

Admitted patient palliative care National Minimum Data Set

National Health Data Dictionary, Version 12

National Health Data Committee

2003

Australian Institute of Health and Welfare
Canberra

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Introduction

A National Minimum Data Set (NMDS) 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 NMDS may include data elements that are also included in another NMDS. A NMDS 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 (bilateral agreements between the Commonwealth and State/Territory governments about funding and delivery of health services).

The following pages contain the Admitted patient palliative care NMDS and its associated data elements and data element concepts.

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Admitted patient palliative care NMDS

Admin. status:	CURRENT	1/07/2001	Version number: 2
Metadata type:	NATIONAL MINIMUM DATA SET		
Start date:	1 July 2000		
Scope:	<p>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.</p> <p>Palliative care patients are identified by the data element Care type.</p>		
Statistical units:	Episodes of care for admitted patients.		
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:	<p>Additional diagnosis, version 4</p> <p>Admission date, version 4</p> <p>Area of usual residence, version 3</p> <p>Care type, version 4</p> <p>Country of birth, version 3[∇]</p> <p>Date of birth, version 4[∇]</p> <p>Establishment identifier, version 4[∇]</p> <p>Funding source for hospital patient, version 1</p> <p>Indigenous status, version 4[∇]</p> <p>Mode of admission, version 4</p> <p>Mode of separation, version 3</p> <p>Number of days of hospital-in-the-home care, version 1</p> <p>Person identifier, version 1[∇]</p> <p>Previous specialised treatment, version 3</p> <p>Principal diagnosis, version 3</p> <p>Separation date, version 5</p> <p>Sex, version 3[∇]</p>		
Supporting data elements and data element concepts:	<p>Admission, version 3</p> <p>Admitted patient, version 3</p> <p>Diagnosis, version 1</p> <p>Episode of care, version 1</p>		

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.

Data elements included

Additional diagnosis

Identifying and Definitional Attributes

Knowledgebase ID:	000005	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility.		

Context: Additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian refined Diagnosis related groups.

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANN.NN
Minimum size:	3
Maximum size:	6

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

Guide for use: Record each additional diagnosis relevant to 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. Generally, External cause, Place of occurrence and Activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

Verification rules:

Collection methods: An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Related metadata: supersedes previous data element Additional diagnosis – ICD-9-CM code vers 3
relates to the data element Diagnosis onset type vers 1
is used in the derivation of Diagnosis related group vers 1
supplements the data element Principal diagnosis vers 3

Administrative Attributes

Source document: International Classification of Diseases, version 10, Australian Modification, 3rd edition, 2002

Source organisation: National Centre for Classification in Health (Sydney)

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

NMDS - Admitted patient care

NMDS - Admitted patient mental health care

NMDS - Admitted patient palliative care

Start date

End date

01/07/1998

01/07/1998

01/07/2000

Comments:

Admission date

Identifying and Definitional Attributes

Knowledgebase ID:	000008	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/99		
Definition:	Date on which an admitted patient commences an episode of care.		
Context:	Required to identify the period in which the admitted patient episode and hospital stay 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 date

Guide for use:

Verification rules: Right justified and zero filled.
Admission date <= separation date.
Admission date >= date of birth

Collection methods:

Related metadata: relates to the data element concept Admission vers 3
supersedes previous data element Admission date vers 3
relates to the data element Admission time vers 2
relates to the data element concept Admitted patient vers 3
is used in conjunction with Care type vers 4
relates to the data element Emergency department departure status vers 2
is used in the derivation of the derived data element Diagnosis related group vers 1
is used in the calculation of the derived data element Emergency department waiting time to admission vers 1
is used in the calculation of the derived data element Length of stay vers 3
relates to the data element Type of visit to emergency department vers 2
is used in the calculation of the derived data element Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:

NMDS - Admitted patient care

NMDS - Admitted patient mental health care

NMDS - Admitted patient palliative care

Start date

End date

01/07/1999

01/07/1999

01/07/2000

Comments:

Area of usual residence

Identifying and Definitional Attributes

Knowledgebase ID:	000016	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	Geographical location of usual residence of the person.		

