

# Data Elements

## Ca – Cv

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## Capital expenditure

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000248 **Version No:** 1

**Metadata type:** Data Element

**Admin. status:** Current  
01/07/89

**Definition:** Gross capital expenditure is capital expenditure as reported by the particular establishment having regard to State health authority and other authoritative guidelines as to the differentiation between capital and recurrent expenditure (a concise indication of the basis on which capital and recurrent expenditure have been differentiated is to form part of national minimum data sets).

**Context:** Health expenditure:  
Capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Currency

**Representational layout:** \$999,999,999

**Minimum size:** 2

**Maximum size:** 12

**Data domain:** Amount of expenditure in Australian dollars rounded to the nearest dollar.

**Guide for use:** Record values up to hundreds of millions of dollars.

Calculate separately for each type described below:

1 Land and buildings:

This includes outlays on construction, major alterations and additions to buildings that relate to the establishment. Included are transfer and similar costs in respect of the purchase (sale) of second hand dwellings and installation of new permanent fixtures such as stoves, air conditioning, lighting, plumbing and other fixed equipment normally installed before dwellings are occupied. Costs relating to repair and maintenance replacement of buildings that amount to recurrent expenditure should not be included.

2 Computer equipment/installations:

Expenditure of a capital nature on computer installations and equipment such as mainframe computers, mini-computers, extensive personal computer networks and related hardware should be included here.

3 Major medical equipment:

Expenditure on major items of medical equipment such as CT scanners, MRI equipment, X-ray equipment, ICU monitors and transplant equipment should be included here.

## 4 Plant and (other) equipment:

Details of expenditure on plant and other equipment should be included here. Plant and/or equipment that is an integral part of any building or construction (and is thus included under expenditure on land and buildings), equipment included above under major medical equipment, motor vehicles and items of equipment that would normally be classified as recurrent expenditure should not be included.

## 5 Expenditure in relation to intangible assets:

This category bears specific regard to the private sector. Included here is any expenditure during the financial year in respect of intangible assets such as formation expenses or goodwill.

## 6 Other capital expenditure:

Any expenditure of a capital nature not included elsewhere should be included here. For example, if any State or establishment treats expenditure on new and second hand motor vehicles (including ambulances) as capital expenditure, this should be included as should any expenditure on furniture and fittings if treated by a State or establishment as expenditure of a capital nature.

**Verification rules:** Must be in Currency format

**Collection methods:**

**Related metadata:** relates to the data element Capital expenditure – gross (accrual accounting) vers 2

relates to the data element Capital expenditure – net (accrual accounting) vers 2

**Administrative Attributes****Source document:**

**Source organisation:** National minimum data set working parties

**Information model link:**

NHIM Capital expenditure

**Data Set Specifications:**

NMDS – Public hospital establishments

**Start date**

**End date**

01/07/1998

**Comments:**

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## Capital expenditure – gross (accrual accounting)

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### Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000325	<i>Version No:</i>	2
<i>Metadata type:</i>	Data Element		
<i>Admin. status:</i>	Current		
	01/07/97		
<i>Definition:</i>	Expenditure in a period on the acquisition or enhancement of an asset (excluding financial assets).		

*Context:* Health expenditure:

Gross capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

### Relational and Representational Attributes

<i>Datatype:</i>	Numeric
<i>Representational form:</i>	Currency
<i>Representational layout:</i>	\$999,999,999
<i>Minimum size:</i>	2
<i>Maximum size:</i>	12

*Data domain:* Amount of expenditure in Australian dollars rounded to the nearest dollar.

*Guide for use:* Record values up to hundreds of millions of dollars.

This definition is for use where the accrual method of accounting has been adopted.

Calculate separately for each type of capital expenditure described below:

- 1 Land:
 

A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.
- 2 Buildings and building services (including plant):
 

An edifice that has a service potential constructed, acquired or held by a financial lease for the specific purposes of the entity. Includes hospitals, residential aged care services and other buildings used for providing the service. Includes expenditure on installation, alteration and improvement of fixtures, facilities and equipment that are an integral part of the building and that contribute to the primary function of a building to either directly or indirectly support the delivery of products and services. Excludes repair and replacement of worn-out or damaged fixtures (to be treated as maintenance).
- 3 Constructions (other than buildings):
 

Expenditure on construction, major alterations and additions to fixed assets other than buildings such as car parks, roads, bridges, storm water channels, dams, drainage and sanitation systems, sporting facilities, gas, water and

electricity mains, communication systems, landscaping and grounds reticulation systems. Includes expenditure on land reclamation, land clearance and raising or levelling of building sites.

4-7 Equipment:

An asset, not an integral part of any building or construction, used by an entity to support the delivery of products and services. Items may be fixed or moveable.

4 Information technology:

Computer installations and equipment such as mainframe and mini-computers, personal computer networks and related hardware.

5 Major medical equipment:

Major items of medical equipment such as medical imaging (CT scanners, MRI, radiology), ICU monitors and transplant equipment.

6 Transport:

Expenditure on vehicles or equipment used for transport such as motor vehicles, aircraft, ships, railway, tramway rolling stock, and attachments (such as trailers). Includes major parts such as engines.

7 Other equipment:

Includes machinery and equipment not elsewhere classified, such as furniture, art objects, professional instruments and containers.

8 Intangible:

An asset which does not have physical substance, such as copyright, design, patent, trademark, franchise or licence.

**Verification rules:** Must be in currency format

**Collection methods:**

**Related metadata:** supersedes previous data element Capital expenditure vers 1  
relates to the data element Capital expenditure - net (accrual accounting) vers 2

## Administrative Attributes

**Source document:**

**Source organisation:** National minimum data set working parties

**Information model link:**

NHIM Capital expenditure

**Data Set Specifications:**

NMDS - Public hospital establishments

**Start date**

**End date**

01/07/1997

**Comments:**

The capital expenditure data elements on an accrual accounting basis and on a cash accounting basis will remain in use until all health authorities have adopted accrual accounting.

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## Capital expenditure – net (accrual accounting)

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### Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000396	<i>Version No:</i>	2
<i>Metadata type:</i>	Data Element		
<i>Admin. status:</i>	Current		
	01/07/97		
<i>Definition:</i>	Gross capital expenditure less trade-in values of replaced items and receipts from the sale of replaced or otherwise disposed items.		

*Context:* Health expenditure:

Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

### Relational and Representational Attributes

<i>Datatype:</i>	Numeric
<i>Representational form:</i>	Currency
<i>Representational layout:</i>	\$999,999,999
<i>Minimum size:</i>	2
<i>Maximum size:</i>	12

*Data domain:* Amount of expenditure in Australian dollars rounded to the nearest dollar.

*Guide for use:* Record values up to hundreds of millions of dollars.

This definition is for use where the accrual method of accounting has been adopted.

Calculate separately for each type of capital expenditure described below:

- 1 Land:
 

A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.
- 2 Buildings and building services (including plant):
 

An edifice that has a service potential constructed, acquired or held by a financial lease for the specific purposes of the entity. Includes hospitals, residential aged care services and other buildings used for providing the service. Includes expenditure on installation, alteration and improvement of fixtures, facilities and equipment that are an integral part of the building and that contribute to the primary function of a building to either directly or indirectly support the delivery of products and services. Excludes repair and replacement of worn-out or damaged fixtures (to be treated as maintenance).
- 3 Constructions (other than buildings):
 

Expenditure on construction, major alterations and additions to fixed assets other than buildings such as car parks, roads, bridges, storm water channels, dams, drainage and sanitation systems, sporting facilities, gas, water and

electricity mains, communication systems, landscaping and grounds reticulation systems. Includes expenditure on land reclamation, land clearance and raising or levelling of building sites.

4-7 Equipment:

An asset, not an integral part of any building or construction, used by an entity to support the delivery of products and services. Items may be fixed or moveable.

4 Information technology:

Computer installations and equipment such as mainframe and mini-computers, personal computer networks and related hardware.

5 Major medical equipment:

Major items of medical equipment such as medical imaging (CT scanners, MRI, radiology), ICU monitors and transplant equipment.

6 Transport:

Expenditure on vehicles or equipment used for transport such as motor vehicles, aircraft, ships, railway, tramway rolling stock, and attachments (such as trailers). Includes major parts such as engines.

7 Other equipment:

Includes machinery and equipment not elsewhere classified, such as furniture, art objects, professional instruments and containers.

8 Intangible:

An asset which does not have physical substance, such as copyright, design, patent, trademark, franchise or licence.

**Verification rules:** Must be in Currency format

**Collection methods:**

**Related metadata:** supersedes previous data element Capital expenditure vers 1  
relates to the data element Capital expenditure – gross (accrual accounting)  
vers 2

## Administrative Attributes

**Source document:**

**Source organisation:** National minimum data set working parties

**Information model link:**

NHIM Capital expenditure

**Data Set Specifications:**

NMDS - Public hospital establishments

**Start date**

**End date**

01/07/1997

**Comments:**

## Cardiovascular medication – current

### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000810	<b>Version No:</b> 1
<b>Metadata type:</b>	Data Element	
<b>Admin. status:</b>	Current	
	01/01/03	
<b>Definition:</b>	Whether the individual is taking some of the following cardiovascular medications: <ul style="list-style-type: none"> <li>- Angiotensin converting enzyme (ACE) inhibitors</li> <li>- Angiotensin II (A2) antagonists</li> <li>- Beta blockers</li> <li>- Calcium antagonists</li> </ul>	
<b>Context:</b>	Public health, health care and clinical settings.	

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Code

**Representational layout:** N

**Minimum size:** 1

**Maximum size:** 4

<b>Data domain:</b>	1	Angiotensin converting enzyme (ACE) inhibitors
	2	Angiotensin II (A2) receptor blockers
	3	Beta blockers
	4	Calcium antagonists
	8	None of the above
	9	Not stated/Inadequately described

<b>Guide for use:</b>	A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be recorded sequentially.	
	Code 1	ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril andtrandolapril).
	Code 2	Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan).
	Code 3	Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol).
	Code 4	Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil).
		<i>Example 1:</i> If a person takes one of the ACE inhibitors and a Beta blocker, the code recorded would be 13.
		<i>Example 2:</i> If a person takes one of the ACE inhibitors, an Angiotensin II receptor blocker and a Beta blocker, the code recorded would be 123.
	Code 8	is used when none of the listed medications is being taken by the person.

Code 9 should only be used in situations where it is not practicable to ask the questions.

**Verification rules:**

**Collection methods:**

The person should be asked a series of questions about any current medication for a cardiovascular condition as follows:

Are you currently taking any medication for a cardiovascular condition?

Yes  No

If the person answers 'NO', then code 8 should be applied.

If the person answers 'YES', then ask which one(s) (from the list of drugs in the Guide for use).

Ace Inhibitors  Yes  No

Angiotensin II receptor blockers  Yes  No

Beta blockers  Yes  No

Calcium antagonists  Yes  No

The appropriate code should be recorded for each type of medication currently in use.

**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 Date of birth vers 4

relates to the data element Hypertension – treatment vers 1

## Administrative Attributes

**Source document:**

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Australian Medicines Handbook: last modified by February 2001 Contents of Cardiovascular, Version 3, 1999 Therapeutic Guidelines Limited (05/042002).

**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**

**End date**

01/01/2003

**Comments:**

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## Care type

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### 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 e.g. 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 of 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:**

	<b>Start date</b>	<b>End date</b>
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.

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## Carer availability

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000022 **Version No:** 3

**Metadata type:** Data Element

**Admin. status:** Current  
01/01/03

**Definition:** Whether someone, such as a family member, friend or neighbour, has been identified as providing regular and sustained care and assistance to the person requiring care.

Carers include those people who receive a pension or benefit for their caring role but does not include paid or volunteer carers organised by formal services.

**Context:** Personal and social support, clinical settings:

Recent years have witnessed a growing recognition of the critical role that informal support networks play in caring for frail older people and people with disabilities within the community. Not only are informal carers responsible for maintaining people with often high levels of functional dependence within the community, but the absence of an informal carer is a significant risk factor contributing to institutionalisation. Increasing interest in the needs of carers and the role they play has prompted greater interest in collecting more reliable and detailed information about carers and the relationship between informal care and the provision of and need for formal services.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Code

**Representational layout:** N

**Minimum size:** 1

**Maximum size:** 1

**Data domain:**

1	Has no carer
2	Has a carer
9	Not stated/inadequately described

**Guide for use:** This data element is purely descriptive of a client's circumstances. It is not intended to reflect whether the carer is considered by the service provider to be capable of undertaking the caring role.

In line with this, the expressed views of the client and/or their carer should be used as the basis for determining whether the client is recorded as having a carer or not.

A carer is someone who provides a significant amount of care and/or assistance to the person on a regular and sustained basis. Excluded from the definition of carers are paid workers or volunteers organised by formal services (including paid staff in funded group houses). When asking a client about the availability of a carer, it is important for agencies to recognise that a carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the client does not have to live with the client in order to be called a carer.

The availability of a carer should also be distinguished from living with someone else. Although in many instances a co-resident will also be a carer, this

is not necessarily the case. The data element Living arrangement is designed to record information about person(s) with whom the client may live.

**Verification rules:**

**Collection methods:**

Agencies and service providers may collect this item at the beginning of each service episode and also assess this information at subsequent assessments or re-assessments. Some agencies/providers may record this information historically so that they can track changes over time. Historical recording refers to the practice of maintaining a record of changes over time where each change is accompanied by the appropriate date.

**Related metadata:**

supersedes previous data element Carer availability vers 2  
relates to the data element Formal support access status vers 1  
relates to the data element Living arrangement vers 1  
is used in conjunction with Service contact date vers 1

## Administrative Attributes

**Source document:** HACC Data Dictionary Version 1.0, 1998

**Source organisation:** Australian Institute of Health and Welfare

**Information model link:**

NHIM Request for/entry into service event

**Data Set Specifications:**

DSS - Cardiovascular disease (clinical)

**Start date**

**End date**

01/01/2003

**Comments:**

There is inconsistency between this definition of 'Carer availability' and the ABS definition of 'Principal carer', 1993 Disability, Ageing and Carers Survey and 'Primary carer' used in the 1998 survey. The Australian Bureau of Statistics definitions require that the carer has or will provide care for a certain amount of time and that they provide certain types of care. This may not be appropriate for community services agencies wishing to obtain information about a person's carer regardless of the amount of time that care is for or the types of care provided. Information such as the amount of time for which care is provided can of course be collected separately but, if it is not needed, it would place a burden on service providers.

DSS - Cardiovascular disease (clinical):

Informal carers are now present in 1 in 20 households in Australia (Schofield HL, Herrman HE, Bloch S, Howe A and Singh B. ANZ J PubH. 1997) and are acknowledged as having a very important role in the care of stroke survivors (Stroke Australia Task Force. National Stroke Strategy. NSF; 1997) and in those with end-stage renal disease.

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

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## Cataract – history

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000811	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes.		
<b>Context:</b>	Public health, health care and clinical settings.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1
<b>Data domain:</b>	<p>1 Cataract currently present or has been previously removed from the right eye</p> <p>2 Cataract currently present or has been previously removed from the left eye</p> <p>3 Cataract currently present or has been previously removed from both eyes</p> <p>4 No cataract present or has not been previously removed from either eye</p> <p>9 Not stated/inadequately described</p>

#### Guide for use:

#### Verification rules:

**Collection methods:** Examination of the lens of the eye through a dilated pupil (visible through the pupil by the use of an ophthalmoscope) by an ophthalmologist or optometrist, as a part of the ophthalmological assessment.

Ask the individual if he/she has a cataract in either or both eyes or has had a Cataract removed from either or both eyes previously. Alternatively obtain information from an ophthalmologist or optometrist or 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 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
- relates to the data element Visual acuity vers 1

## Administrative Attributes

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

**Source organisation:** National Diabetes Data Working Group

**Information model link:**

NHIM Physical wellbeing

**Data Set Specifications:**

DSS - Diabetes (clinical)

**Start date**

**End date**

01/01/2003

**Comments:**

Cataract is a clouding of the lens of the eye or its capsule sufficient to reduce vision. The formation of cataract occurs more rapidly in patients with a history of ocular trauma, uveitis, or diabetes mellitus. Cataract is an associated diabetic eye problem that could lead to blindness.

Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone vision-threatening complications. A comprehensive ophthalmological examination includes:

- check visual acuity with Snellen chart - correct with pinhole if indicated
- examine for cataract
- examine fundi with pupils dilated.

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## Category reassignment date

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000391	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/97		
<b>Definition:</b>	The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of clinical review for the awaited procedure, or is assigned to a different patient listing status category ('ready for care' or 'not ready for care').		
<b>Context:</b>	Elective surgery: This date is necessary for the calculation of Waiting time at removal from elective surgery waiting list and Waiting time at a census date.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	DATE
<b>Representational layout:</b>	DDMMYYYY
<b>Minimum size:</b>	8
<b>Maximum size:</b>	8
<b>Data domain:</b>	Valid date
<b>Guide for use:</b>	The date needs to be recorded each time a patient's urgency classification or listing status changes.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	relates to the data element Clinical review vers 1 is used in conjunction with Clinical urgency vers 2 is used in conjunction with Patient listing status vers 3 supersedes previous data element Urgency reassignment date vers 1 is used in the calculation of Waiting time at a census date vers 2 is used in the calculation of Waiting time at removal from elective surgery waiting list vers 2 is used in the calculation of Waiting time at removal from elective surgery waiting list vers 2

### Administrative Attributes

<b>Source document:</b>			
<b>Source organisation:</b>	National Health Data Committee		
<b>Information model link:</b>	NHIM Assessment event		
<b>Data Set Specifications:</b>		<b>Start date</b>	<b>End date</b>
NMDS - Elective surgery waiting times		01/07/1997	30/06/2002

**Comments:**

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## Census date

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000174	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/97		
<b>Definition:</b>	Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.		
<b>Context:</b>	Elective surgery: This data element is necessary for the calculation of the waiting time until a census.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric		
<b>Representational form:</b>	Date		
<b>Representational layout:</b>	DDMMYYYY		
<b>Minimum size:</b>	8		
<b>Maximum size:</b>	8		
<b>Data domain:</b>	Valid date		
<b>Guide for use:</b>	This date is recorded when a census is done of the patients on a waiting list.		
<b>Verification rules:</b>			
<b>Collection methods:</b>			
<b>Related metadata:</b>	supersedes previous data element Census date vers 1 is used in the calculation of Waiting time at a census date vers 2		

### Administrative Attributes

<b>Source document:</b>			
<b>Source organisation:</b>	National Health Data Committee		
<b>Information model link:</b>	NHIM Surveillance/monitoring event		
<b>Data Set Specifications:</b>		<b>Start date</b>	<b>End date</b>
NMDS - Elective surgery waiting times		01/07/1997	
<b>Comments:</b>			

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## Centrelink customer reference number

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000797	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	A personal identifier assigned by Centrelink for the purposes of identifying people (and organisations) eligible for specific services, including some public health care services, such as oral health services.		
<b>Context:</b>	All Health services.		

### Relational and Representational Attributes

<b>Datatype:</b>	Alphanumeric
<b>Representational form:</b>	Identification number
<b>Representational layout:</b>	NNNNNNNNNA
<b>Minimum size:</b>	0
<b>Maximum size:</b>	10
<b>Data domain:</b>	The reference number comprises 9 numeric characters and one alphabetic character.
<b>Guide for use:</b>	The Centrelink Customer Reference Number should only be collected from persons eligible to receive health services that are to be funded by Centrelink. The number may be reported to a Centrelink agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.
<b>Verification rules:</b>	
<b>Collection methods:</b>	The Centrelink Customer Reference Number is provided on 'Health Care Cards' and 'Pensioner Concession Cards'.

#### Related metadata:

### Administrative Attributes

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

<b>Comments:</b>	When a person accesses health services on the basis of being a Centrelink Customer, collection of the Centrelink Customer Reference Number is usually necessary. This data should not be collected and recorded if it is not needed to support the provision of such health services.
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## Cerebral stroke due to vascular disease – history

### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000812	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	Whether the individual has had a cerebral stroke due to vascular disease.		
<b>Context:</b>	Public health, health care and clinical settings.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric										
<b>Representational form:</b>	Code										
<b>Representational layout:</b>	N										
<b>Minimum size:</b>	1										
<b>Maximum size:</b>	1										
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>Cerebral stroke – occurred in the last 12 months</td> </tr> <tr> <td>2</td> <td>Cerebral stroke – occurred prior to the last 12 months</td> </tr> <tr> <td>3</td> <td>Cerebral stroke – occurred both in and prior to the last 12 months</td> </tr> <tr> <td>4</td> <td>No history of cerebral stroke due to vascular disease</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Cerebral stroke – occurred in the last 12 months	2	Cerebral stroke – occurred prior to the last 12 months	3	Cerebral stroke – occurred both in and prior to the last 12 months	4	No history of cerebral stroke due to vascular disease	9	Not stated/inadequately described
1	Cerebral stroke – occurred in the last 12 months										
2	Cerebral stroke – occurred prior to the last 12 months										
3	Cerebral stroke – occurred both in and prior to the last 12 months										
4	No history of cerebral stroke due to vascular disease										
9	Not stated/inadequately described										

#### Guide for use:

#### Verification rules:

**Collection methods:** Obtain this information from appropriate documentation or from the patient

#### 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 Hypertension – treatment vers 1

### Administrative Attributes

<b>Source document:</b>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
<b>Source organisation:</b>	National Diabetes Data Working Group		
<b>Information model link:</b>	NHIM Physical wellbeing		
<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>	
DSS – Diabetes (clinical)	01/01/2003		
<b>Comments:</b>	Cerebral stroke is a medical emergency condition with a high mortality rate, which is often recognised as a vascular complication of diabetes mellitus.		

The risk of stroke in patients with diabetes is at least twice that in non-diabetic patients according to Meigs et al. (Intern Med. 1998). Diabetes may increase actual stroke risk up to fivefold by increasing atheromatous deposits. Patients with diabetes who have a first stroke have 5-year survival rate reduced to 50% in comparison to non-diabetic stroke patients. The duration of diabetes clearly influences the severity of vascular disease. Atherosclerosis is more common and more severe earlier in the course of diabetes. In large arteries, plaque occurs from direct endothelial membrane injury, adverse balance of lipoproteins, and hyperinsulinemia (JAMA 1997). Small vessels are also affected more frequently than they are in non-diabetic stroke, resulting in an increased risk of lacunar stroke.

References:

Meigs J, Nathan D, Wilson P et al. Metabolic risk factors worsen continuously across the spectrum of non-diabetic glucose tolerance. *Ann Intern Med.* 1998; 128:524-533.

Gorelick PB, Sacco RL, Smith DB, et al. Prevention of a first stroke: a review of guidelines and a multidisciplinary consensus statement from the National Stroke Association. *JAMA* 1999; 281:1112-1120.

## Cessation of treatment episode for alcohol and other drugs

### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000422	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element Concept		
<b>Admin. status:</b>	Current		
	01/07/01		
<b>Definition:</b>	Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.		
<b>Context:</b>	Alcohol and other drug treatment services.		

### Relational and Representational Attributes

<b>Datatype:</b>	
<b>Representational form:</b>	
<b>Representational layout:</b>	
<b>Minimum size:</b>	
<b>Maximum size:</b>	
<b>Data domain:</b>	
<b>Guide for use:</b>	A client is identified as ceasing a treatment episode if one or more of the following apply: <ul style="list-style-type: none"> <li>- their treatment plan is completed</li> <li>- they have had no contact with the treatment provider for a period of three months, nor is there a plan in place for further contact</li> <li>- their 'principal drug of concern for alcohol and other drugs' has changed</li> <li>- their 'main treatment type for alcohol and other drugs' has changed</li> <li>- their 'treatment delivery setting for alcohol and other drugs' has changed</li> <li>- their treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice, transferred to another service provider, died etc).</li> </ul>
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	<p>supersedes previous data element Cessation of treatment vers 1</p> <p>relates to the data element Date of cessation of treatment episode for alcohol and other drugs vers 2</p> <p>relates to the data element Reason for cessation of treatment episode for alcohol and other drugs vers 2</p>

### Administrative Attributes

<b>Source document:</b>		
<b>Source organisation:</b>	Intergovernmental Committee on Drugs NMDS WG	
<b>Information model link:</b>		
NHIM	Exit/leave from service event	
<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>

**Comments:**

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## Cholesterol-HDL – measured

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000651	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	A person's measured high-density lipoprotein cholesterol (HDL-C).		
<b>Context:</b>	Public health, health care and clinical settings: The evidence is strong that HDL-C has a direct protective effect against the development of arteriosclerosis.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	N.NN
<b>Minimum size:</b>	2
<b>Maximum size:</b>	3
<b>Data domain:</b>	Measurement in mmol/L to 2 decimal places 9.99 Not measured/inadequately described
<b>Guide for use:</b>	When reporting, record whether or not the measurement of HDL Cholesterol was performed in a fasting specimen. 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 assessment should be recorded. DSS – Diabetes (clinical): When reporting, record absolute result of the most recent HDL Cholesterol measurement in the last 12 months to the nearest 0.01 mmol/L.
<b>Verification rules:</b>	
<b>Collection methods:</b>	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. <ul style="list-style-type: none"> <li>To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.</li> <li>Prolonged tourniquet use can artefactually increase levels by up to 20%.</li> </ul>
<b>Related metadata:</b>	is used in the calculation of Cholesterol-LDL calculated vers 1 relates to the data element Cholesterol-total – measured 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 Triglycerides – measured vers 1

## Administrative Attributes

**Source document:** National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines – 2001, MJA 2001; 175: S57–S88.

**Source organisation:** CV-Data Working Group  
National Diabetes Data Working Group

### Information model link:

NHIM Service provision event

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

### Comments:

DSS – Cardiovascular disease (clinical):

High-density lipoprotein cholesterol (HDL-C) is easily measured and has been shown to be a negative predictor of future coronary events.

An inverse relationship between the level of HDL-C and the risk of developing premature coronary heart disease (CHD) has been a consistent finding in a large number of prospective population studies. In many of these studies, the level of HDL-C has been the single most powerful predictor of future coronary events. Key studies of the relationship between HDLs and CHD include the Framingham Heart Study (Castelli et al. 1986), the PROCAM Study (Assman et al. 1998), the Helsinki Heart Study (Manninen et al. 1992) and the MRFIT study (Stamler et al. 1986; Neaton et al. 1992).

There are several well-documented functions of HDLs that may explain the ability of these lipoproteins to protect against arteriosclerosis (Barter and Rye 1996). The best recognised of these is the cholesterol efflux from cells promoted by HDLs in a process that may minimise the accumulation of foam cells in the artery wall. The major proteins of HDLs and also other proteins (e.g. paraoxonase) that co-transport with HDLs in plasma have anti-oxidant properties. Thus, HDLs have the ability to inhibit the oxidative modification of LDLs and may therefore reduce the atherogenicity of these lipoproteins.

Overall, it has been concluded from the prospective population studies that for every 0.025 mmol/L increase in HDL-C, the coronary risk is reduced by 2–5%. For a review of the relationship between HDL-C and CHD, see Barter and Rye (1996). A level below 1.0 mmol/L increases risk approximately 2-fold (Gordon et al. 1989; Assmann et al. 1998). (Lipid Management Guidelines – 2001, MJA 2001; 175: S57–S88.

In settings such as general practice where the monitoring of a person's health is ongoing and where a measure can change over time, the Service contact date should be recorded.

DSS – Diabetes (clinical):

Lowered HDL-C, with increased serum triglyceride and increased low-density lipoprotein cholesterol are important risk factors for vascular disease in type 2 diabetes.

In the NSW Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, recommendations are that HDL, total cholesterol, triglycerides are to be measured:

- every 1–2 years (if normal)
- every 3–6 months (if abnormal or on treatment)

and the target is:

- to increase HDL Cholesterol to more than or equal to 1.0 mmol/L
- to reduce total Cholesterol to less than 5.5 mmol/L

- to reduce triglyceride levels to less than 2.0 mmol/L.

If pre-existing cardiovascular disease (bypass surgery or myocardial infarction) total cholesterol should be less than 4.5 mmol/L. A level below 1.0 mmol/L increases risk approximately 2-fold (Gordon et al. 1989; Assmann et al. 1998), (Draft NHF Lipid Guidelines Paper 2001). It has been concluded from prospective population studies that for every 0.025 mmol/L increase in HDL-C, the coronary risk is reduced by 2-5%.

In settings such as general practice where the monitoring of a person's health is ongoing and where a measure can change over time, the date of assessment should be recorded.

References:

National Heart Foundation of Australia - Lipid Management Guidelines 2001.

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## Cholesterol-LDL – calculated

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000652	<b>Version No:</b>	1
<b>Metadata type:</b>	Derived Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	A person's calculated low-density lipoprotein cholesterol (LDL-C).		
<b>Context:</b>	Public health, health care and clinical setting.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	NN.N
<b>Minimum size:</b>	2
<b>Maximum size:</b>	3
<b>Data domain:</b>	Calculated value recorded in mmol/L to one decimal place
<b>Guide for use:</b>	Formula: LDL-C = (plasma total cholesterol) - (high-density lipoprotein cholesterol) - (fasting plasma triglyceride divided by 2.2).

### Verification rules:

<b>Collection methods:</b>	The LDL-C is usually calculated from the Friedwald Equation (Friedwald et al. 1972), which depends on knowing the blood levels of the total cholesterol and high-density lipoprotein cholesterol and the fasting level of the triglyceride. Note that the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L. Note also that while cholesterol 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.
	<ul style="list-style-type: none"> <li>• 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.</li> <li>• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.</li> </ul>

<b>Related metadata:</b>	is calculated using Cholesterol-HDL – measured vers 1
	is calculated using Cholesterol-total – measured vers 1
	is calculated using Fasting status vers 1
	is used in conjunction with Service contact date vers 1
	is calculated using Triglycerides – measured vers 1

### Administrative Attributes

<b>Source document:</b>	National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines, 2001, MJA 2001; 175: S57-S88.
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**Source organisation:** CV-Data Working Group

**Information model link:**

NHIM Service provision event

**Data Set Specifications:**

DSS - Cardiovascular disease (clinical)

**Start date**

**End date**

01/01/2003

**Comments:**

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease (CHD).

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

The majority of the cholesterol in plasma is transported as a component of LDL-C. Thus, the evidence linking CHD to plasma total cholesterol and LDL-C is essentially the same.

DSS - Cardiovascular disease (clinical):

Many studies have demonstrated the significance of blood cholesterol components as risk factors for heart, stroke and vascular disease.

Scientific studies have shown a continuous relationship between lipid levels and CHD and overwhelming evidence that lipid lowering interventions reduces CHD progression, morbidity and mortality.

There are many large-scale, prospective population studies defining the relationship between plasma total (and LDL) cholesterol and the future risk of developing CHD. The results of prospective population studies are consistent and support several general conclusions:

- the majority of people with CHD do not have markedly elevated levels of plasma total cholesterol or LDL-C
- there is a continuous positive but curvilinear relationship between the concentration of plasma total (and LDL) cholesterol and the risk of having a coronary event and of dying from CHD
- there is no evidence that a low level of plasma (or LDL) cholesterol predisposes to an increase in non-coronary mortality.

The excess non-coronary mortality at low cholesterol levels in the Honolulu Heart Study (Yano et al. 1983; Stemmermann et al. 1991) was apparent only in people who smoked and is consistent with a view that smokers may have occult smoking-related disease that is responsible for both an increased mortality and a low plasma cholesterol.

It should be emphasised that the prospective studies demonstrate an association between plasma total cholesterol and LDL-C and the risk of developing CHD. (Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88 and Commonwealth Department of Health & Ageing and Australian Institute of Health and Welfare (1999) National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra 14-17).

In settings such as general practice where the monitoring of a person's health is ongoing and where a measure can change over time, the service contact date should be recorded.

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## Cholesterol-total – measured

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000653 **Version No:** 1

**Metadata type:** Data Element

**Admin. status:** Current  
01/01/03

**Definition:** A person's measured total cholesterol (TC).

**Context:** Public health, health care and clinical settings.

### 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 one decimal place  
99.9 Not stated/Inadequately described

**Guide for use:** Record the absolute result of the TC measurement. When reporting, record whether or not the measurement of Cholesterol-total – measured was performed in a fasting specimen.  
DSS – Diabetes (clinical):  
When reporting, record absolute result of the most recent Cholesterol-total - measured in the last 12 months to the nearest 0.1 mmol/L.

### Verification rules:

**Collection methods:** 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.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

**Related metadata:** 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 Triglycerides – measured vers 1

### Administrative Attributes

**Source document:** National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines – 2001, MJA 2001; 175: S57–S88  
National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra.

The Royal College of Pathologists of Australasia web-based Manual of Use and Interpretation of Pathology Tests

**Source organisation:** CV-Data Working Group

**Information model link:**

NHIM Service provision event

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

**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 service contact date should be recorded.

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease.

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

DSS - Cardiovascular disease (clinical):

Scientific studies have shown a continuous relationship between lipid levels and coronary heart disease and overwhelming evidence that lipid lowering interventions reduce coronary heart disease progression, morbidity and mortality. Studies show a positive relationship between an individual's total blood cholesterol level and risk of coronary heart disease as well as death (Kannel & Gordon 1970; Pocock et al. 1989).

Many studies have demonstrated the significance of blood cholesterol components as risk factors for heart, stroke and vascular disease.

Several generalisations can be made from these cholesterol lowering trials:

- That the results of the intervention trials are consistent with the prospective population studies in which (excluding possible regression dilution bias) a 1.0 mmol/L reduction in plasma total cholesterol translates into an approximate 20% reduction in the risk of future coronary events.
- It should be emphasised, however, that this conclusion does not necessarily apply beyond the range of cholesterol levels which have been tested in these studies.
- That the benefits of cholesterol lowering are apparent in people with and without coronary artery disease.

There is high level evidence that in patients with existing coronary heart disease, lipid intervention therapy reduces the risk of subsequent stroke.

DSS - Diabetes (clinical):

The risk of coronary and other macrovascular disorders is 2-5 times higher in people with diabetes than in non-diabetic subjects and increases in parallel with the degree of dyslipidaemia.

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, the targets for lipids management are:

- to reduce total cholesterol to less than 5.5 mmol/L
- to reduce triglyceride levels to less than 2.0 mmol/L
- to increase HDL-C to more than or equal to 1.0 mmol/L.

If pre-existing cardiovascular disease (bypass surgery or myocardial infarction), total cholesterol should be less than 4.5 mmol/L.

Large clinical trials have shown that people at highest risk of cardiovascular events (e.g. pre-existing ischaemic heart disease) will derive the greatest benefit from lipid lowering drugs. For this group of patients, the optimum threshold plasma lipid concentration for drug treatment is still a matter of research. In May 1999 the PBS threshold total cholesterol concentration, for subsidy of drug treatment, was reduced from 5.5 to 4.0 mmol/L. (Australian Medical Handbook).

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## Classification of health labour force job

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000023 **Version No:** 1

**Metadata type:** Data Element

**Admin. status:** Current  
01/07/95

**Definition:** Position or job classification is a broad description of the roles and levels within a general organisational or industrial structure for health professions, and classifications vary among the professions according to organisational arrangements.

**Context:** Health labour force:  
Distribution of a professional labour force across job classification categories cross classified with other variables allows analysis of:

- career progression
- age and gender distribution
- imputed salary/wage distribution.

### Relational and Representational Attributes

**Datatype:** Alphanumeric

**Representational form:** Code

**Representational layout:** ANN

**Minimum size:** 3

**Maximum size:** 3

**Data domain:**

- A01 Medicine - General practitioner working mainly in general practice
- A02 Medicine - General practitioner working mainly in a special interest area
- A03 Medicine - Salaried non-specialist hospital practitioner: RMO or intern
- A04 Medicine - Salaried non-specialist hospital practitioner: other hospital career medical officer
- A05 Medicine - Specialist
- A06 Medicine - Specialist in training (e.g. registrar)
- B01 Dentistry (private practice only) - Solo practitioner
- B02 Dentistry (private practice only) - Solo principal with assistant(s)
- B03 Dentistry (private practice only) - Partnership
- B04 Dentistry (private practice only) - Associateship
- B05 Dentistry (private practice only) - Assistant
- B06 Dentistry (private practice only) - Locum
- C01 Nursing - Enrolled nurse
- C02 Nursing - Registered nurse
- C03 Nursing - Clinical nurse
- C04 Nursing - Clinical nurse consultant/supervisor
- C05 Nursing - Nurse manager
- C06 Nursing - Nurse educator
- C07 Nursing - Nurse researcher

- C08 Nursing – Assistant director of nursing
- C09 Nursing – Deputy director of nursing
- C10 Nursing – Director of nursing
- C11 Nursing – Tutor/lecturer/senior lecturer in nursing (tertiary institution)
- C12 Nursing – Associate professor/professor in nursing (tertiary institution)
- C98 Nursing – Other (specify)
- C99 Nursing – Unknown/inadequately described/not stated
- D01 Pharmacy (Community pharmacist) – Sole proprietor
- D02 Pharmacy (Community pharmacist) – Partner-proprietor
- D03 Pharmacy (Community pharmacist) – Pharmacist-in-charge
- D04 Pharmacy (Community pharmacist) – Permanent assistant
- D05 Pharmacy (Community pharmacist) – Reliever, regular location
- D06 Pharmacy (Community pharmacist) – Reliever, various locations
- E01 Pharmacy (Hospital/clinic pharmacist) – Director/deputy director
- E02 Pharmacy (Hospital/clinic pharmacist) – Grade III pharmacist
- E03 Pharmacy (Hospital/clinic pharmacist) – Grade II pharmacist
- E04 Pharmacy (Hospital/clinic pharmacist) – Grade I pharmacist
- E05 Pharmacy (Hospital/clinic pharmacist) – Sole pharmacist
- F01 Podiatry – Own practice (or partnership)
- F02 Podiatry – Own practice and sessional appointments elsewhere
- F03 Podiatry – Own practice and fee-for-service elsewhere
- F04 Podiatry – Own practice, sessional and fee-for-service appointments elsewhere
- F05 Podiatry – Salaried podiatrist
- F06 Podiatry – Locum, regular location
- F07 Podiatry – Locum, various locations
- F08 Podiatry – Other (specify)
- G01 Physiotherapy – Own practice (or partnership)
- G02 Physiotherapy – Own practice and sessional appointments elsewhere
- G03 Physiotherapy – Own practice and fee-for-service elsewhere
- G04 Physiotherapy – Own practice, sessional and fee-for-service appointments elsewhere
- G05 Physiotherapy – Salaried physiotherapist
- G06 Physiotherapy – Locum, regular location
- G07 Physiotherapy – Locum, various locations

***Guide for use:******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

**End date****Comments:**

Position or job classifications are specific to each profession and may differ by State or Territory. The classifications above are simplified so that comparable data presentation is possible and possible confounding effects of enterprise-specific structures are avoided. For example, for medicine, the job classification collected in the national health labour force collection is very broad. State/Territory health authorities have more detailed classifications for salaried medical practitioners in hospitals.

These classifications separate interns, the resident medical officer levels, registrar levels, career medical officer positions, and supervisory positions including clinical and medical superintendents. Space restrictions do not at present permit these classes to be included in the National Health Labour Force Collection questionnaire.

## Client type – alcohol and other drug treatment services

### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000426	<b>Version No:</b>	3
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/03		
<b>Definition:</b>	The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person.		

<b>Context:</b>	Alcohol and other drug treatment services: Required to differentiate between clients according to whether the treatment episode concerns their own alcohol and/or other drug use or that of another person to provide a basis for description of the people accessing alcohol and other drug treatment services.
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### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1
<b>Data domain:</b>	1 Own alcohol or other drug use 2 Other's alcohol or other drug use
<b>Guide for use:</b>	Code 1 A client who receives treatment or assistance concerning their own alcohol and/or other drug use. Code 2 A client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person. Where a client is receiving treatment or assistance for both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person code to 1.
<b>Verification rules:</b>	
<b>Collection methods:</b>	To be collected on commencement of a treatment episode with a service. For clients covered under code 2, exclude the collection of the following data elements: Principal drug of concern, Other drugs of concern, Injecting drug use and Method of use for principal drug of concern.
<b>Related metadata:</b>	supersedes previous data element Client type – alcohol and other drug treatment services vers 2 is a qualifier of Injecting drug use status vers 2 is a qualifier of Method of use for principal drug of concern vers 1 is a qualifier of Other drug of concern vers 2 is a qualifier of Principal drug of concern vers 2

## Administrative Attributes

**Source document:**

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

**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:**

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## Clinical intervention

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000399	<b>Version No:</b> 1
<b>Metadata type:</b>	Data Element Concept	
<b>Admin. status:</b>	Current	
	01/07/99	
<b>Definition:</b>	<p>An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.</p> <p>Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.</p> <p>Invasive:</p> <p>(a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device)</p> <p>(b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).</p> <p>Non-invasive:</p> <p>Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).</p> <p>Cognitive:</p> <p>An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).</p>	
<b>Context:</b>	<p>Health services:</p> <p>Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.</p>	

### Relational and Representational Attributes

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

### Administrative Attributes

<b>Source document:</b>	
<b>Source organisation:</b>	National Health Data Committee

**Information model link:**

NHIM Service provision event

**Data Set Specifications:**

*Start date*

*End date*

**Comments:**

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## Clinical review

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000024	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element Concept		
<b>Admin. status:</b>	Current		
	01/07/95		
<b>Definition:</b>	The examination of a patient by a clinician after the patient has been added to the waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.		
<b>Context:</b>	Admitted patient care.		

### Relational and Representational Attributes

<b>Datatype:</b>	
<b>Representational form:</b>	
<b>Representational layout:</b>	
<b>Minimum size:</b>	
<b>Maximum size:</b>	
<b>Data domain:</b>	
<b>Guide for use:</b>	
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	relates to the data element Clinical urgency vers 2

### Administrative Attributes

<b>Source document:</b>			
<b>Source organisation:</b>	Hospital Access Program Waiting List Working Group National Health Data Committee		
<b>Information model link:</b>	NHIM Assessment event		
<b>Data Set Specifications:</b>		<b>Start date</b>	<b>End date</b>
<b>Comments:</b>			

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## Clinical urgency

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000025	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/97		
<b>Definition:</b>	A clinical assessment of the urgency with which a patient requires elective hospital care.		
<b>Context:</b>	Elective surgery: Categorisation of waiting list patients by clinical urgency assists hospital management and clinicians in the prioritisation of their workloads. It gives health consumers a reasonable estimate of the maximum time they should expect to wait for care. Clinical urgency classification allows a meaningful measure of system performance to be calculated, namely the number or proportion of patients who wait for times in excess of the maximum desirable time limit for their urgency category (data element 'Overdue patient').		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1
<b>Data domain:</b>	<ol style="list-style-type: none"> <li>1 Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency</li> <li>2 Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency</li> <li>3 Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency</li> </ol>
<b>Guide for use:</b>	The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	<ul style="list-style-type: none"> <li>is used in conjunction with Category reassignment date vers 2</li> <li>relates to the data element concept Clinical review vers 1</li> <li>is a qualifier of Extended wait patient vers 1</li> <li>is a qualifier of Overdue patient vers 3</li> <li>is used in conjunction with Patient listing status vers 3</li> <li>is a qualifier of Waiting time at a census date vers 2</li> <li>is a qualifier of Waiting time at removal from elective surgery waiting list vers 2</li> </ul>

## Administrative Attributes

**Source document:**

**Source organisation:** National Health Data Committee

**Information model link:**

NHIM Assessment event

**Data Set Specifications:**

NMDS - Elective surgery waiting times

**Start date**

**End date**

01/07/1997

**Comments:**

A patient's classification may change if he or she undergoes clinical review during the waiting period. 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).

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## Commencement of treatment episode for alcohol and other drugs

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000427	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element Concept		
<b>Admin. status:</b>	Current		
	01/07/01		
<b>Definition:</b>	Commencement of a treatment episode for alcohol and other drugs is the first service contact when assessment and/or treatment occurs with the treatment provider.		
<b>Context:</b>	Alcohol and other drug treatment services.		

### Relational and Representational Attributes

<b>Datatype:</b>	
<b>Representational form:</b>	
<b>Representational layout:</b>	
<b>Minimum size:</b>	
<b>Maximum size:</b>	
<b>Data domain:</b>	
<b>Guide for use:</b>	A client is identified as commencing a treatment episode if one or more of the following apply: <ul style="list-style-type: none"> <li>- they are a new client</li> <li>- they are a client recommencing treatment after they have had had no contact with the treatment provider for a period of three months or had any plan in place for further contact</li> <li>- their Principal drug of concern for alcohol and other drugs has changed</li> <li>- their Main treatment type for alcohol and other drugs has changed</li> <li>- their Treatment delivery setting for alcohol and other drugs has changed.</li> </ul>
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	supersedes previous data element Commencement of treatment vers 1 relates to the data element Date of commencement of treatment episode for alcohol and other drugs vers 2

### Administrative Attributes

<b>Source document:</b>			
<b>Source organisation:</b>	Intergovernmental Committee on Drugs NMDS WG		
<b>Information model link:</b>	NHIM Request for/entry into service event		
<b>Data Set Specifications:</b>		<b>Start date</b>	<b>End date</b>

**Comments:**

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## Compensable status

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000026	<b>Version No:</b>	3
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/00		
<b>Definition:</b>	<p>A compensable patient is an individual who is entitled to receive or has received a compensation payment with respect to an injury or disease.</p> <p>A compensable patient is a person who:</p> <ul style="list-style-type: none"> <li>- is entitled to claim damages under Motor Vehicle Third Party insurance or</li> <li>- is entitled to claim damages under worker's compensation or</li> <li>- has an entitlement to claim under public liability or common law damages.</li> </ul>		
<b>Context:</b>	To assist in the analyses of utilisation and health care funding.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric						
<b>Representational form:</b>	Code						
<b>Representational layout:</b>	N						
<b>Minimum size:</b>	1						
<b>Maximum size:</b>	1						
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>Compensable</td> </tr> <tr> <td>2</td> <td>Non-compensable</td> </tr> <tr> <td>9</td> <td>Not stated/not known</td> </tr> </table>	1	Compensable	2	Non-compensable	9	Not stated/not known
1	Compensable						
2	Non-compensable						
9	Not stated/not known						

**Guide for use:** This definition excludes eligible beneficiaries (Department of Veterans' Affairs), Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.

DVA beneficiaries are identified by the data element Department of Veterans' Affairs patient.

**Verification rules:**

**Collection methods:**

**Related metadata:** supersedes previous data element Compensable status vers 2

### Administrative Attributes

**Source document:**

**Source organisation:** National Health Data Committee

**Information model link:**

NHIM Insurance/benefit characteristic

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
NMDS - Admitted patient care	01/07/2000	30/06/2001
NMDS - Non-admitted patient emergency department care	01/07/2003	

**Comments:**

In Version 9 of the Dictionary, the data elements Admitted patient election status, Medicare eligibility status, Compensable status and Department of Veterans' Affairs patient were collected in the NMDS - Admitted patient care in order to determine from where funding for a patient was obtained.

From Version 10, the data elements Compensable status and Department of Veterans' Affairs patient are replaced in the NMDS from 01/07/2001 with the data element Funding source for hospital patient.

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## Complication of labour and delivery

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000027	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/98		
<b>Definition:</b>	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.		
<b>Context:</b>	Perinatal statistics: Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.		

### Relational and Representational Attributes

<b>Datatype:</b>	Alphanumeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	ANN.NN
<b>Minimum size:</b>	3
<b>Maximum size:</b>	6
<b>Data domain:</b>	ICD-10-AM 3rd edition
<b>Guide for use:</b>	There is no arbitrary limit on the number of conditions specified.
<b>Verification rules:</b>	Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM
<b>Collection methods:</b>	
<b>Related metadata:</b>	<p>supersedes previous data element Complication of labour and delivery – ICD-9-CM code vers 1</p> <p>is used in conjunction with Method of birth vers 1</p> <p>is used in conjunction with Perineal status vers 2</p> <p>is used in conjunction with Postpartum complication vers 2</p> <p>is used in conjunction with Presentation at birth vers 1</p>

### Administrative Attributes

<b>Source document:</b>	International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002) National Centre for Classification in Health, Sydney.		
<b>Source organisation:</b>	National Perinatal Data Development Committee		
<b>Information model link:</b>	NHIM Birth event		
<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>	

**Comments:**

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## Complications of pregnancy

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000028	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/98		
<b>Definition:</b>	Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.		
<b>Context:</b>	Perinatal statistics: Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the foetus and perinatal morbidity.		

### Relational and Representational Attributes

<b>Datatype:</b>	Alphanumeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	ANN.NN
<b>Minimum size:</b>	3
<b>Maximum size:</b>	6
<b>Data domain:</b>	ICD-10-AM 3rd edition disease codes
<b>Guide for use:</b>	Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.
<b>Verification rules:</b>	Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM
<b>Collection methods:</b>	
<b>Related metadata:</b>	supersedes previous data element Complications of pregnancy – ICD-9-CM code vers 1 is used in conjunction with Maternal medical conditions vers 2

### Administrative Attributes

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

**Comments:**

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## Congenital malformations

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000030	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/98		
<b>Definition:</b>	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.		
<b>Context:</b>	Admitted patient care: Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.		

### Relational and Representational Attributes

<b>Datatype:</b>	Alphanumeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	ANN.NN
<b>Minimum size:</b>	3
<b>Maximum size:</b>	6
<b>Data domain:</b>	ICD-10-AM 3rd edition
<b>Guide for use:</b>	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see the data element Congenital malformations – BPA classification).
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	supersedes previous data element Congenital malformations – ICD-9-CM code vers 1 is used in conjunction with Neonatal morbidity vers 2

### Administrative Attributes

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

**Comments:**

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## Congenital malformations – BPA code

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000029	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/96		
<b>Definition:</b>	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.		
<b>Context:</b>	Perinatal statistics: Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	ANNNN
<b>Minimum size:</b>	5
<b>Maximum size:</b>	5
<b>Data domain:</b>	British Paediatric Association (BPA) Classification of Diseases (1979)
<b>Guide for use:</b>	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. NMDS – Perinatal: Use of BPA codes is preferred as this is more detailed.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	is used in conjunction with Neonatal morbidity vers 2

### Administrative Attributes

<b>Source document:</b>	British Paediatric Association Classification of Diseases (1979)		
<b>Source organisation:</b>	National Perinatal Data Development Committee		
<b>Information model link:</b>	NHIM Physical wellbeing		
<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>	

**Comments:** There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the States and Territories have used the 5-digit British Paediatric Association (BPA) Classification of Diseases to code congenital malformations since the early 1980s.

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## Contract establishment identifier

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000416	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/00		
<b>Definition:</b>	The establishment identifier of the other hospital involved in the contracted care.		
<b>Context:</b>	Admitted patient care and public hospital establishments.		

### Relational and Representational Attributes

<b>Datatype:</b>	Alphanumeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	NNANNN
<b>Minimum size:</b>	6
<b>Maximum size:</b>	6
<b>Data domain:</b>	Valid list of establishment numbers
<b>Guide for use:</b>	The contracted hospital will record the establishment identifier of the contracting hospital. The contracting hospital will record the establishment identifier of the contracted hospital.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	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 Establishment identifier vers 4 relates to the data element Total contract patient days vers 1

### Administrative Attributes

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

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## Contract procedure flag

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000417	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/00		
<b>Definition:</b>	Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service.		
<b>Context:</b>	Admitted patient care.		

### Relational and Representational Attributes

<b>Datatype:</b>	Alphanumeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1
<b>Data domain:</b>	<p>1 Contracted admitted procedure</p> <p>2 Contracted non-admitted procedure</p> <p>Otherwise blank</p>

<b>Guide for use:</b>	<p>Procedures performed at another hospital under contract (Hospital B) are recorded by both hospitals, but flagged by the contracting hospital only (Hospital A). This flag is to be used by the contracting hospital to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service.</p> <p>Allocation of procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.</p> <p>Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate. Some jurisdictions may require these to be separately identified and they could be distinguished from contracted hospital procedures through the use of an additional code in the contract procedure flag data item.</p>
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### Verification rules:

### Collection methods:

<b>Related metadata:</b>	relates to the data element Contract establishment identifier 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 Total contract patient days vers 1

## Administrative Attributes

*Source document:*

*Source organisation:*

*Information model link:*

NHIM Request for/entry into service event

*Data Set Specifications:*

*Start date*

*End date*

*Comments:*

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## Contract role

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000418	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/00		
<b>Definition:</b>	Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital).		
<b>Context:</b>	Admitted patient care and public hospital establishments.		

### Relational and Representational Attributes

<b>Datatype:</b>	Alphabetic
<b>Representational form:</b>	Code
<b>Representational layout:</b>	A
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1
<b>Data domain:</b>	A Hospital A B Hospital B
<b>Guide for use:</b>	Hospital A is the contracting hospital (purchaser). Hospital B is the contracted hospital (provider).
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	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 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 Total contract patient days vers 1

### Administrative Attributes

<b>Source document:</b>		
<b>Source organisation:</b>		
<b>Information model link:</b>		
NHIM Organisation role		
<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
<b>Comments:</b>		

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## Contract type

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000419	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/00		
<b>Definition:</b>	Contract type describes the contract arrangement between the contractor and the contracted hospital. Contract types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.		
<b>Context:</b>	Admitted patient care and public hospital establishments.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1
<b>Data domain:</b>	<ul style="list-style-type: none"> <li>1 Contract type B</li> <li>2 Contract type ABA</li> <li>3 Contract type AB</li> <li>4 Contract type (A)B</li> <li>5 Contract type BA</li> </ul>

<b>Guide for use:</b>	<p>The contracting hospital (purchaser) is termed Hospital A. The contracted hospital (provider) is termed Hospital B.</p> <p>1 Contract type B: A health authority/other external purchaser contracts hospital B for admitted service which is funded outside the standard funding arrangements.</p> <p>2 Contract type ABA: Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient returns to Hospital A on completion of service by Hospital B. For example, a patient has a hip replacement at Hospital A, then receives aftercare at Hospital B, under contract to Hospital A. Complications arise and the patient returns to Hospital A for the remainder of care.</p> <p>3 Contract type AB: Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient does not return to Hospital A on completion of service by Hospital B. For example, a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.</p>
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**4 Contract type (A)B:**

This Contract type occurs where a Hospital A contracts Hospital B for the whole episode of care. The patient does not attend Hospital A. For example, a patient is admitted for endoscopy at Hospital B under contract to Hospital A.

**5 Contract type BA:**

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care.

For example, a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after-care.

**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 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 Total contract patient days vers 1

**Administrative Attributes****Source document:****Source organisation:****Information model link:**

NHIM Organisation role

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

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## Contracted care commencement date

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000420	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/00		
<b>Definition:</b>	The date the period of contracted care commenced.		
<b>Context:</b>	Admitted patient care.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Date
<b>Representational layout:</b>	DDMMYYYY
<b>Minimum size:</b>	8
<b>Maximum size:</b>	8
<b>Data domain:</b>	Valid date
<b>Guide for use:</b>	This item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	<ul style="list-style-type: none"> <li>relates to the data element Contract establishment identifier vers 1</li> <li>relates to the data element Contract procedure flag vers 1</li> <li>relates to the data element Contract role vers 1</li> <li>relates to the data element Contract type vers 1</li> <li>relates to the data element Contracted care completion date vers 1</li> <li>relates to the data element Contracted hospital care vers 1</li> <li>relates to the data element Total contract patient days vers 1</li> </ul>

### Administrative Attributes

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

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## Contracted care completion date

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000428	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/00		
<b>Definition:</b>	The date the period of contracted care is completed.		
<b>Context:</b>	Admitted patient care.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Date
<b>Representational layout:</b>	DDMMYYYY
<b>Minimum size:</b>	8
<b>Maximum size:</b>	8
<b>Data domain:</b>	Valid date
<b>Guide for use:</b>	This item is to be used by the contracting hospital to record the date of completion of the contracted hospital care and will be the separation date for the contracted hospital.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	<ul style="list-style-type: none"> <li>relates to the data element Contract establishment identifier vers 1</li> <li>relates to the data element Contract procedure flag vers 1</li> <li>relates to the data element Contract role vers 1</li> <li>relates to the data element Contract type vers 1</li> <li>relates to the data element Contracted care commencement date vers 1</li> <li>relates to the data element Contracted hospital care vers 1</li> <li>relates to the data element Total contract patient days vers 1</li> </ul>

### Administrative Attributes

<b>Source document:</b>		
<b>Source organisation:</b>		
<b>Information model link:</b>		
NHIM	Exit/leave from service event	
<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
<b>Comments:</b>		

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## Contracted hospital care

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### Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000337	<i>Version No:</i>	1
<i>Metadata type:</i>	Data Element Concept		
<i>Admin. status:</i>	Current		
	01/07/00		
<i>Definition:</i>	Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).		
<i>Context:</i>	Admitted patient care.		

### Relational and Representational Attributes

*Datatype:*

*Representational form:*

*Representational layout:*

*Minimum size:*

*Maximum size:*

*Data domain:*

*Guide for use:*

Related contracted hospital care data items should only be completed where services are provided which represent some, but not all of the contracted hospital's total services. It is not necessary to complete contracted hospital care data items where all of the hospital services are contracted by a health authority, e.g. privately owned and/or operated public hospitals.

Contracted hospital care must involve all of the following:

- a purchaser, which can be a public or private hospital, or a health authority (department or region) or another external purchaser
- a contracted hospital, which can be a public or private hospital or day procedure centre
- the purchaser paying the contracted hospital for the contracted service; thus, services provided to a patient in a separate facility during their episode of care, where the patient is directly responsible for payment of this additional service, are not considered contracted services for reporting purposes
- the patient being physically present in the contracted hospital for the provision of the contracted service.

Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for reporting purposes.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (ie not a recognised hospital) should be coded if appropriate but are not considered to be contracted hospital procedures.

Any DRG derived for episodes involving contracted hospital care, should reflect the total treatment provided (all patient days and procedures), even where part of the treatment was provided under contract by another hospital.

**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 Inter-hospital same-day contracted patient vers 2  
 relates to the data element Total contract patient days vers 1

**Administrative Attributes****Source document:****Source organisation:****Information model link:**

NHIM Service provision event

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

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## Coronary artery disease – history of intervention or procedure

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000813	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent.		
<b>Context:</b>	Public health, health care and clinical settings.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric										
<b>Representational form:</b>	Code										
<b>Representational layout:</b>	N										
<b>Minimum size:</b>	1										
<b>Maximum size:</b>	1										
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>CABG, angioplasty or stent – undertaken in last 12 months</td> </tr> <tr> <td>2</td> <td>CABG, angioplasty or stent – undertaken prior to the last 12 months</td> </tr> <tr> <td>3</td> <td>CABG, angioplasty or stent – both within and prior to the last 12 months</td> </tr> <tr> <td>4</td> <td>No CABG, angioplasty or stent undertaken</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	CABG, angioplasty or stent – undertaken in last 12 months	2	CABG, angioplasty or stent – undertaken prior to the last 12 months	3	CABG, angioplasty or stent – both within and prior to the last 12 months	4	No CABG, angioplasty or stent undertaken	9	Not stated/inadequately described
1	CABG, angioplasty or stent – undertaken in last 12 months										
2	CABG, angioplasty or stent – undertaken prior to the last 12 months										
3	CABG, angioplasty or stent – both within and prior to the last 12 months										
4	No CABG, angioplasty or stent undertaken										
9	Not stated/inadequately described										

#### Guide for use:

#### Verification rules:

**Collection methods:** Ask the individual if he/she has had a CABG, angioplasty or coronary stent. If so, determine when it was undertaken within or prior to the last 12 months or both.

**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 Cerebral stroke due to vascular disease – history vers 1
- relates to the data element Hypertension – treatment vers 1
- relates to the data element Myocardial infarction – history vers 1

### Administrative Attributes

<b>Source document:</b>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
<b>Source organisation:</b>	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:**

CABG is known as 'bypass surgery,' when a piece of vein (taken from the leg) or of an artery (taken from the chest or wrist) is used to form a connection between the aorta and the coronary artery distal to the obstructive lesion, making a bypass around the blockage.

Angioplasty is an elective surgery technique of blood vessels reconstruction.

Stenting is a non-surgical treatment used with balloon angioplasty or after, to treat coronary artery disease to widen a coronary artery. A stent is a small, expandable wire mesh tube that is inserted. The purpose of the stent is to help hold the newly treated artery open, reducing the risk of the artery re-closing (re-stenosis) over time.

Angioplasty with stenting typically leaves less than 10% of the original blockage in the artery (Heart Center Online).

These three procedures are commonly used to improve blood flow to the heart muscle when the heart's arteries are narrowed or blocked.

The sooner procedures are done, the greater the chances of saving heart muscle.

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## Country of birth

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### 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

<b><i>Data Set Specifications:</i></b>	<b><i>Start date</i></b>	<b><i>End date</i></b>
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.

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## Creatinine serum – measured

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000655 **Version No:** 1

**Metadata type:** Data Element

**Admin. status:** Current  
01/01/03

**Definition:** A person's measured serum creatinine.

**Context:** Clinical settings and population survey:  
Serum creatinine can be used to help determine renal function. Serum creatinine by itself is an insensitive measure of renal function because it does not reliably increase above the normal range until more than 50% of renal function has been lost.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Quantitative value

**Representational layout:** NNNN

**Minimum size:** 2

**Maximum size:** 4

**Data domain:** Measured in  $\mu\text{mol/L}$  (micromoles per litre)

**Guide for use:** Record the absolute result of the most recent serum creatinine measurement.  
Note: If the measurement is obtained in  $\text{mmol/L}$  it is to be multiplied by 1000.  
Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/function. The calculation uses the Cockcroft-Gault formula.  
DSS - Diabetes (clinical):  
Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest  $\mu\text{mol/L}$  (micromoles per litre)

### Verification rules:

**Collection methods:** Measurement of creatinine should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

- Single venous blood test taken at the time of other screening blood tests.
- Fasting not required.

**Related metadata:** is used in conjunction with Date of birth vers 4  
relates to the data element Diabetes status vers 1  
is used in conjunction with Renal disease – end stage, diabetes complication vers 1  
is used in conjunction with Service contact date vers 1  
is used in conjunction with Sex vers 3  
is used in conjunction with Weight – measured vers 2

## Administrative Attributes

**Source document:** Caring for Australians with Renal Impairment (CARI) Guidelines. Australian Kidney Foundation

**Source organisation:** CV-Data Working Group  
National Diabetes Data Working Group

### Information model link:

NHIM Service provision event

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

### 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 service contact date should be recorded.

There is no agreed standard as to which units serum creatinine should be recorded in.

In combination with age, sex and body weight, it could be used for a more accurate assessment of renal function.

Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function.

GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal function in the elderly tends to be overestimated, and GFR should be used to assess renal function, according to the Cockcroft-Gault formula:

$$\text{GFR (ml/min)} = \frac{(140 - \text{age [yrs]}) \times \text{body wt (kg)}}{814 \times \text{serum creatinine (mmol/l)}} \left[ \times 0.85 \text{ (for women)} \right]$$

To determine chronic renal impairment

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

Note: The above GFR measurement should be for a period greater than 3 months. GFR may also be assessed by 24-hour creatinine clearance adjusted for body surface area.

In general, patients with GFR < 30 ml/min 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 (ie. hypertensive, proteinuric (> 1 g/24 hours), significant comorbid illness) should be considered for referral to a nephrologist well before function declines to less than 30 ml/min. (CARI Guidelines 2002. Australian Kidney Foundation). Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

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## Crude rate

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000770	<b>Version No:</b>	1
<b>Metadata type:</b>	Derived Data Element		
<b>Admin. status:</b>	Current		
	01/07/02		
<b>Definition:</b>	The ratio of the number of events in the population being studied during a certain time period to the estimated population size midway through that time period.		
<b>Context:</b>	Population health and health services research: Required to calculate population rates, such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	NNN.N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	4

#### Data domain:

<b>Guide for use:</b>	Formula: $R = d/n$
	Where: R is the crude rate for the population being studied d is the number of events for that population group n is the total population for that population group

#### Verification rules:

#### Collection methods:

**Related metadata:** relates to the data element Age-standardised rate vers 1

### Administrative Attributes

**Source document:** Textbooks of epidemiology, demography and biostatistics. The presentation of formulae in this data element is based on the notation used in Armitage P & Berry G 1994. Statistical Methods in Medical Research. Oxford: Blackwell Scientific Publications.

**Source organisation:** Australian Institute of Health and Welfare

#### Information model link:

NHIM Program evaluation

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

**Comments:** Crude rates are generally multiplied by 1,000 or 100,000 to avoid small decimal fractions. It is then called the crude rate per 1,000 or 100,000 population.

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## CVD drug therapy – condition

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000664	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	Describes the condition(s) for which drug therapy is being used for the prevention or long-term treatment of cardiovascular disease.		

<b>Context:</b>	Public health, health care and clinical settings: Its main use is to enable categorisation of drug management regimens used in the community for the long-term care of patients with or at increased risk of vascular disease.
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### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	NN
<b>Minimum size:</b>	2
<b>Maximum size:</b>	2
<b>Data domain:</b>	<ul style="list-style-type: none"> <li>01 Heart failure</li> <li>02 Ischaemic heart disease</li> <li>03 Hypertension</li> <li>04 Atrial fibrillation (AF)</li> <li>05 Other dysrhythmia or conductive disorder</li> <li>06 Dyslipidaemia</li> <li>07 Peripheral vascular disease (PVD)</li> <li>08 Renal vascular disease</li> <li>09 Stroke</li> <li>10 Transient ischaemic attack (TIA)</li> <li>97 Other</li> <li>98 No CVD drugs prescribed</li> <li>99 Not recorded</li> </ul>

<b>Guide for use:</b>	More than one code can be recorded. The categorisations may be made using the most recent version of the Australian Modification of the appropriate International Classification of Diseases codes.
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#### Verification rules:

#### Collection methods:

<b>Related metadata:</b>	is used in conjunction with Service contact date vers 1 relates to the data element Vascular history vers 1
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## Administrative Attributes

**Source document:** The reference document for CVD drug therapy is the Australian Medicines Handbook, 2000.

**Source organisation:** CV-Data Working Group

**Information model link:**

NHIM Physical wellbeing

**Data Set Specifications:**

DSS - Cardiovascular disease (clinical)

**Start date**

**End date**

01/01/2003

**Comments:**

References such as the Australian Medicines Handbook can be used to identify specific drugs that are appropriate for use in the management of the conditions identified in the data domain.