in the registry. This includes the start date and end date of the relationship.

- **Start Date:** is a record of the date on which the specific version of the metadata item in the relationship first became CURRENT.
- **End Date:** is a record of the date on which the specific version of the metadata item in the relationship ceased to exist the cause the specific metadata item was RETIRED or SUPERSEDED.

**Comments:** Any additional explanatory remarks on the data element.
Terminology used in International Standard 11179-3:2002

The following terms are excerpts from the International Standard 11179-3:2002. It is intended to review this standard in the coming months to determine its relevance to the national health metadata collection. It is possible that the next version of the National Health Data Dictionary could be using some or all of these terms.

Classification Scheme

The descriptive information for an arrangement or division of objects into groups based on characteristics which the objects have in common. An example of a classification scheme is ICD-10-AM. While this type of metadata is not currently available on the Knowledgebase, it is possible for such to be included in future.

Metadata item

Any item of a metadata that is normally stored in a Register (this is the equivalent of a data element). This can be a data element, a data element concept, a model, a classification scheme, a metadata set, a National Minimum Data Set etc.

This is a generic term for any item described by the metamodel (whether or not it is stored in a registry).

Metadata register

The information store or database in which metadata items are stored.

This term is usually abbreviated to Register and in relation to the National Health Data Dictionary this is the database tables that make up the Knowledgebase.

Metadata registry

An information system for registering metadata. This term is usually abbreviated to Registry and in relation to the National Health Data Dictionary this is the Knowledgebase.

Metadata set

A generic term for any collection or grouping of metadata items.

Metadata type

The classification of the type of metadata. In the National Health Data Dictionary this can be a:

- classification scheme;
- data element;
- data element concept;
- metadata set;
- performance indicator.

ISO 11179 allows for the following as well:

- conceptual domain;
- context;
- object class;
- property;
- representation class;
- value domain.
Performance indicator

A special type of derived data element that is a ratio of two or more measurements defined by individual data elements. In the health sector indicators are measures of some aspect of the health system, including measures of the status of a performance, or situations, or outcomes.

Registrar

The person or organisation responsible for the physical maintenance of the Metadata registry. In relation to the National Health Data Dictionary this organisation is the Australian Institute of Health and Welfare.

Registration Authority

Registration Authority is the organisation authorised to register metadata i.e. all metadata must be endorsed and approved for inclusion in the NHDD metadata register. In relation to the NHDD this organisation is the National Health Information Management Group. All requests for all new and the modification of existing metadata items must be approved by the relevant Registration Authority.

Source organisation

The organisation responsible for the content of the original metadata item and the source for all future reference in relation to modification of the metadata item. This is not necessarily the same as the Submitting organisation.

Each metadata item must have a Source organisation that is an ongoing organisation. If a registered Source organisation ceases to exist, a new Source organisation must be found. The Steward will undertake temporary responsibility of Source organisation until such time as this occurs.

Should no such Source organisation be found, the Registration Authority has three options:
- appoint the Steward as the Source organisation, or
- appoint no Source organisation in which case the metadata item can not be modified, or
- deregister the metadata item (i.e. it is no longer a standard).

Steward

A person or organisation that is charged with the responsibility for the implementation and maintenance of a metadata registry including the associated administration record(s). In relation to the NHDD the Steward is the National Health Data Committee.

Submitting organisation

The organisation responsible for the initial development of the metadata item. Such an organisation needs to have significant recognition in a specific field of health care or within the Commonwealth/State/Territory health sector before consideration will be given to registration of any metadata items.
Appendix C: Submission templates

A brief description of the project to the NHDC Secretariat using the Project Summary template is the preferred action. This information is made available to all Committee members. These data development project summaries assist with planning the Committee’s workload throughout the year by indicating the nature and likely timing, scope and workload implications of future submissions to the NHDC.

Once metadata items have been developed to the stage where the NHDC is requested to consider them, an agenda paper outlining the development process to date etc. and documentation of each metadata item should be submitted to the NHDC on the Agenda item template and the metadata item template. See Appendix B for definitions of fields used in the metadata item template.

All papers for National Health Data Committee consideration should be with the National Health Data Committee Secretariat 15 working days prior to any meeting. Every paper considered at a National Health Data Committee meeting needs to be presented by a member of the Committee or the Secretariat. The meeting agenda and accompanying papers are dispatched by the Secretariat to Committee members 10 days prior to the scheduled meeting. The agenda specifies the action required for each item (for decision, for information). Any paper that is not received by the Secretariat at least 15 days prior to a scheduled meeting will be placed last on the agenda and will be considered at the discretion of the Committee.
## Project summary template

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<td>Auspice org/agency</td>
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<tr>
<td><strong>Purpose</strong></td>
<td>(i.e. aim of project/activity and/or reasons for undertaking project)</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>(i.e. the types of persons, services or issues to which the data development activity relates)</td>
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<tr>
<td><strong>Group/committee overseeing or undertaking data development activity/project</strong></td>
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<td><strong>Other consultative mechanisms</strong></td>
<td>(i.e. details of consultative arrangements in place to ensure product of activity/project is supported by the relevant stakeholders)</td>
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<td><strong>Relationship with NHIMG processes</strong></td>
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<td>If No, is it intended to submit the project/activity for inclusion on the Work Program? YES/NO</td>
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<tr>
<td><strong>Collection/reporting status of data elements being developed</strong></td>
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<td>If No, is such agreement anticipated or being sought? YES/NO</td>
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<td>Are any of the proposed data items the same as, or similar to, existing National Health Data Dictionary items? YES/NO</td>
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<td>If Yes, what changes (if any) are proposed? Any further comment?</td>
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# National Health Data Committee agenda paper template

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**Purpose:** for decision/information/comment [delete two]

**Item Name [overwrite]**

**Recommendation**

That NHDC…

1. …………………………
2. …………………………
   etc

**Issues**

(Describe the issues that require a new or changed data element)

**Background**

(The historical/technical background of the development process including

- origins and rationale for the proposal
- development process undertaken to date
- details of national consultation, including details of experts and/or others involved with or consulted during development
- degree of consensus reached on submitted data elements
- results of pilot testing, where completed, or proposed pilot testing arrangements
- identification of the users of the data and the uses to which the data will be put
- name and contact details of person for follow-up information on submission)
### Metadata item template

#### Name of metadata item

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<td>DSS -</td>
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<tr>
<td><strong>Comments:</strong></td>
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</table>

This template is available from the AIHW web site in Microsoft Word © format.
Principles for developing National Health Data definitions

National Health Data Dictionary definitions should:

1. Be developed within the conceptual framework of the National Health Information Model
   The National Health Information Model is available on the Knowledgebase and is reproduced in the CD and the hard copy of the National Health Data Dictionary.

2. Conform to the concepts of uniformity and utility
   The data element is to be capable of uniform application across multiple providers, collectors and users of the data. That is, the data definition is to be capable of clearly and consistently communicating the meaning of the data. It is assumed that there will continue to be multiple systems for recording, processing and using the data element; but when a data element is recorded and later abstracted, it will always conform to its definition.
   A data element definition is included in the National Health Data Dictionary only after determination that the definition has demonstrated utility for many user groups. Data element definitions which are of limited utility or which are useful only to limited user groups will be excluded.

3. Employ existing concepts and standards
   The National Health Information Agreement states that data standards adopted by the Australian Bureau of Statistics and other authoritative national and international organisations will be employed wherever possible and variations made explicit when this is not possible. Also, wherever possible, utilise existing data elements from the National Health Data Dictionary.