Context:	<p>Geographical location is reported using Statistical Local Area (SLA) to enable accurate aggregation of information to larger areas within the Australian Standard Geographical Classification (ASGC) (such as Statistical Subdivisions and Statistical Divisions) as well as detailed analysis at the SLA level. The use of SLA also allows analysis relating the data to information compiled by the Australian Bureau of Statistics on the demographic and other characteristics of the population of each SLA. Analyses facilitated by the inclusion of SLA information include</p> <ul style="list-style-type: none"> - comparison of the use of services by persons residing in different geographical areas, - characterisation of catchment areas and populations for establishments for planning purposes, and - documentation of the provision of services to residents of States or Territories other than the State or Territory of the provider.
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Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNNNN
Minimum size:	5
Maximum size:	5

Data domain: Valid ASGC codes reported using a five digit numerical code.

Guide for use: The geographical location is reported using a five digit numerical code. The first digit is the single-digit code to indicate State or Territory. The remaining four digits are the numerical code for the SLA within the State or Territory.

The single digit codes for the States and Territories and the four digit codes for the SLAs are as defined in the *Australian Standard Geographical Classification*.

The *Australian Standard Geographical Classification* is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.

The codes for SLA are unique within each State and Territory, but not within the whole country. Thus, to define a unique location, the code of the State or Territory is required in addition to the code for the SLA.

The Australian Bureau of Statistics' *National Localities Index* (NLI) (Catalogue number 1252.0) can be used to assign each locality or address in Australia to a SLA. The NLI is a comprehensive list of localities in Australia with their full code (including State or Territory and SLA) from the main structure of the ASGC.

For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign a SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA. In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the person's residence is used with the Streets Sub-index of the NLI to assign the SLA.

If the information available on the person's address indicates that it is in a split locality but is insufficient to assign an SLA, the code for the SLA which includes most of the split locality should be reported. This is in accordance with the NLI assignment of SLA when a split locality is identified and further detail about the address is not available.

The NLI does not assign a SLA code if the information about the address is insufficient to identify a locality, or is not an Australian locality. In these cases, the appropriate codes for undefined SLA within Australia (State or Territory unstated), undefined SLA within a stated State or Territory, no fixed place of abode (within Australia or within a stated State or Territory) or overseas should be used.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Area of usual residence vers 2

Administrative Attributes

Source document: Australian Standard Geographical Classification, Australian Bureau of Statistics, catalogue number 1216.0

Source organisation: National Health Data Committee

Information model link:

NHIM Address element

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/1997	
NMDS - Admitted patient mental health care	01/07/1997	
NMDS - Community mental health care	01/07/2001	
NMDS - Admitted patient palliative care	01/07/2000	
NMDS - Non-admitted patient emergency department care	01/07/2003	

Comments:

Care type

Identifying and Definitional Attributes

Knowledgebase ID: 000168 **Version No:** 4

Metadata type: Data Element

Admin. status: Current
01/07/00

Definition: The care type defines the overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care).

Context: Admitted patient care and hospital activity:
For admitted patients, the type of care received will determine the appropriate casemix classification employed to classify the episode of care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: (N)N.N

Minimum size: 3

Maximum size: 4

Data domain:

- 1.0 Acute care (admitted care)
- 2.0 Rehabilitation care (admitted care)
- 2.1 Rehabilitation care delivered in a designated unit (optional)
- 2.2 Rehabilitation care according to a designated program (optional)
- 2.3 Rehabilitation care is the principal clinical intent (optional)
- 3.0 Palliative care
- 3.1 Palliative care delivered in a designated unit (optional)
- 3.2 Palliative care according to a designated program (optional)
- 3.3 Palliative care is the principal clinical intent (optional)
- 4.0 Geriatric evaluation and management
- 5.0 Psychogeriatric care
- 6.0 Maintenance care
- 7.0 Newborn care
- 8.0 Other admitted patient care
- 9.0 Organ procurement – posthumous (other care)
- 10.0 Hospital boarder (other care)

Guide for use: Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principal clinical intent of the care received.

Admitted care can be one of the following:

1.0 Acute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

2.0 Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in a designated rehabilitation unit (code 2.1)
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2)
- under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).

Optional

2.1 A designated rehabilitation care unit (code 2.1) is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

2.2 In a designated rehabilitation care program (code 2.2), care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

2.3 Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

3.0 Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- in a palliative care unit (code 3.1)
- in a designated palliative care program (code 3.2)
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3).

Optional

3.1 A designated palliative care unit (code 3.1) is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

3.2 In a designated palliative care program (code 3.2), care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

3.3 Palliative care as principal clinical intent (code 3.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

4.0 Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit
- in a designated geriatric evaluation and management program
- under the principal clinical management of a geriatric evaluation and management physician
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

5.0 Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatric care unit
- in a designated psychogeriatric care program
- under the principal clinical management of a psychogeriatric physician
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatric care.

6.0 Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting eg at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

7.0 Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are

- separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (e.g. transferred from another hospital) are admitted with newborn care type
- patients aged greater than 9 days not previously admitted (e.g. transferred from another hospital) are either boarders or admitted with an acute care type
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

8.0 Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above.

Other care can be one of the following:

9.0 Organ procurement – posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

10.0 Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Verification rules:

Collection methods:

Related metadata:

is used in conjunction with Number of qualified days for newborns vers 2
 is used in conjunction with Newborn qualification status, version 2
 supersedes previous data element Type of episode of care vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

Data Set Specifications:

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

Comments:

Unqualified newborn days (and separations consisting entirely of unqualified newborn days) are not to be counted under the Australian Health Care Agreements and they are ineligible for health insurance benefit purposes.

Country of birth

Identifying and Definitional Attributes

Knowledgebase ID: 000035 **Version No:** 3

Metadata type: Data Element

Admin. status: Current
01/07/01

Definition: The country in which the person was born.

Context: Country of birth is important in the study of access to services by different population sub-groups. Country of birth is the most easily collected and consistently reported of possible data items. The item provides a link between the Census of Population and Housing, other Australian Bureau of Statistics' (ABS) statistical collections and regional data collections. Country of birth may be used in conjunction with other data elements such as Period of residence in Australia, etc., to derive more sophisticated measures of access to services by different population sub-groups and may help in identifying population sub-group(s) that may be at increased risk of cardiovascular disease.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

Data domain: Standard Australian Classification of Countries (SACC) 4-digit (individual country) level. ABS catalogue no. 1269.0 (1998).

Guide for use: A country, even if it comprises other discrete political entities such as 'states', is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Verification rules: DSS - Health care client identification:
Country of birth for newborn babies should be 'Australia'.

Collection methods:

Related metadata: supersedes previous data element Country of birth vers 2

Administrative Attributes

Source document: ABS Catalogue No. 1269.0 (1998)

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Demographic characteristic

Data Set Specifications:

	Start date	End date
NMDS - Admitted patient care	01/07/2000	
NMDS - Admitted patient mental health care	01/07/2000	
NMDS - Perinatal	01/07/2001	
NMDS - Community mental health care	01/07/2001	
NMDS - Admitted patient palliative care	01/07/2001	
NMDS - Alcohol and other drug treatment services	01/07/2001	
NMDS - Non-admitted patient emergency department care	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments:

The Standard Australian Classification of Countries (SACC) (ABS 1269.0 1998) supersedes the Australian Standard Classification of Countries for Social Statistics (ASCCSS) which was reported in version 9 of the NHDD.

Date of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000036	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The date of birth of the person.		
Context:	Required to derive age at a point of time for clinical or administrative use. National Minimum Data Sets: Used for demographic analyses, for analysis by age and for use to derive a diagnosis related group (admitted patients).		

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:	If date of birth is not known, provision should be made to collect age (in years) and a date of birth derived from age.
Verification rules:	This field must not be null. For the provision of State and Territory hospital data to Commonwealth agencies this field must: <ul style="list-style-type: none"> - be less than or equal to Admission date - be consistent with diagnoses and procedure codes, for records to be grouped.
Collection methods:	It is recommended that in cases where all components of the date of birth are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.
Related metadata:	supersedes previous data element Date of birth vers 3 is used in the derivation of Diagnosis related group vers 1 is qualified by Estimated date flag vers 1 is used in the calculation of Length of stay (antenatal) 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 Demographic characteristic

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Health labour force	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
NMDS - Perinatal	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments:

Any new information collections should allow for 0000YYYY. (Refer Standards Australia, AS5017 Health care client identification).