4. Minimise the burden on service providers required to collect the data
   The National Health Data Dictionary is designed primarily (although not exclusively) to support the collection and provision of standardised health information as a by-product of service providers’ administrative practice, particularly National Minimum Data Set collections. Data element definitions should minimise the burden on service providers required to collect information under National Minimum Data Set agreements. Data element definitions that are not included in National Minimum Data Sets should, as far as possible, be appropriate for collection via administrative processes as well as through other data collection methods (e.g. national surveys).

Features of a good quality data definition

A good quality data definition will:

- be unique within the data dictionary in which it appears
- be stated in the singular
- state what the concept is, not only what it is not
- be stated as a descriptive phrase or sentence(s)
- contain only commonly understood abbreviations
- be expressed without embedding definitions of other data elements or underlying concepts
- state the essential meaning of the concept
- be precise and unambiguous
- be concise
- be able to stand alone
- avoid circular reasoning
- use the same terminology and consistent logical structure for related definitions.
# Appendix D: Data elements common across NMDSs

<table>
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<th>Data element</th>
<th>National Minimum Data Set</th>
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The table above shows the data elements with their respective types and associated data sets. Each row represents a specific data element, and the columns indicate whether the element is included in each data set represented by the headers. The 'X' indicates the presence of the data element in the data set.
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## Appendix E: Cross-classificatory variables—Staffing Category

The following definitions of staffing categories used in the data elements Full-time equivalent staff and Salaries and wages are presented in an abbreviated form in this version of the Dictionary. A more detailed list is provided in Version 6 of the National Health Data Dictionary.

<table>
<thead>
<tr>
<th>C1: Staffing category</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>C1.1: Salaried Medical Officers</strong></td>
<td>Medical officers employed by the hospital on a full-time or part-time salaried basis. This excludes visiting medical offices engaged on an honorary, sessional or fee for service basis. This category includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).</td>
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<tr>
<td><strong>C1.2 Registered Nurses</strong></td>
<td>Registered nurses include persons with at least a three year training certificate and nurses holding post-graduate qualifications. Registered nurses must be registered with the State/Territory registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.</td>
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<td><strong>C1.3: Enrolled nurse</strong></td>
<td>Enrolled nurses are second-level nurses who are enrolled in all States except Victoria where they are registered by the State registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some States).</td>
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<tr>
<td><strong>C1.4: Establishment-based student nurses</strong></td>
<td>Student nurses are persons employed by the establishment currently studying in years one to three of a three-year certificate course. This includes any person commencing or undertaking a three-year course of training leading to registration as a nurse by the State or Territory registration board. This includes full-time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post-basic training courses.</td>
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<td>C1.5: Trainee/pupil nurse</td>
<td>Trainee/pupil nurse includes any person commencing or undertaking a 1-year course of training leading to registration as an enrolled nurse on the State/Territory registration board (includes all trainee nurses).</td>
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<td>C1.6: Other personal care staff</td>
<td>This category includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.</td>
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<td>C1.7: Diagnostic and health professionals</td>
<td>Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).</td>
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<tr>
<td>C1.8: Administrative and clerical staff</td>
<td>Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category.</td>
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</tbody>
</table>
| C1.9: Domestic and other staff | Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.  
This category also includes all staff not elsewhere included (primarily maintenance staff, trades-people and gardening staff). |
Appendix F: Establishment—activity definitions

The objective of data definitions related to the activities of health care establishments is to enable a description of health service systems, including the type of care delivered by the establishment. The unit of enumeration is a separately administered establishment. The term establishment is used in a very broad sense to mean organisational units, whether institutions, organisations or community based services, which provide health services. Establishments are considered to be separately administered if the finances, budget and activities are managed as an independent unit. The term establishment thus covers conventional establishments such as hospitals, residential aged care facilities and community health centres, but is also used to cover organisations providing services in the community (e.g. domiciliary nursing services) or support services to other establishments (e.g. a centralised pathology laboratory service). The situation where establishment-level data for components of an area health service are not available separately at a central authority is not grounds for treating such a group of establishments as a single establishment unless such data are not available at any level in the health care system.

Two major measures of service provision are defined for each establishment. They are the recording of services by type of episode (admitted patients) and by service type (non-admitted patients). As there are no nationally agreed data definitions at the person-level for non-admitted patients or for outreach/community clients, definitions for non-admitted patient activity are based on a cost centre or functional unit approach; that is, where the service was performed rather than the procedure or the diagnosis of the patient.

The activity for acute care hospitals is represented as a count of separations and patient-days for admitted patients according to the treatment mode categories same-day and overnight-stay.

The number of separations for renal dialysis and endoscopy and related procedures are identified separately for admitted and non-admitted patients. This enables comparison of the provision of these services across institutional settings, whether these patients are admitted or treated as non-admitted patients.

Separations and patient-days for admitted patients are contrasted with an occasion of service or group session as a measure of non-admitted patient activity. It is recognised that the comparison of these as a measure of activity is not ideal but it will be used until a more comprehensive set of definitions is developed to describe patients treated and non-admitted patient activity.

The number of separations, patient days and occasions of service is the measure of activity for same-day establishments and for acute hospitals.

The definition and counting of separations and patient-days for public psychiatric and alcohol and drug treatment centres is the same as for the acute care hospitals, except that the treatment mode category is expanded to distinguish between short-stay and long-stay patients. This is to reflect the greater %age of patients with extended lengths of stay in these institutions.
Appendix G: Establishment – resource use definitions

The use of resources (facilities, financial and human) in health services is a major focus of interest to all users of information published using the definitions contained in the National Health Data Dictionary. To enable a comprehensive picture of resource use to be obtained requires uniform data definitions on health care institutions of the States, Territories, the Commonwealth and the private sector. The main categories of resource data that are defined at the establishment level are:

- establishment characteristics (type and location);
- Staffing data (full-time equivalent staff);
- Recurrent expenditure (salary and non-salary); and
- Revenue.

Significant measures of resources not included above are capital expenditure, physical details and monetary values of major buildings, facilities, equipment, plant and so on. Capital expenditure is included in the National Health Data Dictionary at the system level (see Appendix G), but the formation of detailed uniform data definitions to describe items relating to facilities and equipment have yet to be agreed on and implemented. The classification of the type of establishment is currently under review by a working group (Organisational Units Working Group) which is expected to report to the NHDC in 1999.

Financial aspects

The establishment of the National Minimum Data Sets was not seen as an appropriate vehicle for undertaking a review of national accounting practice. During the formation of the definitions it was inevitable that some aspects of accounting practice were discussed (e.g. offsetting practices). The National Health Data Dictionary makes reference to established accounting standards with Accounting Standard 17 in relation to financial and operating leases and Accounting Standard 4 in relation to the depreciation of non-current assets. The absence of completely uniform accounting standards and practices for health institutions between States and Territories and within States and Territories limits the comparability of financial data. The Directors of Finance of the State and Territory government health authorities are developing national expenditure reporting standards, particularly with regard to hospitals.

Standard national health expenditure definitions

The development of agreed definitions on the major areas of health expenditure is being undertaken under the National Health Information Work Program. A set of definitions has been adopted by the Australian Bureau of Statistics for use in public finance statistics and is being discussed and refined in consultation with key stakeholders, including State and Territory government Directors of Finance.

Boundaries between capital and recurrent expenditure

Some differences exist in the practice of differentiating between capital and recurrent expenditure in the States and Territories. The definition of capital expenditure is included in the Dictionary and recurrent expenditure is implicitly defined as that part of total expenditure which is not capital expenditure. The major difference with regard to capital expenditure, between the States and Territories is in regard to the level of capitalisation. The
Dictionary states that ‘the minimum level for capitalisation is no higher than $5,000’, and some States use $5,000 but others use $1,000 or even lower in some cases.

**Offsetting practices**

As a general rule, offsetting revenue against related expenditure is not good accounting practice and both gross revenue and gross expenditure should be reported. However, it is recognised that there are circumstances (such as hospital to hospital transfers/services) where offsetting is done to avoid the duplication of costs. Where it is difficult to identify specific costs in relation to inter-hospital transfers, the practice of bringing in revenue to inter-hospital services through recoveries is considered acceptable.
Appendix H: System-level resource definitions

System-level definitions relate to all of a particular type of establishment, such as public hospitals, or community health centres, at the State, Territory, or Commonwealth level (whichever is the highest level of overall administration of the system). The data definitions in the National Health Data Dictionary at the system or State health authority level are related to capital expenditure and indirect health care expenditure.

Capital expenditure

A working party of the NHDC developed a new definition of capital expenditure during 1994. The NHIMG agreed that both the new definition (previously known as item S1b) and the former definition (previously known as item S1a) will be current in the dictionary until all relevant jurisdictions have implemented accrual accounting procedures.

Indirect health care expenditure

The system-level definitions represent expenditure on health care that cannot be directly related to programs operated by a particular establishment but can be indirectly related to the admitted patients, residents, non-admitted patients, non-residents and community/outreach patients served by that establishment. These definitions are designed to improve the overall picture of health expenditure and to assist in understanding differences in costs for similar establishments in different States and regions. They are also designed to detect differences in the extent to which support services and other services to resident/admitted patients and non-admitted patients of an establishment may be provided by the establishment itself, at a State level or by other organisations. This concept will be reviewed by the NHDC during 1999.

Glossary of terms

The following glossary of terms supports the definitions of capital expenditure:

Asset

An asset is the service potential and/or future economic benefits controlled by the reporting entity as a result of past transactions or other past events including:

- Physical assets
  - current physical assets;
  - non-current physical assets
- intangible assets

The ‘service potential’ of an asset is its economic utility to the entity, based on the total benefit expected to be derived by the entity from the use and/or through subsequent disposal of the asset.

Financial asset

A financial asset is an asset that has a counterpart liability in the books of another accounting entity. For the purpose of the National Health Data Dictionary, financial assets are excluded.
**Control**

The recognition of an asset is based on the test of control rather than ownership. This may result in assets being recognised by a reporting agency that is not the registered owner (for example, denominational/third schedule/non-profit hospitals). Control is the capacity of the entity to benefit from the asset in pursuit of the entity objectives and to deny or regulate the access of others to that benefit. Ownership of an asset occurs when the asset is purchased by or donated to an accounting entity. Acquisition means undertaking the risks and receiving the rights to future benefits, as would be conferred with ownership, in exchange for a cost of acquisition.

Note: In cases where there is a building providing public health services under government control situated on land owned by a non-profit organisation, the value of the building should be included as a public asset, but not that of the land.

**Asset capitalisation**

Asset capitalisation occurs when an item of expenditure meets the criteria of an asset and is:
- recorded in the books of an accounting entity;
- recorded in an asset management system and depreciated; and
- the minimum level for capitalisation is no higher than $5,000.

**Asset disposal**

When an asset is considered unserviceable, obsolete or in excess of probable requirements it is disposed of using designated procedures. The asset is removed from both the accounting entity’s asset management system and the book of accounts.

**Asset enhancement**

Expenditure on an existing asset is to be treated as an enhancement where there has been an affective and significant increase in the present or planned service potential of the asset. If the increase in service potential is incidental to some necessary maintenance and the incremental level will not be used in the foreseeable future, the expenditure would be more appropriately classified as maintenance.

Service potential has three components:
- Service capacity: the expenditure increases the capacity to provide services and meet increases in demand for the asset’s services.
- Service quality: improvement in the standard of the service provided, including efficiency improvements such as cost reductions, can represent an enhancement to an existing asset.
- Useful life: the initial assessment of an asset’s useful life will have assumed that certain maintenance expenditure (both routine and major periodic) would be necessary for the asset to achieve its anticipated useful life. An expenditure can only be accounted for as an enhancement if it increases (rather than assumes the achievement of) the asset’s pre-determined useful life. This would include major work undertaken to extend the service potential of an asset, recognising that its function may change (e.g. refurbishment). It may result in a need to re-assess the life span of the asset.

**Grouped assets**

Most assets, particularly system assets, consist of a number of components. In principle, each component can provide service potential or future economic benefit and can therefore be classified as an asset. In practice, however, the key criterion for a separate asset is an independent operating unit whose components function as a cohesive whole to provide a common service. Such a unit is referred to as a ‘grouped asset’.
For example, a computer network operates as a cohesive whole yet it may contain individual personal computers that can also operate independently. A network of roads, a water sewerage system, an electricity distribution system and a communications network are examples of extensive and integrated components operating as part of a total asset system. Another example of a group of assets used together to provide a common service is office furniture and equipment.

Grouped assets (including network assets) should be primary units for accounting recognition because their components function as a cohesive whole to provide a common service. This is subject to the capitalisation threshold.

The threshold tests should be applied to individual assets as well as grouped assets. The cost of each item making up a set of office furniture or of each computer in a computer network may be less than the capitalisation threshold, but if the total cost of the network or grouped asset exceeds the threshold, each item should be capitalised.

**Cost of acquisition**

The purchase consideration (price) paid for an asset plus any costs incidental to the acquisition. The cost of an asset must include (where appropriate):

- installation
- commissioning
- transport
- customs duty
- any other incidental costs

Interest and other finance costs incurred in acquiring the service potential embodied in an asset (for example, exchange fluctuations on loans) should not be included in the acquisition cost of that asset.

**Asset construction**

The following costs should be included in relation to construction of an asset:

- costs that relate directly to the construction of an asset, including:
  - direct labour and material costs;
  - depreciation of physical non-current assets used on construction of the asset; and
  - set up costs directly related to the construction of an asset.
- costs that are reliably attributable to the construction activity and are capable of being allocated on a reasonable basis to specific assets, including:
  - purchasing administration costs;
  - insurance;
  - costs of design and technical activities; and
  - project overheads (such as direct administration and holding costs of the project).
- the following costs, which are related to activities of the agency or asset construction generally, but not specific to the asset being constructed, should be excluded as they cannot be reliably attributed to the asset:
  - general administration costs; and
  - depreciation of plant and equipment not related to construction activities (including idle plant and equipment).
Lease
A grant or possession of an asset for a stated period of time at specified rentals and subject to various conditions. The register proprietor has certain re-entry rights if the lessee defaults by not observing the conditions of the lease or by not paying the specified rentals.
## Appendix I: National Health Information Model entity definitions