Do not use punctuation (slashes or hyphens) or spaces.

In cases where all components of the date of birth are not known or where an estimate is arrived at from age, use 00 for day and 00 for month and estimate year of birth according to the person's approximate age. As soon as known or on re-presentation, always update the Date of Birth (DOB) field. The use of the Estimated date flag is also to be used to signify that an estimate is being made.

Establishment identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000050	Version No:	4
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	Identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.		

Context:

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	NNA(N)NNNNN
Minimum size:	9
Maximum size:	9

Data domain:	Concatenation of: State/Territory identifier (character position 1) Establishment sector (character position 2) Region code (character positions 3 - 4) Establishment number (character positions 5 - 9)
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Guide for use:

Verification rules:

Collection methods:

Related metadata:	supersedes previous data element Establishment identifier vers 3 is composed of Establishment number vers 4 is composed of Establishment sector vers 3 relates to the data element Person identifier vers 1 relates to the data element Person identifier type - health care vers 1 is composed of Region code vers 2 is composed of State/territory identifier vers 3
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Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee
Information model link:	
NHIM	Organisation characteristic

Data Set Specifications:

	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Community mental health establishments	01/07/2003	
NMDS - Elective surgery waiting times	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Public hospital establishments	01/07/2003	
DSS - Health care client identification	01/01/2003	

Comments:

Establishment identifier should be able to distinguish between all health care establishments nationally.

Funding source for hospital patient

Identifying and Definitional Attributes

Knowledgebase ID:	000632	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	Expected principal source of funds for an admitted patient episode or non-admitted patient service event.		
Context:	Admitted patient care.		
	Hospital non-admitted patient care.		

Relational and Representational Attributes

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

Data domain:	01	Australian Health Care Agreements
	02	Private health insurance
	03	Self-funded
	04	Worker's compensation
	05	Motor vehicle third party personal claim
	06	Other compensation (e.g. public liability, common law, medical negligence)
	07	Department of Veterans' Affairs
	08	Department of Defence
	09	Correctional facility
	10	Other hospital or public authority (contracted care)
	11	Reciprocal health care agreements (with other countries)
	12	Other
	99	Not known

Guide for use:	<p>The major funding source should be recorded if there is more than one source of funding. The final payment class recorded by the hospital should be used.</p> <p>Australian Health Care Agreements (category 1) should be recorded as the funding source for admitted patients who elect to be treated as public patients. However, overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as public patients (as detailed at www.health.gov.au/haf/docs/visthlth/2000hlth.htm#rhca) should be recorded as Reciprocal health care agreement (category 11).</p> <p>Self-funded (category 3) includes funded by the patient, by the patient's family or friends, or by other benefactors.</p> <p>Department of Veterans' Affairs (category 7) should be used for Department of Veterans' Affairs patients (as defined in the data element Department of Veterans' Affairs patient).</p>
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Compensable patients (as defined in the data element Compensable status), should be recorded as Worker's compensation (category 4), Motor vehicle third party personal claim (category 5) or Other compensation (category 6), as appropriate.

Overseas visitors for whom travel insurance is the major funding source should be recorded as Other (category 12).

Verification rules:

Collection methods:

Related metadata:

relates to the data element Admitted patient vers 3

relates to the data element Admitted patient election status vers 1

relates to the data element concept Non-admitted patient service event vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Insurance/benefit characteristic

Data Set Specifications:

	Start date	End date
NMDS - Admitted patient care	01/07/2001	
NMDS - Admitted patient mental health care	01/07/2001	
NMDS - Admitted patient palliative care	01/07/2001	

Comments:

Indigenous status

Identifying and Definitional Attributes

Knowledgebase ID:	000001	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. This is in accord with the first two of three components of the Commonwealth definition. See Comments for the Commonwealth definition.		
Context:	<p>Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area.</p> <p>The purpose of this data element is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin. Agencies wishing to determine the eligibility of individuals for particular benefits, services or rights will need to make their own judgements about the suitability of the standard measure for these purposes, having regard to the specific eligibility criteria for the program concerned.</p>		