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accessibility factor</strong></td>
<td>An instance of a factor that influences, determines or affects access to services, providers and information. For example, privacy of records, location of persons and providers, distance from medical services etc.</td>
</tr>
<tr>
<td><strong>Accommodation characteristic</strong></td>
<td>The living arrangements of a PERSON. For example, the type of dwelling, age of dwelling, number of bedrooms, modification of dwelling to account for restricted movement etc. In the National Health Information Model, ACCOMMODATION CHARACTERISTIC may relate to where a PERSON usually resides or it may be of interest at an instance in time – for example while a PERSON is in receipt of care.</td>
</tr>
<tr>
<td><strong>Acute event</strong></td>
<td>An acute ILLNESS EVENT (such as the incidence of disease) experienced by a PERSON.</td>
</tr>
<tr>
<td><strong>Address element</strong></td>
<td>The part of a LOCATION which is a component part of an address (e.g. 12 Main Street), but which is not a GEOGRAPHIC STANDARD (country, city, postcode) or a LOCATION GROUP (region).</td>
</tr>
<tr>
<td><strong>Advocacy event</strong></td>
<td>An EVENT associated with the act of communicating, defending and recommending a cause or position or acting as an agent.</td>
</tr>
<tr>
<td><strong>Advocate role</strong></td>
<td>A PERSON in their role as an advocate for another PARTY.</td>
</tr>
<tr>
<td><strong>Aggregate health and wellbeing</strong></td>
<td>A composite measure of the health and wellbeing of a PERSON. It generally involves measures/instruments that assess the multi-dimensional factors contributing to health and wellbeing. For example, measures currently in use in Australia include SF-36 and SF-12 scores, quality of life measures, health expectancies etc.</td>
</tr>
<tr>
<td><strong>Aggregate resource</strong></td>
<td>An instance of aggregate or total resources. For example, total nursing staff or the total budget allocated to a program or organisation. Although the National Health Information Model recognises individual resource items (MATERIAL, FINANCIAL, HUMAN and INFORMATION RESOURCE items), the totals of these items are most commonly used in resource management.</td>
</tr>
<tr>
<td><strong>Assessment event</strong></td>
<td>An EVENT associated with the gathering and analysing of information concerning a PARTY.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td><strong>Attitude</strong></td>
<td>The ATTITUDEs of a PERSON towards health, health care and the health and welfare systems.</td>
</tr>
<tr>
<td><strong>Availability factor</strong></td>
<td>An instance of a factor that influences, determines or affects availability of services for a PERSON or group. For example, the availability of services such as employment assistance for a PERSON with a disability.</td>
</tr>
<tr>
<td><strong>Belief</strong></td>
<td>The BELIEFs of a PERSON about health, health care and the health and welfare systems.</td>
</tr>
<tr>
<td><strong>Benchmark</strong></td>
<td>A criterion against which something is measured. Compare with STANDARD.</td>
</tr>
<tr>
<td><strong>Birth event</strong></td>
<td>The EVENT of being born. It describes EVENTs which happen to both the baby and the mother during the birth.</td>
</tr>
<tr>
<td><strong>Built environment</strong></td>
<td>The built (man-made) environment in which a PERSON or community lives. For example, quality of housing, access to appropriate sanitation systems etc.</td>
</tr>
<tr>
<td><strong>Business agreement</strong></td>
<td>An agreement or contract between PARTYs which specifies the roles and responsibilities of each in relation to a HEALTH AND WELFARE PROGRAM. For example, purchaser-provider agreements, employment contracts, service contracts and other funding agreements.</td>
</tr>
</tbody>
</table>
| **Business factors**  | This 'box' is a super-entity in the National Health Information Model. It is not an entity in its own right but rather, provides a simple grouping facility to access entities relating to business factors. The following entities have been grouped in this 'box':
  * BUSINESS AGREEMENT
  * BUSINESS PROGRAM
  * BUSINESS STATEMENT
  * PERFORMANCE GOAL |
<p>| <strong>Business program</strong>  | A program conducted by a business or organisation.                                                                                                                                                      |
| <strong>Business statement</strong>| A policy statement or business plan.                                                                                                                                                                     |
| <strong>Capital expenditure</strong> | Expenditure on capital items incurred by an ORGANISATION.                                                                                                                                             |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Care plan</td>
<td>A sequenced list of treatments, other services, and resources that are prescribed to improve a PERSON's STATE OF HEALTH AND WELLBEING. For example, a rehabilitation program for a back injury. A CARE PLAN is a scheme which groups and specifies the roles of material or human resources, planned events, and parties in providing health and welfare services to an individual or group. A CARE PLAN may not always be formally notified or even documented. This 'box' is a super-entity in the National Health Information Model.</td>
</tr>
<tr>
<td>Carer role</td>
<td>A PERSON in their role as a carer of another PERSON/s who are ill or disabled and unable to perform the tasks of daily living for themselves. For example, a PERSON providing respite care.</td>
</tr>
<tr>
<td>Citizen role</td>
<td>A PERSON, about which information may be required, but who is not engaged in a specific role within the HEALTH AND WELFARE sector. For example, the identification of an individual (often anonymously) who is participating in a population-based health or welfare survey.</td>
</tr>
<tr>
<td>Community event</td>
<td>An EVENT which is initiated by or affects members of a community. For example, meetings of support groups (e.g. SIDA), and actions or decisions by a community to undertake or not undertake a course of action on such subjects as curfews, right to life, use of alcohol and sex education. Extreme examples include protests, demonstrations and riots.</td>
</tr>
<tr>
<td>Community organisation</td>
<td>An ORGANISATION operating for the purpose of meeting community needs. For example, a religious, recreational, sporting or volunteer organisation.</td>
</tr>
<tr>
<td>Component health and wellbeing</td>
<td>COMPONENT HEALTH AND WELLBEING is a single measure/assessment of the health and wellbeing of a PERSON. For example, diagnosis of illness, disease or injury, self-assessed health status, enough money to buy food, ability to look after oneself etc.</td>
</tr>
<tr>
<td>Crisis event</td>
<td>An acute LIFE EVENT (such as the incidence or prevalence of disease or injury) experienced by a PERSON.</td>
</tr>
<tr>
<td>Cultural characteristic</td>
<td>A characteristic of a PERSON which identifies their religious, political, linguistic and ethnic affiliations.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td>Cultural wellbeing</td>
<td>Those aspects of a PERSONs or community's wellbeing that can be ascribed to cultural factors.</td>
</tr>
<tr>
<td>Death event</td>
<td>The EVENT of death. Attributes of this entity would normally include such data elements as date, time and cause of death. The DEATH EVENT does not necessarily imply the end of all events relating to a PERSON, since events such as organ donation and transmission of disease may occur.</td>
</tr>
<tr>
<td>Demographic characteristic</td>
<td>A characteristic of a PERSON that contributes to the specification of the population or sub-population to which they belong. For example, sex, country of birth, year of arrival in Australia, Indigenous status etc.</td>
</tr>
<tr>
<td>Economic wellbeing</td>
<td>Those aspects of a PERSONs or community's wellbeing that can be ascribed to economic factors. For example, insufficient funds to support an acceptable standard of living.</td>
</tr>
<tr>
<td>Education characteristic</td>
<td>A characteristic of a PERSON that relates to their education. For example, highest qualification held, age when left school etc.</td>
</tr>
<tr>
<td>Education event</td>
<td>The instance of a PARTY educating another PARTY about the availability, knowledge and access of health and welfare services. For example, school-based drug and alcohol education programs.</td>
</tr>
<tr>
<td>Educational system</td>
<td>The public or private provision of education services. For example, the availability of kindergarten, primary school, secondary school and tertiary education facilities in a locality or community.</td>
</tr>
<tr>
<td>Employment agreement</td>
<td>An agreement or contract for employing a PERSON and being employed by a PARTY. The EMPLOYMENT AGREEMENT normally involves two PARTYs, one in an employer role and the other in the employee role.</td>
</tr>
<tr>
<td>Enabling factors</td>
<td>This 'box' is a super-entity in the National Health Information Model. It is not an entity in its own right but rather, provides a simple grouping facility to access entities that relate to factors that enable events to occur. The following entities have been grouped in this 'box':</td>
</tr>
<tr>
<td></td>
<td>• RESOURCE</td>
</tr>
<tr>
<td></td>
<td>• OTHER ENABLING FACTOR</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td><strong>Environmental event</strong></td>
<td>A change in the environment which has an effect on one or more PARTYs. Although all events obviously occur within an 'environment', the concept of an ENVIRONMENTAL EVENT is an event that has the environment (physical, chemical, biological, social, economic, cultural) as its principal focus. Examples of ENVIRONMENTAL EVENTS include storms, floods, riots and war, spillage of hazardous chemicals, liquids or gases and economic recession.</td>
</tr>
</tbody>
</table>
| **Environmental factors**   | This 'box' is a super-entity in the National Health Information Model. It is not an entity in its own right but rather, provides a simple grouping facility to access entities relating to environmental factors. The following entities have been included in this box:  
- PHYSICAL ENVIRONMENT  
- SOCIAL ENVIRONMENT                                     |
| **Event**                   | Something that happens to or with a PARTY. This 'box' is a super-entity in the National Health Information Model. It is comprised of the following entities:  
- PERSON EVENT  
- HEALTH AND WELFARE SERVICE EVENT  
- LEGAL STATUS EVENT  
- COMMUNITY EVENT  
- ENVIRONMENTAL EVENT  
- RESEARCH EVENT  
- OTHER EVENT  
This super-entity reflects the emphasis in the NHIM on events that happen, and that may trigger or influence other events. Since the model is also date/time stamped at different instances in time, the model can accommodate the development of people and their health and welfare status and wellbeing by tracking these events. |
<p>| <strong>Exit / leave from service event</strong> | The instance of an exit or period of leave by a PERSON from a SERVICE DELIVERY SETTING.                                                                                                               |
| <strong>Expectation</strong>             | The EXPECTATIONs of a PERSON about health, health care and the health and welfare systems. For example, a hospital separation, leave from a hospital / nursing home for an agreed period of time etc. |
| <strong>Expected outcome</strong>        | A desired level of attainment to be achieved through one or more HEALTH AND WELFARE SERVICE EVENTs. An outcome in the National Health Information Model most commonly relates to a PERSON but may also be stated for a PARTY or ORGANISATION. |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **Expenditure**                  | Expenditure on capital items (land, buildings) or recurrent expenditure (patient transport, cleaning services) incurred by an ORGANISATION. This 'box' is a super-entity in the National Health Information Model. It is comprised of the following entities:  
     • CAPITAL EXPENDITURE  
     • RECURRENT EXPENDITURE                                                                                                                                                                                                                                                                                                                                                                                  |
| **Family member role**           | A PERSON in their role of family member. For example, mother, father, guardian, child. A family may or may not live within the same household.                                                                                                                                                                                                                                                                                                                                 |
| **Financial resource**           | The existence of funds and budgets to undertake activities. Although this entity has no subtypes in the National Health Information Model, it is a major component of health and welfare systems, and one which can and should be separately modelled.                                                                                                                                                                                                                      |
| **Functional wellbeing**         | The ability of a person to perform the usual tasks of daily living and to carry out social roles.                                                                                                                                                                                                                                                                                                                                                                         |
| **Funding agreement**            | An agreement between PARTYs for the provision and use of funds for a purpose.                                                                                                                                                                                                                                                                                                                                                                                                  |
| **Geographic standard**          | Those parts of a location that are defined or classified in law or have some official standing. For example, country, State/Territory, postcode.                                                                                                                                                                                                                                                                                                                                 |
| **Goal / objective**             | A statement of what is to be achieved in a shorter time frame, as compared with a longer term VISION / MISSION.                                                                                                                                                                                                                                                                                                                                                             |
| **Health and welfare policy / plan** | A statement or document which may include a VISION/MISSION, GOAL/OBJECTIVE, directions for development, PRIORITYs for action, actions to be taken, EXPECTED OUTCOMEs and PERFORMANCE INDICATORs in relation to HEALTH AND WELFARE PROGRAMs for particular PARTYs, particular LOCATIONs and particular periods in time.  
HEALTH AND WELFARE POLICY/PLAN is an entity subtype which reflects instances of policies and plans which are made up of components (HEALTH AND WELFARE POLICY/PLAN ELEMENTs).  
Other business statements will exist which are not created for or by the health and welfare sectors but which still impact on a PARTY's STATE OF HEALTH AND WELLBEING. |
<p>| <strong>Health and welfare policy / plan element</strong> | A component part of a HEALTH AND WELFARE POLICY / PLAN.                                                                                                                                                                                                                                                                                                                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and welfare program</strong></td>