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Code	
Representational layout:	N	
Minimum size:	1	
Maximum size:	1	
Data domain:	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
	9	Not stated/inadequately described

Guide for use:	<p>This data element is based on the Australian Bureau of Statistics' (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS web site as indicated below in the Source document section.</p> <p>The classification for 'Indigenous status' has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:</p> <p>Indigenous:</p> <ul style="list-style-type: none"> - Aboriginal but not Torres Strait Islander Origin - Torres Strait Islander but not Aboriginal Origin
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- both Aboriginal and Torres Strait Islander Origin

Non-indigenous:

- neither Aboriginal nor Torres Strait Islander Origin

Not stated/inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- primarily when importing data from other data collections that do not contain mappable data
- where an answer was refused
- where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

Verification rules:

Collection methods:

The standard question for Indigenous status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander Origin'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander Origin' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen-based data capture systems. An additional response category:

Yes, both Aboriginal and Torres Strait Islander.....

may be included if this better suits the data collection practices of the agency concerned.

Related metadata: supersedes previous data element Indigenous status vers 3

Administrative Attributes

Source document: Available on the ABS web site. From the ABS Home page (www.abs.gov.au) select: About Statistics/About Statistical Collections (Concepts & Classifications) /Other ABS Statistical Standards/Standards for Social Labour and Demographic Variables/Cultural Diversity Variables/Indigenous Status.

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments: The following definition, commonly known as 'The Commonwealth Definition' was given in a High Court judgement in the case of Commonwealth v Tasmania (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth Definition:

- descent
- self-identification
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Mode of admission

Identifying and Definitional Attributes

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

Relational and Representational Attributes

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

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

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

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

Comments:

Mode of separation

Identifying and Definitional Attributes

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

Relational and Representational Attributes

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

Data domain:	1	Discharge/transfer to an(other) acute hospital
	2	Discharge/transfer to a nursing home
	3	Discharge/transfer to an(other) psychiatric hospital
	4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals and hostels recognised by the Commonwealth Department of Health and Ageing, unless this is the usual place of residence)
	5	Statistical discharge - type change
	6	Left against medical advice/discharge at own risk
	7	Statistical discharge from leave
	8	Died
	9	Other (includes discharge to usual residence, own accommodation or welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Guide for use:	Code 4: In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of code 1.
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Verification rules:

Collection methods:

Related metadata:	is used in the derivation of Diagnosis related group vers 1
	is supplemented by the data element Source of referral to acute hospital or private psychiatric hospital vers 3
	is supplemented by the data element Source of referral to public psychiatric hospital vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Admitted patient care	01/07/2000	
NMDS - Admitted patient mental health care	01/07/1997	
NMDS - Admitted patient palliative care	01/07/2000	

Comments:

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

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:

Related metadata:

- relates to the data element Admission date vers 4
- 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:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:

Start date

End date

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.

Person identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000127	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	Person identifier unique within an establishment or agency.	
Context:	This item could be used for editing at the establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.	

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Identification number
Representational layout:	AN(20)
Minimum size:	6
Maximum size:	20
Data domain:	Valid person identification number.
Guide for use:	Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.
Verification rules:	Field cannot be blank.
Collection methods:	
Related metadata:	relates to the data element Establishment identifier vers 4 is qualified by Person identifier type – health care vers 1

Administrative Attributes

Source document: AS5017 Health care client identification (with adaptation)

Source organisation: National minimum data set working parties

Information model link:

NHIM Recipient role

Data Set Specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2000	
NMDS – Admitted patient mental health care	01/07/2000	
NMDS – Perinatal	01/07/1997	
NMDS – Community mental health care	01/07/2000	
NMDS – Admitted patient palliative care	01/07/2000	
NMDS – Alcohol and other drug treatment services	01/07/2000	
NMDS – Non-admitted patient emergency department care	01/07/2003	
DSS – Cardiovascular disease (clinical)	01/01/2003	
DSS – Health care client identification	01/01/2003	

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:

	Start date	End date
NMDS - Admitted patient mental health care	01/07/1999	
NMDS - Admitted patient palliative care	01/07/2000	

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.