<td>A business program specifically created for or by the health and welfare sectors. HEALTH AND WELFARE PROGRAM is an entity subtype which reflects instances of programs which are made up of components (HEALTH AND WELFARE PROGRAM ELEMENTs). Other business programs will exist that are not created for or by the health and welfare sectors but which still impact on a PARTY's STATE OF HEALTH AND WELLBEING.</td>
</tr>
<tr>
<td><strong>Health and welfare program element</strong></td>
<td>A component part of a HEALTH AND WELFARE PROGRAM.</td>
</tr>
<tr>
<td><strong>Health and welfare service event</strong></td>
<td>An instance of an EVENT which is part of the delivery or receipt of health and welfare services or care. These EVENTS include delivery of community programs, consultations with service providers, diagnoses, treatment, operations, delivery of care and rehabilitation, delivery of palliative care, counselling services, and voluntary care.</td>
</tr>
<tr>
<td><strong>Health status</strong></td>
<td>An instance of the state of health of a PERSON, PARTY GROUP or population measured against accepted standards.</td>
</tr>
<tr>
<td><strong>Human resource item</strong></td>
<td>An instance of people with capacity, capability and availability as resources to provide health and welfare services. This entity represents specialist service providers, nurses etc., but can also accommodate voluntary carers and those who have the potential to provide services i.e. a spouse who could care for a partner who became ill. The idea of skills and expertise is also included in this entity, providing a measure of both capacity and capability. Data elements within this entity reflect the view of the ORGANISATION or employer as compared with data elements that reflect the view of the PERSON in their role as a specialist service provider, nurse and so on.</td>
</tr>
<tr>
<td><strong>Illness event</strong></td>
<td>An acute or chronic LIFE EVENT experienced by a PERSON but not involving a HEALTH AND WELFARE SERVICE EVENT. For example, the incidence or prevalence of disease.</td>
</tr>
<tr>
<td><strong>Information resource item</strong></td>
<td>An instance of information or knowledge that supports the health and welfare system. This broad concept includes what we know about the human body from a medical and scientific perspective, what we know about drugs and interventions, what we know about other factors affecting wellbeing, and so on. Research is a process which generates or refines instances of this entity.</td>
</tr>
<tr>
<td><strong>Injury event</strong></td>
<td>An acute LIFE EVENT experienced by a PERSON involving the occurrence of an injury but not involving a HEALTH AND WELFARE SERVICE EVENT.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Insurance / benefit characteristic</td>
<td>A characteristic of a PERSON that relates to their health insurance or social security status.</td>
</tr>
<tr>
<td>Judicial system</td>
<td>Provision, availability and access to legal services within a community.</td>
</tr>
<tr>
<td>Knowledge factor</td>
<td>An instance of a factor that influences, determines or affects a PERSONs, PARTY GROUPs or ORGANISATIONs state of knowledge or cognisance, particularly of elements of wellbeing, health and welfare, and their services. For example, factors that influence 'How much a person knows about the risk from smoking', 'How much a person knows about the availability of counselling services', 'How much a service provider knows about the latest technique for treating a particular illness'.</td>
</tr>
<tr>
<td>Labour characteristic</td>
<td>A characteristic of a PERSON that relates to their employment or labour force status. For example, their occupation, industry of employment, hours worked etc.</td>
</tr>
<tr>
<td>Legal characteristic</td>
<td>A characteristic of a PERSON which relates to their legal status. For example, ward of the State, held in custody etc.</td>
</tr>
<tr>
<td>Legal status event</td>
<td>An EVENT that changes a PARTY's legal status. For example, reaching 18 years of age, marriage, or the decision by a Review Board or Tribunal to change an individual from an 'involuntary' to a 'voluntary' status under the Mental Health Act.</td>
</tr>
<tr>
<td>Legally constituted organisation</td>
<td>An organisation established under law. LEGALLY CONSTITUTED ORGANISATIONs may be ORGANISATIONs in a one-to-one relationship with a statute, (e.g. the Australian Institute of Health and Welfare and the Australian Institute of Health and Welfare Act) or ORGANISATIONs that are examples of a class or ORGANISATIONs established under and regulated by a statute (e.g. hospitals, incorporated bodies).</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Life event</td>
<td>An instance of an EVENT which occurs to or with a PERSON during their life. The LIFE EVENT entity provides the means of identifying those things that happen during a person's life which affect their STATE OF HEALTH AND WELLBEING and occur between their BIRTH EVENT and their DEATH EVENT. This entity does not include events identified elsewhere, e.g. HEALTH AND WELFARE SERVICE EVENTs, LEGAL STATUS EVENTs, COMMUNITY EVENTs, ENVIRONMENTAL EVENTs, RESEARCH EVENTs OR OTHER EVENTs, but does include such things as puberty, the onset of disease, the loss of employment etc. While the actual date and time when some of these events occur may not need or be able to be known, this entity provides a means to consistently represent this information.</td>
</tr>
<tr>
<td>Lifestyle characteristic</td>
<td>A behavioural attribute, trait or feature of a PERSON that describes an aspect of their lifestyle. For example, cigarette smoking, participation in regular physical exercise, dietary habits or use of illicit drugs.</td>
</tr>
<tr>
<td>Location</td>
<td>This 'box' is a super-entity in the National Health Information Model. It is comprised of the following entities: • LOCATION GROUP • LOCATION ELEMENT • SETTING A LOCATION is a site or position where something happens, or where a person, group or organisation is located, may be contacted or conduct their business, etc. For example, an address or geographical region.</td>
</tr>
<tr>
<td>Location element</td>
<td>The elements of a LOCATION. This sub-entity provides for the combination of different location elements to form a known address or location. In this way this entity can accommodate more diverse locational constructs, such as electronic mail addresses, or 'the backyard', or 'the Sydney Football Stadium'. An actual address, such as a residential postal address, is normally made up of a number of components from this entity, including a detailed residential title (12 Main Street), plus city/town, postcode, State/Territory, and Country values (see also SETTING).</td>
</tr>
<tr>
<td>Location group</td>
<td>A notional grouping of other geographic location elements, including address elements to form a recognisable address. For example, areas, regions and districts (such as the Southern Highlands), where these are not defined as a GEOGRAPHIC STANDARD, and postal and house addresses.</td>
</tr>
<tr>
<td>Material resource</td>
<td>An instance of a material resource. For example, drugs, buildings, plant, operating theatres, organs and blood products.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td>Mental wellbeing</td>
<td>The wellbeing of a PERSON, based on their mental state. For example, test results, symptoms, diagnoses and self-perceived health status specific to the mental state of a PERSON.</td>
</tr>
<tr>
<td>Natural environment</td>
<td>The natural environment in which a PERSON or community lives. For example, the air we breathe, the quality of water, noise pollution etc.</td>
</tr>
<tr>
<td>Need / issue</td>
<td>The reason why a PARTY is seeking access to health and welfare services. For example, the need for emergency accommodation. This 'box' is a super-entity in the National Health Information Model. It is not intended to represent assessed need (ASSESSMENT EVENT) as determined by a service provider. Nor does it represent a STATE OF HEALTH AND WELLBEING once the assessment has been made.</td>
</tr>
<tr>
<td>Non-acute event</td>
<td>A non-acute ILLNESS EVENT experienced by a PERSON. For example, the prevalence of chronic disease such as diabetes or asthma.</td>
</tr>
<tr>
<td>Organisation</td>
<td>A business or administrative concern created for particular ends.</td>
</tr>
<tr>
<td>Organisation characteristic</td>
<td>A characteristic of an ORGANISATION (but unrelated to BUSINESS FACTORS). For example, the nature of the business or reason for trading. This entity has been included in Version 2 of the National Health Information Model to describe information about an ORGANISATION.</td>
</tr>
<tr>
<td>Organisation role</td>
<td>An instance of an ORGANISATION participating in a specific role in the health and welfare sector. For example, an ORGANISATION as a funder of services, purchaser of services or other organisation role.</td>
</tr>
<tr>
<td>Organisation sub-unit</td>
<td>A constituent part of an ORGANISATION. ORGANISATION SUB-UNITs are normally the smaller components of organisations such as departments, divisions, units and sections. ORGANISATION SUB-UNITs may exist in a hierarchical structure.</td>
</tr>
<tr>
<td>Organisational setting</td>
<td>An instance of where an EVENT occurs, described in terms of the ORGANISATION. For example, a hospital, a government department etc.</td>
</tr>
<tr>
<td>Other agreement</td>
<td>A BUSINESS AGREEMENT other than a FUNDING AGREEMENT or EMPLOYMENT AGREEMENT. For example, purchaser-provider agreements, service contracts etc.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td>Other crisis event</td>
<td>An acute LIFE EVENT experienced by a PERSON but not involving an ILLNESS, INJURY or HEALTH AND WELFARE SERVICE EVENT.</td>
</tr>
<tr>
<td></td>
<td>For example, emergency accommodation needs, crisis counselling.</td>
</tr>
<tr>
<td>Other enabling factor</td>
<td>Resources are a major 'enabling' factor in health and welfare. However, there are other important enabling factors, e.g. access, knowledge and availability, which are recognised by this entity.</td>
</tr>
<tr>
<td>Other event</td>
<td>An EVENT which is not a PERSON EVENT, HEALTH AND WELFARE SERVICE EVENT, COMMUNITY EVENT, LEGAL STATUS EVENT, RESEARCH EVENT or ENVIRONMENTAL EVENT.</td>
</tr>
<tr>
<td>Other health and welfare service event</td>
<td>A HEALTH AND WELFARE SERVICE EVENT other than a REQUEST FOR/ENTRY INTO SERVICE EVENT, SERVICE PROVISION EVENT, EXIT/LEAVE FROM SERVICE EVENT, ASSESSMENT EVENT, SCREENING EVENT, EDUCATION EVENT, ADVOCACY EVENT, PLANNING EVENT, SURVEILLANCE/MONITORING EVENT or PAYMENT/CONTRIBUTION EVENT.</td>
</tr>
<tr>
<td>Other life event</td>
<td>A LIFE EVENT that a PERSON experiences other than a SELF HELP EVENT or CRISIS EVENT (such as illness, injury or other crisis).</td>
</tr>
<tr>
<td>Other organisation role</td>
<td>An instance of an ORGANISATION ROLE within the health and welfare sector which is not a SERVICE FUNDER ROLE or a SERVICE PURCHASER ROLE.</td>
</tr>
<tr>
<td>Other person characteristic</td>
<td>A characteristic of a PERSON other than a DEMOGRAPHIC CHARACTERISTIC, LABOUR CHARACTERISTIC, LIFESTYLE CHARACTERISTIC, EDUCATION CHARACTERISTIC, SOCIAL CHARACTERISTIC, CULTURAL CHARACTERISTIC, PARENTING CHARACTERISTIC, ACCOMMODATION CHARACTERISTIC, INSURANCE/BENEFIT CHARACTERISTIC or LEGAL CHARACTERISTIC.</td>
</tr>
<tr>
<td>Other person role</td>
<td>The role of a PERSON other than as a citizen, family member, carer, advocate, service provider or as a provider of resources.</td>
</tr>
<tr>
<td>Other policy / plan element</td>
<td>HEALTH AND WELFARE POLICY/PLAN ELEMENTs other than those identified by the subtypes (VISION/MISSION, GOAL/OBJECTIVE, PRIORITY, and PERFORMANCE INDICATOR).</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td>Other role</td>
<td>A ROLE other than a PARTY RELATIONSHIP ROLE, PERSON ROLE, PARTY GROUP ROLE, ORGANISATION ROLE, RECIPIENT ROLE, SERVICE PROVIDER ROLE or RESEARCH ROLE. An expanded list of subtypes relating to PERSONs and ORGANISATIONs can be found within the entities PERSON ROLE and ORGANISATION ROLE.</td>
</tr>
<tr>
<td>Other setting</td>
<td>An instance of where, in generic terms, something happens, which is not in an ORGANISATIONAL SETTING or a SERVICE DELIVERY SETTING. For example, 'at home', 'on a sports field', 'at work' etc.</td>
</tr>
<tr>
<td>Other social environment</td>
<td>The social environment in which a PERSON or community lives other than the JUDICIAL SYSTEM, the EDUCATIONAL SYSTEM or a COMMUNITY ORGANISATION.</td>
</tr>
</tbody>
</table>
| Outcome                    | A recorded change in the wellbeing of a PARTY which is expected or presumed to be, or to have been, caused by a HEALTH AND WELFARE SERVICE EVENT. This 'box' is a super-entity in the National Health Information Model. It is comprised of the following entities:  
  - STATED OUTCOME  
  - EXPECTED OUTCOME |
| Parenting characteristic   | A characteristic of a PERSON that relates to their role as a parent. For example, breastfeeding a baby or use of child care facilities. |
| Party                      | Those PERSONs, PARTY GROUPs or ORGANISATIONs who are part of the health and welfare systems including those who are known to the system and those who are of interest to it. Essentially this includes all persons in Australia. For example, a PARTY as a recipient of services, provider of services, purchaser of services or funder of services. This 'box' is a super-entity in the National Health Information Model. |
| Party characteristic       | This 'box' is a super-entity in the National Health Information Model. It is comprised of the following entities:  
  - ORGANISATION CHARACTERISTIC  
  - PARTY GROUP CHARACTERISTIC  
  - PERSON CHARACTERISTIC  
  - PERSON VIEW  
  - STATE OF HEALTH AND WELLBEING  
  PARTY CHARACTERISTIC is not a entity in its own right but rather, a loose grouping of like entities. |
<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Party group</td>
<td>An instance of a number of PARTYs, normally PERSONs, considered as a collective unit. For example, families, communities and tribes. The Australian population, or sub-populations within it, are represented in the National Health Information Model as a PARTY GROUP.</td>
</tr>
<tr>
<td>Party group characteristic</td>
<td>A characteristic of a PARTY GROUP (apart from those associated with a PERSON or those that are derived from aggregating PERSON data). For example, the main language spoken or religious affiliation of a community. This entity has been included in Version 2 of the National Health Information Model to describe information about a PARTY GROUP.</td>
</tr>
<tr>
<td>Party group role</td>
<td>An instance of a PARTY GROUP participating in a role within the health and welfare sectors.</td>
</tr>
<tr>
<td>Party relationship role</td>
<td>An instance of a relationship between PARTYs which is relevant to an EVENT. Many of these relationships have been expanded in Version 2 of the National Health Information Model and are now found within the expanded entities PERSON ROLE, PARTY GROUP ROLE and ORGANISATION ROLE. This entity does not include PARTYs in a RECIPIENT ROLE, SERVICE PROVIDER ROLE, RESEARCH ROLE or OTHER ROLE.</td>
</tr>
<tr>
<td>Party role</td>
<td>An instance of a PARTY participating in a role in the health and welfare sectors. The concept of PARTY ROLE in the National Health Information Model provides for different persons, groups and organisations to have different roles at different times. Some of these roles refer to service delivery, planning, resource allocation or agreements. This 'box' is a super-entity in the National Health Information Model. It is comprised of the following entities:</td>
</tr>
<tr>
<td></td>
<td>• PARTY RELATIONSHIP ROLE</td>
</tr>
<tr>
<td></td>
<td>• PERSON ROLE</td>
</tr>
<tr>
<td></td>
<td>• PARTY GROUP ROLE</td>
</tr>
<tr>
<td></td>
<td>• ORGANISATION ROLE</td>
</tr>
<tr>
<td></td>
<td>• RECIPIENT ROLE</td>
</tr>
<tr>
<td></td>
<td>• SERVICE PROVIDER ROLE</td>
</tr>
<tr>
<td></td>
<td>• RESEARCH ROLE</td>
</tr>
<tr>
<td></td>
<td>• OTHER ROLE</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td><strong>Payment/contribution event</strong></td>
<td>The instance of a PARTY making a payment or contribution as part of their involvement in a HEALTH AND WELFARE SERVICE EVENT. For example, a Medicare payment or a private health fund payment.</td>
</tr>
<tr>
<td><strong>Performance goal</strong></td>
<td>A level of performance against which the performance of a PARTY ROLE will be judged.</td>
</tr>
<tr>
<td><strong>Performance indicator</strong></td>
<td>A PERFORMANCE INDICATOR is used to assess performance against goals and targets. PERFORMANCE INDICATOR is alternately referred to as Key Performance Indicator or KPI.</td>
</tr>
<tr>
<td><strong>Person</strong></td>
<td>An individual human being. A PERSON is identified by the role he or she plays. See subtypes within the entity PERSON ROLE. A PERSON will possess a range of characteristics and views. See subtypes within the entity PERSON CHARACTERISTIC and PERSON VIEW.</td>
</tr>
<tr>
<td><strong>Person characteristic</strong></td>
<td>Features which characterise a PERSON. A PERSON CHARACTERISTIC is either a DEMOGRAPHIC CHARACTERISTIC, PHYSICAL CHARACTERISTIC, LABOUR CHARACTERISTIC, LIFESTYLE CHARACTERISTIC, EDUCATION CHARACTERISTIC, SOCIAL CHARACTERISTIC, PARENTING CHARACTERISTIC, ACCOMMODATION CHARACTERISTIC, INSURANCE/BENEFIT CHARACTERISTIC, LEGAL CHARACTERISTIC or OTHER PERSON CHARACTERISTIC. This entity reflects the emphasis in the National Health Information Model on the PERSON.</td>
</tr>
<tr>
<td><strong>Person event</strong></td>
<td>An EVENT that happens to a person which affects their STATE OF HEALTH AND WELLBEING from the time of their birth until their death.</td>
</tr>
<tr>
<td><strong>Person role</strong></td>
<td>A PERSON in a role as distinct from a PARTY GROUP in a role or an ORGANISATION in a role For example, a PERSON in a role as a citizen, family member, carer, advocate, resource or other person role. The expansion of the PERSON ROLE entity replaces PERSON IDENTIFIER as a subtype of PERSON CHARACTERISTIC from Version 1 of the National Health Information Model.</td>
</tr>
<tr>
<td><strong>Person view</strong></td>
<td>The attitudes, beliefs, expectations and values of an individual in relation to health, health care and the health and welfare systems.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
</tr>
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</tr>
<tr>
<td>Physical characteristic</td>
<td>A characteristic of a PERSON which relates to their physical features.</td>
</tr>
<tr>
<td>Physical environment</td>
<td>The physical environment in which a PERSON or community lives. For example, the NATURAL ENVIRONMENT and BUILT ENVIRONMENT including air and water quality, noise pollution, quality of housing, sanitation etc.</td>
</tr>
<tr>
<td>Physical wellbeing</td>
<td>The wellbeing of a person based on their physical, chemical and biological state.</td>
</tr>
<tr>
<td>Planning event</td>
<td>The instance of a PARTY planning the provision of a HEALTH AND WELFARE SERVICE EVENT.</td>
</tr>
<tr>
<td>Priority</td>
<td>Something given special attention, normally involving special precedence over others.</td>
</tr>
<tr>
<td>Program activity</td>
<td>An identified action to be taken as part of a program or plan. This is distinct from the National Health Information Model entity of EVENT, which is the actual instance or occurrence of these activities.</td>
</tr>
<tr>
<td>Program evaluation</td>
<td>A process to be conducted as part of a program or plan to determine the extent to which the program or plan achieved its GOAL/OBJECTIVE.</td>
</tr>
<tr>
<td>Program strategy</td>
<td>An intended course of action to be conducted as part of a program or plan.</td>
</tr>
<tr>
<td>Recipient role</td>
<td>An instance of a role that a PARTY as a recipient of services or care plays in EVENTs. For example, a patient, client, consumer, customer etc.</td>
</tr>
<tr>
<td>Recurrent expenditure</td>
<td>Expenditure incurred by an ORGANISATION on a recurring basis for the provision of services, excluding CAPITAL EXPENDITURE, but including indirect expenditure.</td>
</tr>
<tr>
<td>Request for / entry into service event</td>
<td>An instance of a request for services or for entry into a SERVICE DELIVERY SETTING from one service provider to another.</td>
</tr>
<tr>
<td>Research event</td>
<td>An instance of a PARTY undertaking research of interest to the health and welfare sector.</td>
</tr>
<tr>
<td>Research role</td>
<td>An instance of a role a PARTY plays in research activities.</td>
</tr>
<tr>
<td>Resource</td>
<td>The material necessary for an activity. For example, buildings, reusable and consumable items, financial resources and people, and the information or knowledge required.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td>Resource role</td>
<td>An instance of a role a PERSON plays in the management, allocation and use of RESOURCES. For example, a manager, a cleaner, a computer programmer etc. A PERSON in a RESOURCE ROLE excludes individuals providing health and welfare services.</td>
</tr>
<tr>
<td>Screening event</td>
<td>An instance of a PARTYs involvement in a SCREENING EVENT. For example, mammographic screening, a pap smear etc.</td>
</tr>
<tr>
<td>Self help event</td>
<td>A PERSON actively seeking help, education or assistance or participating in activities of interest to the health and welfare sector. For example, attending a quit smoking course, modification of one's diet etc.</td>
</tr>
<tr>
<td>Service delivery setting</td>
<td>An instance of where an EVENT occurs, described in terms of the SERVICE DELIVERY SETTING. For example, a birthing centre, child care centre or hospital emergency department etc.</td>
</tr>
<tr>
<td>Service funder role</td>
<td>An instance of a role that an ORGANISATION, as a health and welfare service funder, plays in EVENTs.</td>
</tr>
<tr>
<td>Service provider role</td>
<td>An instance of a role that a PARTY, as a health and welfare service provider, plays in EVENTs. This includes both PERSONs who are formally nominated as service providers (e.g. nurses and general practitioners) and PERSONs who provide voluntary or informal care.</td>
</tr>
<tr>
<td>Service provision event</td>
<td>An instance of the provision of a HEALTH AND WELFARE SERVICE EVENT by a service provider to a PERSON or PARTY GROUP. For example, treatment, conduct of tests etc.</td>
</tr>
<tr>
<td>Service purchaser role</td>
<td>An instance of a role that an ORGANISATION, as a health and welfare service purchaser, plays in EVENTs.</td>
</tr>
<tr>
<td>Setting</td>
<td>A description of where something happens. SETTING differs from LOCATION in the National Health Information Model, as an EVENT may occur at the LOCATION of 'Corner of Jones and Smith Streets, SomeCity, WA', but it may be more relevant to describe an event as having occurred in 'a hospital' (the SETTING).</td>
</tr>
<tr>
<td>Social characteristic</td>
<td>A specific SOCIAL CHARACTERISTIC of a PERSON. For example, marital status, language spoken in the home etc.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
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</tr>
<tr>
<td>Social environment</td>
<td>The social environment in which a PERSON or community lives including the JUDICIAL SYSTEM, the EDUCATIONAL SYSTEM, COMMUNITY ORGANISATION or OTHER SOCIAL ENVIRONMENT.</td>
</tr>
<tr>
<td>Social wellbeing</td>
<td>The wellbeing of a PERSON, based on their interaction with other people. For example, a PERSON's experience with discrimination, racism, violence, family-related matters, gambling or drinking problems.</td>
</tr>
<tr>
<td>Specific resource</td>
<td>The resources used in the production and delivery of health and welfare services, be they material, financial, human or information. The SPECIFIC RESOURCE entity provides for the actual instances of these resources.</td>
</tr>
<tr>
<td>Spiritual wellbeing</td>
<td>The wellbeing of a person, based on their perception of or relationship to sacred or religious theory.</td>
</tr>
<tr>
<td>Standard</td>
<td>An accepted or approved example of something against which others are judged or measured. Compare with BENCHMARK.</td>
</tr>
<tr>
<td>State of health and wellbeing</td>
<td>The health and wellbeing of a PARTY (usually a PERSON) measured or assessed in aggregate (e.g. the total wellbeing of a PARTY) or in component terms (e.g. HEALTH STATUS, SOCIAL WELLBEING, ECONOMIC WELLBEING, CULTURAL WELLBEING and SPIRITUAL WELLBEING). For example, SF-36 instrument of health status measurement, an illness diagnosis, an injury, enough money to buy food, ability to look after oneself etc.). The STATE OF HEALTH AND WELLBEING entity replaces the STATE OF WELLBEING entity in Version 1 of the National Health Information Model.</td>
</tr>
<tr>
<td>Stated outcome</td>
<td>The information recorded by a PARTY in a role about an OUTCOME which has occurred, as distinct from an OUTCOME which was planned or expected. The STATED OUTCOME is distinguished as an entity from the EXPECTED OUTCOME.</td>
</tr>
<tr>
<td>Surveillance / monitoring event</td>
<td>An instance of a PARTY's involvement in a surveillance or monitoring EVENT within the health and welfare sector.</td>
</tr>
<tr>
<td>Value</td>
<td>The VALUEs of a PERSON about health, health care and the health and welfare systems.</td>
</tr>
<tr>
<td>Vision / mission</td>
<td>The highest level statement of why something is to happen or where a situation or organisation should be in a set period of time. Vision or mission statements normally contain the aspirations of those stating them.</td>
</tr>
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