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

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:	<p>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.</p> <p>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 2003.</p>
Verification rules:	<p>As a minimum requirement the Principal diagnosis code must be a valid code from ICD-10-AM (3rd edition).</p> <p>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.</p> <p>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.</p>

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:	Start date	End date
NMDS - Admitted patient care	01/07/1989	
NMDS - Admitted patient mental health care	01/07/1997	
NMDS - Community mental health care	01/07/1998	
NMDS - Admitted patient palliative care	01/07/2000	

Comments:

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: <ul style="list-style-type: none"> - 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.

Sex

Identifying and Definitional Attributes

Knowledgebase ID:	000149	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	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:	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

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.

Supporting data elements and data element concepts

Admission

Identifying and Definitional Attributes

Knowledgebase ID:	000007	Version No:	3
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/00		
Definition:	<p>Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.</p> <p>Formal admission: The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.</p> <p>Statistical admission: The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.</p>		
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 following admission 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:	<ul style="list-style-type: none"> supersedes previous data element 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 concept Episode of care vers 1 relates to the data element concept Separation vers 3

Administrative Attributes

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

Comments:

Admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: 000011 **Version No:** 3

Metadata type: Data Element Concept

Admin. status: Current
01/07/00

Definition: A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- the patient's condition requires clinical management and/or facilities not available in their usual residential environment
- the patient requires observation in order to be assessed or diagnosed
- the patient requires at least daily assessment of their medication needs
- the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation)
- there is a legal requirement for admission (e.g. under child protection legislation)
- the patient is aged nine days or less.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: This data element concept should be used in conjunction with the definition of same-day patient in the data element Same-day patient.
Part 2 of Schedule 3 of the *National Health Act* (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients.
All babies born in hospital are admitted patients.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Admitted patient vers 2
relates to the data element Care type vers 4
relates to the data element Newborn qualification status vers 2
relates to the data element Number of qualified days for newborns vers 2
relates to the data element Patient days vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Recipient role

Data Set Specifications:

Start date

End date

Comments:

This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Health Care Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn 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 Health Minister for the purpose of the provision of special care
- remains in hospital without its mother
- is admitted to the hospital without its mother.

Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian Health Care Agreements. Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Diagnosis

Identifying and Definitional Attributes

Knowledgebase ID:	000398	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/98		
Definition:	A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient.		
Context:	Health services:		
	Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.		

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element Additional diagnosis vers 4 relates to the data element Complication of labour and delivery vers 2 relates to the data element Complications of pregnancy vers 2 relates to the data element Congenital malformations vers 2 relates to the data element External cause – admitted patient vers 4 relates to the data element Maternal medical conditions vers 2 relates to the data element Neonatal morbidity vers 2 relates to the data element Postpartum complication vers 2 relates to the data element Principal diagnosis vers 3

Administrative Attributes

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

Comments:	<p>Classification systems which enable the allocation of a code to the diagnostic information:</p> <ul style="list-style-type: none"> International Classification of Diseases – Tenth Revision – Australian Modification (ICD-10-AM) British Paediatric Association Classification of Diseases North America Nursing Diagnosis Association International Classification of Primary Care International Classification of Impairments, Disabilities and Handicaps International Classification of Functioning
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Episode of care

Identifying and Definitional Attributes

Knowledgebase ID:	000445	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/00		
Definition:	The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.		
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 during an episode of care can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element concept Admission vers 3 relates to the data element concept Admission date vers 4 relates to the data element concept Admitted patient vers 3 relates to the data element Care type vers 4 relates to the data element concept Separation vers 3 relates to the data element Separation date vers 5

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:			

Establishment number

Identifying and Definitional Attributes

Knowledgebase ID:	000377	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	An identifier for an establishment, unique within the State or Territory.		
Context:	All health services.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Identification number
Representational layout:	NNNNN
Minimum size:	5
Maximum size:	5
Data domain:	Valid establishment number
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	is a composite part of Establishment identifier vers 4 supersedes previous data element Establishment number vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisation characteristic

Data Set Specifications:	Start date	End date
NMDS - Elective surgery waiting times	01/07/2003	
NMDS - Emergency department waiting times	01/07/2003	
NMDS - Public hospital establishments	01/07/2003	
DSS - Health care client identification	01/01/2003	

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.

Establishment number should be a unique code for the health care establishment used in that State/Territory or uniquely at a national level .

Establishment sector

Identifying and Definitional Attributes

Knowledgebase ID:	000379	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	A section of the health care industry with which a health care establishment can identify.		

Context:

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	1 Public
	2 Private

Guide for use:

Verification rules:

Collection methods:

Related metadata: is a composite part of Establishment identifier vers 4
supersedes previous data element Establishment sector vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisational setting

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2001	
NMDS - Elective surgery waiting times	01/07/2002	
NMDS - Admitted patient mental health care	01/07/2001	
NMDS - Perinatal	01/07/2001	
NMDS - Public hospital establishments	01/07/2001	
NMDS - Community mental health establishments	01/07/2001	
DSS - Health care client identification	01/01/2003	

Comments:

Hospital

Identifying and Definitional Attributes

Knowledgebase ID:	000064	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/94		
Definition:	A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.		
Context:	Admitted patient care, admitted patient palliative care, admitted patient mental health 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 Establishment sector vers 3

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Service delivery setting		
Data Set Specifications:		Start date	End date

Comments:	<p>A hospital thus defined may be located at one physical site or may be a multicampus hospital. A multicampus hospital treats movements of patients between sites as ward transfers.</p> <p>For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital.</p> <p>This definition includes, but is not limited to, hospitals as recognised under Australian Health Care Agreements.</p> <p>Residential aged care services as approved under the <i>National Health Act 1953</i> (Commonwealth) or equivalent State legislation are excluded from this definition.</p> <p>This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).</p>
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Hospital-in-the-home care

Identifying and Definitional Attributes

Knowledgebase ID:	000633	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/01		
Definition:	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.		
Context:	Admitted patient care.		

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: The criteria for inclusion as hospital-in-the-home include but are not limited to:

- without hospital-in-the-home care being available patients would be accommodated in the hospital
- the treatment forms all or part of an episode of care for an admitted patient (as defined in the Admitted patient data element concept)
- the hospital medical record is maintained for the patient
- there is adequate provision for crisis care.

Selection criteria for the assessment of suitable patients include but are not limited to:

- the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment
- the patient does not require continuous 24 hour assessment, treatment or observation
- the patient agrees to this form of treatment
- the patient's place of residence is safe and has carer support available;
- the patient's place of residence is accessible for crisis care
- the patient's place of residence has adequate communication facilities and access to transportation.

Verification rules:

Collection methods:

Related metadata: relates to the data element Admitted patient vers 3
relates to the data element concept Episode of care vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

National Minimum Data Set

Admitted patient palliative care

Information model link:

NHIM Service provision event

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.

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
NMDS - Admitted patient care	01/07/2000	
NMDS - Elective surgery waiting times	01/07/2000	
NMDS - Admitted patient mental health care	01/07/2000	
NMDS - Perinatal	01/07/1997	
NMDS - Public hospital establishments	01/07/2000	
NMDS - Community mental health establishments	01/07/2001	
DSS - Health care client identification	01/01/2003	

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:	<ul style="list-style-type: none"> 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.
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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:	<table> <tr><td>1</td><td>New South Wales</td></tr> <tr><td>2</td><td>Victoria</td></tr> <tr><td>3</td><td>Queensland</td></tr> <tr><td>4</td><td>South Australia</td></tr> <tr><td>5</td><td>Western Australia</td></tr> <tr><td>6</td><td>Tasmania</td></tr> <tr><td>7</td><td>Northern Territory</td></tr> <tr><td>8</td><td>Australian Capital Territory</td></tr> <tr><td>9</td><td>Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)</td></tr> </table>	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)
1	New South Wales																		
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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:	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 Number 1216.0

Source organisation: National Health Data Committee

Information model link:

NHIM Address element

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Public hospital establishments	01/07/2003	
DSS - Health care client identification	01/01/2003	

Comments: