Admitted patient care
National Minimum Data Set

National Health Data Dictionary, Version 12

National Health Data Committee

2003

Australian Institute of Health and Welfare
Canberra

AIHW Cat. No. HWI 48

This publication is part of the Australian Institute of Health and Welfare's National Health Data Dictionary Series. A complete list of the Institute's publications is available from the Publications Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's web site (http://www.aihw.gov.au).

ISSN 1329-4555

ISBN 1 74024 296 3

Suggested citation

Australian Institute of Health and Welfare 2003. Admitted patient care National Minimum Data Set. National Health Data Dictionary. Version 12. AIHW Cat. No. HWI 48. Canberra: Australian Institute of Health and Welfare.

Any inquiries about or comments on this publication should be directed to:

David Neilsen
National Data Development Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Phone: (02) 6244 1148

Fax: (02) 6244 1166

Published by the Australian Institute of Health and Welfare

Introduction

A National Minimum Data Set (NMDS) is a core set of data elements agreed by the National Health Information Management Group for mandatory collection and reporting at a national level. One NMDS may include data elements that are also included in another NMDS. A NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

The *National Health Data Dictionary* contains definitions of data elements that are included in NMDS collections in the health sector, including data elements used to derive some of the performance indicators required under Australian Health Care Agreements (bilateral agreements between the Commonwealth and State/Territory governments about funding and delivery of health services).

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

Contents

Admitted patient care NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Metadata type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1989

Scope: Episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore Territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Statistical units: Episodes of care for admitted patients.

Collection methodology: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant State or Territory health authority on a regular basis (e.g. monthly).

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year.

Data elements included:

Activity when injured, version 2
Additional diagnosis, version 4
Admission date, version 4
Admitted patient election status, version 1
Area of usual residence, version 3
Care type, version 4
Country of birth, version 3∇
Date of birth, version 4∇
Diagnosis-related group, version 1
Establishment identifier, version 4∇
External cause – admitted patient, version 4
Funding source for hospital patient, version 1
Hospital insurance status, version 3
Indigenous status, version 4∇
Infant weight – neonate, stillborn, version 3
Intended length of hospital stay, version 2
Inter-hospital contracted patient, version 2
Mental health legal status, version 5
Major diagnostic category, version 1
Mode of admission, version 4

Data elements included (continued):

Mode of separation, version 3
Number of days of hospital-in-the-home care, version 1
Number of leave periods, version 3
Number of qualified days for newborns, version 2
Person identifier, version 1∇
Place of occurrence of external cause of injury, version 5
Principal diagnosis, version 3
Procedure, version 5
Region code, version 2
Separation date, version 5
Sex, version 3∇
Source of referral to public psychiatric hospital, version 3
Total leave days, version 3
Total psychiatric care days, version 2
Urgency of admission, version 1

Supporting data elements and data element concepts:

Acute care episode for admitted patients, version 1
Admission, version 3
Admitted patient, version 3
Diagnosis, version 1
Episode of care, version 1
Establishment number, version 4
Establishment sector, version 3
Hospital boarder, version 1
Hospital in-the-home care, version 1
Hospital, version 1
Live birth, version 1
Neonate, version 1
Newborn qualification status, version 2
Patient, version 1
Region code, version 2
Same-day patient, version 1
Separation, version 3
State/Territory identifier, version 3

Data elements in common with other NMDSs:

See Appendix D

♦ new in NMDS this version ∇ modified this version

Scope links with other NMDSs:	Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: – Admitted patient mental health care NMDS, version 2. Episodes of care for admitted patients where care type is palliative care: – Admitted patient palliative care NMDS, version 2.
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.

Data elements included

Activity when injured

Identifying and Definitional Attributes

Knowledgebase ID: ***000002*** ***Version No:*** ***2***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The type of activity being undertaken by the person when injured.

Context: Injury surveillance:

Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. This item is the basis for identifying work-related and sport-related injuries.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 1

Maximum size: 2

Data domain:

0	Sports activity
00	Football, rugby
01	Football, Australian
02	Football, soccer
03	Hockey
04	Squash
05	Basketball
06	Netball
07	Cricket
08	Roller blading
09	Other and unspecified sporting activity
1	Leisure activity (excluding sporting activity)
2	Working for income
3	Other types of work
4	Resting, sleeping, eating or engaging in other vital activities
5	Other specified activities
6	Unspecified activities

Guide for use: Use the appropriate codes as fourth and fifth characters to Y93 when using the ICD-10-AM 3rd edition. Used with ICD-10-AM external cause codes V01 – Y34 and assigned according to the Australian Coding Standards.

Verification rules: To be used with ICD-10-AM external cause codes V01 – Y34 only.

Collection methods:

Related metadata: supersedes previous data element Activity when injured vers 1
is used in conjunction with Bodily location of main injury vers 1
relates to the data element Diagnosis onset type vers 1
is used in conjunction with External cause – human intent vers 4
is used in conjunction with External cause – non-admitted patient vers 4
is a qualifier of Narrative description of injury event vers 1
is used in conjunction with Nature of main injury – non-admitted patient vers 1

Administrative Attributes

Source document: ICD-10-AM 3rd edition

Source organisation: National Centre for Classification in Health
National Injury Surveillance Unit

Information model link:

NHIM Injury event

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

Comments:

Additional diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: ***000005*** ***Version No: 4***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility.

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

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.NN

Minimum size: 3

Maximum size: 6

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

Guide for use: Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Generally, External cause, Place of occurrence and Activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.

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

Verification rules:

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

Related metadata: supersedes previous data element Additional diagnosis – ICD-9-CM code vers 3

relates to the data element Diagnosis onset type vers 1

is used in the derivation of Diagnosis related group vers 1

supplements the data element Principal diagnosis vers 3

Administrative Attributes

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

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

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1998	
NMDS – Admitted patient mental health care	01/07/1998	
NMDS – Admitted patient palliative care	01/07/2000	

Comments:

Admission date

Identifying and Definitional Attributes

Knowledgebase ID: ***000008*** ***Version No:*** ***4***

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: Date on which an admitted patient commences an episode of care.

Context: Required to identify the period in which the admitted patient episode and hospital stay occurred and for derivation of length of stay.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use:

Verification rules: Right justified and zero filled.

Admission date <= separation date.

Admission date >= date of birth

Collection methods:

Related metadata: relates to the data element concept Admission vers 3

supersedes previous data element Admission date vers 3

relates to the data element Admission time vers 2

relates to the data element concept Admitted patient vers 3

is used in conjunction with Care type vers 4

relates to the data element Emergency department departure status vers 2

is used in the derivation of the derived data element Diagnosis related group vers 1

is used in the calculation of the derived data element Emergency department waiting time to admission vers 1

is used in the calculation of the derived data element Length of stay vers 3

relates to the data element Type of visit to emergency department vers 2

is used in the calculation of the derived data element Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

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

Comments:

Admitted patient election status

Identifying and Definitional Attributes

Knowledgebase ID: ***000415*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: Accommodation chargeable status elected by patient on admission.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Public

2 Private

Guide for use: At the time of, or as soon as practicable after admission to a public hospital, the patient must elect in writing to be treated as either

- a public patient or
- a private patient in single accommodation or
- a private patient in shared accommodation.

This item is independent of patient's hospital insurance status. Private includes private-single and private-shared.

1 Public patient:

A person, eligible for Medicare, who, on admission to a recognised hospital or soon after:

- receives a public hospital service free of charge or
- elects to be a public patient or
- whose treatment is contracted to a private hospital.

2 Private patient:

A person who, on admission to a recognised hospital or soon after:

- elects to be a private patient treated by a medical practitioner of his or her choice or
- elects to occupy a bed in a single room (where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by any treating medical or dental practitioner) or
- a person, eligible for Medicare, who chooses to be admitted to a private hospital (where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner).

Please see the various Commonwealth/State Health Care Agreements for definitions of patient(s) and patient services.

Verification rules:

Collection methods: Commencing with Version 9 of the Dictionary, four separate data elements Admitted patient accommodation status, Medicare eligibility status, Department of Veterans' Affairs client and Compensable status are recorded in the Dictionary. This is because each element relates to a separate concept and requires separate information to be reported. These data elements replace the previous data elements Patient accommodation eligibility status and Compensable status.

Related metadata: supersedes previous data element Patient accommodation eligibility status vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Insurance/benefit characteristic

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

Comments:

Area of usual residence

Identifying and Definitional Attributes

Knowledgebase ID: ***000016*** ***Version No:*** ***3***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Geographical location of usual residence of the person.

Context: Geographical location is reported using Statistical Local Area (SLA) to enable accurate aggregation of information to larger areas within the Australian Standard Geographical Classification (ASGC) (such as Statistical Subdivisions and Statistical Divisions) as well as detailed analysis at the SLA level. The use of SLA also allows analysis relating the data to information compiled by the Australian Bureau of Statistics on the demographic and other characteristics of the population of each SLA. Analyses facilitated by the inclusion of SLA information include:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for establishments for planning purposes, and
- documentation of the provision of services to residents of States or Territories other than the State or Territory of the provider.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNN

Minimum size: 5

Maximum size: 5

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

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

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

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

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

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

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

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

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document: Australian Standard Geographical Classification, Australian Bureau of Statistics, Cat. No. 1216.0

Source organisation: National Health Data Committee

Information model link:

NHIM Address element

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

Comments:

Care type

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/00

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

Context: Admitted patient care and hospital activity:

For admitted patients, the type of care received will determine the appropriate casemix classification employed to classify the episode of care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: (N)N.N

Minimum size: 3

Maximum size: 4

Data domain:

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

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

Admitted care can be one of the following:

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

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

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

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

Optional

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

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

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

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

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

Optional

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

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

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

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

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

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

- in a psychogeriatic care unit
- in a designated psychogeriatic care program
- under the principal clinical management of a psychogeriatic physician
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic 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:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/2000	
NMDS – Admitted patient mental health care	01/07/2000	
NMDS – Admitted patient palliative care	01/07/2000	

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

Country of birth

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: The country in which the person was born.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

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

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document: ABS Catalogue No. 1269.0 (1998)

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Demographic characteristic

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

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

Date of birth

Identifying and Definitional Attributes

Knowledgebase ID: ***000036*** ***Version No: 4***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The date of birth of the person.

Context: Required to derive age at a point of time for clinical or administrative use.

Used for demographic analyses, for analysis by age and for use to derive a diagnosis related group (admitted patients).

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use: If date of birth is not known, provision should be made to collect age (in years) and a date of birth derived from age.

Verification rules: This field must not be null.

or the provision of State and Territory hospital data to Commonwealth agencies this field must:

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

Collection methods: It is recommended that in cases where all components of the date of birth are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.

Related metadata: supersedes previous data element Date of birth vers 3

is used in the derivation of Diagnosis related group vers 1

is qualified by Estimated date flag vers 1

is used in the calculation of Length of stay (antenatal) vers 1

is used in the calculation of Length of stay (postnatal) vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Demographic characteristic

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

Comments:

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

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

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

Diagnosis related group

Identifying and Definitional Attributes

Knowledgebase ID: ***000042*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/93

Definition: A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital.

Context: The development of Australian refined diagnosis related groups has created a descriptive framework for studying hospitalisation. Diagnosis related groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANNA

Minimum size: 4

Maximum size: 4

Data domain: Australian refined diagnosis related groups, Commonwealth of Australia. Version effective from 1 July each year.

Guide for use:

Verification rules:

Collection methods:

Related metadata: is derived from Additional diagnosis vers 4

is derived from Admission date vers 4

is derived from Date of birth vers 4

is derived from Infant weight, neonate, stillborn vers 3

is derived from Intended length of hospital stay vers 2

is derived from Mode of separation vers 3

is derived from Principal diagnosis vers 3

is derived from Procedure vers 5

is derived from Separation date vers 5

is derived from Sex vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

National Centre for Classification in Health

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1993	
NMDS – Admitted patient mental health care	01/07/1997	

Comments: The Australian refined diagnosis related group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in the related metadata section.

Establishment identifier

Identifying and Definitional Attributes

Knowledgebase ID: ***000050*** ***Version No:*** ***4***

Metadata type: Derived Data Element

Admin. status: Current

01/07/03

Definition: Identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.

Context:

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: NNA(N)NNNNN

Minimum size: 9

Maximum size: 9

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

Guide for use:

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Organisation characteristic

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

Comments:

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

A residential establishment is considered to be separately administered if managed as an independent institution for which there are financial, budgetary and activity statistics. For example, if establishment-level data for components of an area health service are not available separately at a central authority, this is not grounds for treating such components as a single establishment unless such data are not available at any level in the health care system.

This item is now being used to identify hospital contracted care. The use of this item will lead to reduced duplication in reporting patient activity and will enable linkage of services to one episode of care.

External cause – admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000053*** ***Version No:*** ***4***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.

Context: Institutional health care:

Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.NN

Minimum size: 3

Maximum size: 6

Data domain: ICD-10-AM 3rd edition

Guide for use: This code must be used in conjunction with an injury or poisoning codes and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM classification.

An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code (data element Place of occurrence of external cause). External cause codes V01 to Y34 must be accompanied by an activity code (data element Activity when injured).

Verification rules: As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.

Collection methods:

Related metadata: is used in conjunction with Activity when injured vers 2

is used in conjunction with Additional diagnosis vers 4

relates to the data element Diagnosis onset type vers 1

supersedes previous data element External cause – admitted patient – ICD-9-CM code vers 3

is used in conjunction with Place of occurrence of external cause vers 2

is used in conjunction with Principal diagnosis vers 3

Administrative Attributes

Source document: International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002) National Centre for Classification in Health, Sydney.

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

Information model link:

NHIM Injury event

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1998	
NMDS – Injury surveillance	01/07/1998	

Comments: An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.

Funding source for hospital patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000632*** ***Version No:*** ***1***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: Expected principal source of funds for an admitted patient episode or non-admitted patient service event.

Context: Admitted patient care.

Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

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

Guide for use: The major funding source should be recorded if there is more than one source of funding. The final payment class recorded by the hospital should be used.

Australian Health Care Agreements (category 1) should be recorded as the funding source for admitted patients who elect to be treated as public patients. However, overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as public patients (as detailed at www.health.gov.au/haf/docs/visthlth/2000hlth.htm#rhca) should be recorded as Reciprocal health care agreement (category 11).

Self-funded (category 3) includes funded by the patient, by the patient's family or friends, or by other benefactors.

Department of Veterans' Affairs (category 7) should be used for Department of Veterans' Affairs patients (as defined in the data element Department of Veterans' Affairs patient).

Compensable patients (as defined in the data element Compensable status), should be recorded as Worker's compensation (category 4), Motor vehicle third party personal claim (category 5) or Other compensation (category 6), as appropriate.

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

Verification rules:

Collection methods:

Related metadata: relates to the data element Admitted patient vers 3

relates to the data element Admitted patient election status vers 1

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Insurance/benefit characteristic

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/2001	
NMDS – Admitted patient palliative care	01/07/2001	

Comments:

Hospital insurance status

Identifying and Definitional Attributes

Knowledgebase ID: ***000075*** ***Version No:*** ***3***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Hospital insurance under one of the following categories:

- Registered insurance – hospital insurance with a health insurance fund registered under the *National Health Act 1953* (Commonwealth)
- General insurance – hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance
- No hospital insurance or benefits coverage under the above.

Context: To assist in analysis of utilisation and health care financing.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Hospital insurance

2 No hospital insurance

9 Unknown

Guide for use: Persons covered by insurance for benefits of ancillary services only are included in 2 – no hospital insurance.

The 'unknown' category should not be used in primary collections but can be used to record unknown insurance status in databases.

This item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Insurance status vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Insurance/benefit characteristic

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1997	30/06/2000

Comments:

Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*.

Employee health benefits schemes became illegal with the implementation of Schedule 2 of the private health insurance reforms, effective on 1 October 1995.

Under Schedule 4 of the private health insurance reforms, on 1 July 1997, the definition of the 'basic private table' or 'basic table', and 'supplementary hospital table' and any references to these definitions was omitted from the *National Health Act 1953*. All hospital tables offered by registered private health insurers since 29 May 1995 have been referred to as 'Applicable Benefits Arrangements' and marketed under the insurer's own product name.

Indigenous status

Identifying and Definitional Attributes

Knowledgebase ID: ***000001*** ***Version No:*** ***4***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. This is in accord with the first two of three components of the Commonwealth definition. See Comments for the Commonwealth definition.

Context: Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area.

The purpose of this data element is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin. Agencies wishing to determine the eligibility of individuals for particular benefits, services or rights will need to make their own judgements about the suitability of the standard measure for these purposes, having regard to the specific eligibility criteria for the program concerned.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
9	Not stated/inadequately described

Guide for use: This data element is based on the Australian Bureau of Statistics' (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS web site as indicated below in the Source document section.

The classification for 'Indigenous status' has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

Indigenous:

- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal origin

- both Aboriginal and Torres Strait Islander origin

Non-indigenous:

- neither Aboriginal nor Torres Strait Islander origin

Not stated/inadequately described:

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

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

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

Verification rules:

Collection methods:

The standard question for Indigenous status is as follows:

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

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

No.....☐

Yes, Aboriginal.....☐

Yes, Torres Strait Islander.....☐

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

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

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

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

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

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

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

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

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

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

Related metadata: supersedes previous data element Indigenous status vers 3

Administrative Attributes

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

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

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

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

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

There are three components to the Commonwealth Definition:

- descent
- self-identification
- community acceptance.

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

Infant weight, neonate, stillborn

Identifying and Definitional Attributes

Knowledgebase ID: ***000010*** ***Version No:*** ***3***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: The first weight of the live-born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.

Context: Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants. This item is required to generate Australian national diagnosis related groups.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

Data domain: Measured weight in grams

Guide for use: For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000 g and age is less than 365 days.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies, this field must be consistent with diagnoses and procedure codes for valid grouping.

Collection methods:

Related metadata: is used in the derivation of Diagnosis related group vers 1

supersedes previous data element Stillborn, live born baby, infant weight vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1997	
NMDS – Perinatal	01/07/1997	

Comments:

Intended length of hospital stay

Identifying and Definitional Attributes

Knowledgebase ID: ***000076*** ***Version No:*** ***2***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: The intention of the responsible clinician at the time of the patient's admission to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date.

Context: Admitted patient care:

To assist in the identification and casemix analysis of planned same-day patients, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Intended same-day
2	Intended overnight

Guide for use:

Verification rules:

Collection methods: The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

Related metadata: is used in the derivation of Diagnosis related group vers 1

supersedes previous data element Intended length of hospital stay vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Planning event

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/2001	

Comments: Information comparing the intended length of the episode of care and the actual length of the episode of care is considered useful for quality assurance and utilisation review purposes.

Inter-hospital contracted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000079*** ***Version No:*** ***2***

Metadata type: Derived Data Element

Admin. status: Current

01/07/00

Definition: An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals.

Context: Admitted patient care:

To identify patients receiving services that have been contracted between hospitals. This item is used to eliminate potential double-counting of hospital activity in the analysis of patterns of health care delivery and funding and epidemiological studies.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Inter-hospital contracted patient from public sector hospital
2	Inter-hospital contracted patient from private sector hospital
3	Other
9	Not reported

Guide for use: A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.

Verification rules:

Collection methods: All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity. This data element will be derived as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital (Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records the contracted activity within the patient's record for the episode of care). Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital.

Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

Related metadata: is derived from Contract role vers 1
is derived from Contract type vers 1
is used in conjunction with Contracted hospital care vers 1
supersedes previous data element Inter-hospital same-day contracted patient vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

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

Comments:

Major diagnostic category

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/93

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

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

Context: All admitted patient care contexts:

The generation of a major diagnostic category to accompany each Australian national diagnosis related group is a requirement of the latter as diagnosis related groups are not unique.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Australian refined diagnosis related groups

Guide for use: Version effective 1 July each year

Verification rules:

Collection methods:

Related metadata: is derived from Additional diagnosis vers 4

is derived from Admission date vers 4

is derived from Date of birth vers 4

is used in the derivation of Diagnosis related group vers 1

is derived from Infant weight, neonate, stillborn vers 3

is derived from Principal diagnosis vers 3

Administrative Attributes

Source document:

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

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1993	
NMDS – Admitted patient mental health care	01/07/1997	

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

Medicare eligibility status

Identifying and Definitional Attributes

Knowledgebase ID: ***000414*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The patient's eligibility for Medicare as specified under the Commonwealth *Health Insurance Act 1973*.

Context: Admitted patient care:

To facilitate analyses of hospital utilisation and policy relating to health care financing.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Eligible

2 Not eligible

9 Not stated/unknown

Guide for use: An eligible person includes a person who resides in Australia and is one of the following:

- an Australian citizen
- a permanent resident
- a New Zealand citizen
- a temporary resident who has applied for permanent residency and who has either an authority to work in Australia or an immediate family member who is an Australian citizen or permanent resident
- a person, or class of persons, who has been declared eligible for Medicare for the purposes of the *Health Insurance Act 1973*.

Other persons, as temporary residents, who are fully eligible for Medicare include:

- a person who is a head or member of a diplomatic mission or consular post or is a member of such a person's family, where there is a Reciprocal Health Care Agreement in place between Australia and the country they represent (currently United Kingdom, Republic of Ireland, the Netherlands, Malta, Italy, Sweden and Finland) – with the exception of New Zealand diplomats.

Other persons, as visitors or temporary residents, who are eligible for Medicare, in certain circumstances, include:

- persons who are visiting Australia and are eligible persons because there is a Reciprocal Health Care Agreement in place between Australia and their usual country of residence (currently United Kingdom, Republic of

Ireland, the Netherlands, Malta (eligibility limited to 6 months), Italy (eligibility limited to 6 months), Sweden, Finland and New Zealand – it should be noted that the RHCA with New Zealand and the Republic of Ireland limits the access to medical services for their residents to that of public patients in public hospitals) – with the exception of New Zealand diplomats.

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

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

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

Newborn babies take the eligibility status of the mother.

Verification rules:

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

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

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

Related metadata: supersedes previous data element Patient accommodation eligibility status vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Insurance/benefit characteristic

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

Comments:

Mental health legal status

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/00

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

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

Context: Mental health care:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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

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

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

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

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

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

Verification rules:

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

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

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

Related metadata: supersedes previous data element Mental health legal status vers 4

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Legal characteristic

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

Comments:

Mode of admission

Identifying and Definitional Attributes

Knowledgebase ID: ***000385*** ***Version No:*** ***4***

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: Describes the mechanism by which a person begins an episode of care.

Context: To assist in analyses of intersectoral patient flow and health care planning.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Admitted patient transferred from another hospital

2 Statistical admission – episode type change

3 Other

Guide for use: Code 2: use this code where a new episode of care is commenced within the same hospital stay.

Code 3: use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Verification rules:

Collection methods:

Related metadata: supplements the data element Mode of separation vers 3

supersedes previous data element Source of referral to acute hospital or private psychiatric hospital vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

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

Comments:

Mode of separation

Identifying and Definitional Attributes

Knowledgebase ID: ***000096*** ***Version No:*** ***3***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).

Context: Required for outcome analyses, for analyses of intersectoral patient flows and to assist in the continuity of care and classification of episodes into diagnosis related groups.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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

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

Verification rules:

Collection methods:

Related metadata: is used in the derivation of Diagnosis related group vers 1

is supplemented by the data element Source of referral to acute hospital or private psychiatric hospital vers 3

is supplemented by the data element Source of referral to public psychiatric hospital vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

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

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

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

Identifying and Definitional Attributes

Knowledgebase ID: ***000640*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/01

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

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 0

Maximum size: 3

Data domain: Count of patient days.

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

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

Collection methods:

Related metadata: relates to the data element Admission date vers 4

relates to the data element concept Admitted patient vers 3

relates to the data element concept Episode of care vers 1

relates to the data element concept Hospital-in-the-home care vers 1

relates to the data element Separation date vers 5

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:	***Start date***	***End date***
NMDS - Admitted patient care	01/07/2001	

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

Number of leave periods

Identifying and Definitional Attributes

Knowledgebase ID: ***000107*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).

Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN

Minimum size: 1

Maximum size: 2

Data domain: Count of leave periods.

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

Verification rules:

Collection methods:

Related metadata: is used in the derivation of Length of stay vers 3

supersedes previous data element Number of leave periods vers 2

supersedes previous derived data element Number of leave periods exceeding ten days vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

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

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

Number of qualified days for newborns

Identifying and Definitional Attributes

Knowledgebase ID: ***000346*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The number of qualified newborn days occurring within a newborn episode of care.

Context: Admitted patient care – newborn episodes of care only.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain: Count of the number of days.

Guide for use: The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the date of admission, date of separation and any date(s) of change to qualification status:

- the date of admission is counted if the patient was qualified at the end of the day
- the date of change to qualification status is counted if the patient was qualified at the end of the day
- the date of separation is not counted, even if the patient was qualified on that day
- the normal rules for calculation of patient days apply, for example in relation to leave and same day patients

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

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Date of change to qualification status vers 1

is used in conjunction with Newborn qualification status vers 2

supersedes previous data element Number of acute (qualified)/unqualified days for newborns vers 1

is used in the calculation of Patient days vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Performance indicator

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

Comments:

Person identifier

Identifying and Definitional Attributes

Knowledgebase ID: ***000127*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: Person identifier unique within an establishment or agency.

Context: This item could be used for editing at the establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Identification number

Representational layout: AN(20)

Minimum size: 6

Maximum size: 20

Data domain: Valid person identification number.

Guide for use: Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.

Verification rules: Field cannot be blank.

Collection methods:

Related metadata: relates to the data element Establishment identifier vers 4

is qualified by Person identifier type – health care vers 1

Administrative Attributes

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

Source organisation: National minimum data set working parties

Information model link:

NHIM Recipient role

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

Comments:

Place of occurrence of external cause of injury

Identifying and Definitional Attributes

Knowledgebase ID: ***000384*** ***Version No: 5***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The place where the external cause of injury, poisoning or adverse effect occurred.

Context: Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N(N)

Minimum size: 1

Maximum size: 2

Data domain:

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

Guide for use: Admitted patients:

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

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

Collection methods:

Related metadata: relates to the data element Diagnosis onset type vers 1

is used in conjunction with External cause – admitted patient vers 4

is used in conjunction with External cause – non-admitted patient vers 4

supersedes previous data element Place of occurrence of external cause of injury – admitted patient vers 4

supersedes previous data element Place of occurrence of external cause of injury – non-admitted patient vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

National Centre for Classification in Health

AIHW National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Other setting

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

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

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

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

Injury surveillance – type of place:

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

Principal diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: ***000136*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/98

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

Context: Health services:

The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Admitted patients:

The principal diagnosis is a major determinant in the classification of Australian refined diagnosis related groups and Major diagnostic categories.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.NN

Minimum size: 3

Maximum size: 6

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

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

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

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

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

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis.

Diagnosis codes which are morphology codes, cannot be used as principal diagnosis.

Collection methods: A principal diagnosis should be recorded and coded upon separation, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Admitted patients:

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

Related metadata: relates to the data element Additional diagnosis vers 4

is an alternative to Bodily location of main injury vers 1

relates to the data element Diagnosis onset type vers 1

relates to the data element Diagnosis related group vers 1

relates to the data element External cause – admitted patient vers 4

relates to the data element External cause – human intent vers 4

relates to the data element External cause – non-admitted patient vers 4

is used in the derivation of Major diagnostic category vers 1

is used as an alternative to Nature of main injury – non-admitted patient vers 1

supersedes previous data element Principal diagnosis – ICD-9-CM code vers 2

relates to the data element Procedure vers 5

Administrative Attributes

Source document: International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002) National Centre for Classification in Health, Sydney

Source organisation: National Health Data Committee

National Centre for Classification in Health

National Data Standard for Injury Surveillance Advisory Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1989	
NMDS – Admitted patient mental health care	01/07/1997	
NMDS – Community mental health care	01/07/2000	
NMDS – Admitted patient palliative care	01/07/2000	

Comments:

Procedure

Identifying and Definitional Attributes

Knowledgebase ID: ***000137*** ***Version No: 5***

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: A clinical intervention that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNN-NN

Minimum size: 8

Maximum size: 8

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

Guide for use: Admitted patients:

Record all procedures undertaken during an episode of care in accordance with the ICD-10-AM Australian Coding Standards.

The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

Verification rules: As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and State and Territory information systems.

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Procedures are derived from and must be substantiated by clinical documentation.

Related metadata:

is qualified by Additional diagnosis vers 4

supersedes previous data element Additional procedures – ICD-10-AM code vers 4

supersedes previous data element Additional procedures – ICD-9-CM code vers 3

relates to the data element Date of procedure vers 1

is used in conjunction with Indicator procedure vers 3

is qualified by Principal diagnosis vers 3

supersedes previous data element Principal procedure – ICD-10-AM code vers 4

supersedes previous data element Principal procedure – ICD-9-CM code vers 3

Administrative Attributes

Source document: International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002), National Centre for Classification in Health, Sydney.

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

Information model link:

NHIM Service provision event

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

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM.

Separation date

Identifying and Definitional Attributes

Knowledgebase ID: ***000043*** ***Version No: 5***

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: Date on which an admitted patient completes an episode of care.

Context: Required to identify the period in which an admitted patient hospital stay or episode occurred, and for derivation of length of stay.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid dates

Guide for use:

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must:

- be <= last day of financial year
- be >= first day of financial year
- be >= Admission date.

Collection methods:

Related metadata: supersedes previous data element Discharge date vers 4
is used in the calculation of Length of stay (including leave days) vers 1
is used in the calculation of Length of stay (postnatal) vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1999	
NMDS – Admitted patient mental health care	01/07/1999	
NMDS – Perinatal	01/07/1999	
NMDS – Admitted patient palliative care	01/07/1999	

Comments:

There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical separation (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.

Sex

Identifying and Definitional Attributes

Knowledgebase ID: ***000149*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The sex of the person.

Context: Required for analyses of service utilisation, needs for services and epidemiological studies.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Male
2	Female
3	Indeterminate
9	Not stated/inadequately described

Guide for use: An indeterminate sex category may be necessary for situations such as the classification of perinatal statistics when it is not possible for the sex to be determined.

Verification rules: Code 3 Indeterminate should be queried for people aged 90 days (3 months) or greater.

For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnosis and procedure codes, for records grouped in Major diagnostic categories 12, 13 and 14, for valid grouping. For other Major diagnostic categories, sex conflicts should be queried.

Collection methods: Code 9 is not to be an allowable option when data is being collected ie it is not to be a tick box on any collection forms or computer screens. Systems are to take account of any null values that may occur on the primary collection form. It is suggested that the following format be used for data collection:

What is your (the person's) sex?

___ Male ___ Female

The term 'sex' refers to the biological differences between males and females, while the term 'gender' refers to the socially expected/perceived dimensions of behaviour associated with males and females – masculinity and femininity.

The Australian Bureau of Statistics advises that the correct terminology for this data element is sex.

Information collection for transsexuals and people with transgender issues should be treated in the same manner.

To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission recorded.

Related metadata: is used in the derivation of Diagnosis related group vers 1

supersedes previous data element Sex vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Demographic characteristic

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

Comments: This item enables standardisation of the collection of information relating to sex (to include indeterminate), gender, people with transgender issues and transsexuals.

In collection systems (ie on forms and computer screens) Male and Female may be mapped to M and F respectively for collection purposes; however, they should be stored within information systems as the codes 1 and 2 respectively.

Source of referral to public psychiatric hospital

Identifying and Definitional Attributes

Knowledgebase ID: ***000150*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current
01/07/97

Definition: Source from which the person was transferred/referred to the public psychiatric hospital.

Context: To assist in analyses of intersectoral patient flow and health care planning.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Private psychiatric practice
02	Other private medical practice
03	Other public psychiatric hospital
04	Other health care establishment
05	Other private hospital
06	Law enforcement agency
07	Other agency
08	Outpatient department
09	Other
10	Unknown

Guide for use:

Verification rules:

Collection methods:

Related metadata: supplements the data element Mode of separation vers 3
supersedes previous data element Source of referral vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

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

Comments:

Total leave days

Identifying and Definitional Attributes

Knowledgebase ID: ***000163*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count in number of days.

Guide for use: A day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and same-day patients:

- the day the patient goes on leave is counted as a leave day
- the day the patient is on leave is counted as a leave day
- the day the patient returns from leave is counted as a patient day
- if the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day
- if the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day
- if the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies:

(Date of separation minus Date of admission) minus Total leave days must be >= 0 days.

Collection methods:

Related metadata: supersedes previous data element Total leave days vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1996	
NMDS – Admitted patient mental health care	01/07/1997	

Comments: It should be noted that for private patients in public and private hospitals, s.3 (12) of the *Health Insurance Act 1973* (Commonwealth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994). This item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Total psychiatric care days

Identifying and Definitional Attributes

Knowledgebase ID: ***000164*** ***Version No: 2***

Metadata type: Derived Data Element

Admin. status: Current

01/07/98

Definition: The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.

Context: Admitted patient and residential mental health care:

This data element is required to identify the characteristics of patients treated in specialist psychiatric units located within acute care hospitals or 24-hour staffed Community-based residential services and to analyse the activities of these units and services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain:

Guide for use: Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in Community-based residences.

Public acute care hospitals:

Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals:

Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals:

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the *Health Insurance Act 1973* (Commonwealth) (now

licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed Community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as Community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour Community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element Care type). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element Care type). Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by State or Territory health authorities. Several mechanisms exist for this data field to be implemented.

- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant State/Territory health authority.
- Acute care hospitals in most States and Territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed Community-based residential services should be identified separately at the level of the establishment.

Verification rules: Total days in psychiatric care must be:
>= zero; and
<= length of stay

Collection methods:

Related metadata: is derived from Admission date vers 4
is derived from Establishment type vers 1
is derived from Separation date vers 5
is derived from Total leave days vers 3
supersedes previous data element Total psychiatric care days vers 1
is derived from Care type vers 4

Administrative Attributes

Source document:

Source organisation: National Mental Health Information Strategy Committee

Information model link:

NHIM Performance indicator

Data Set Specifications:	***Start date***	***End date***
NMDS - Admitted patient care	01/07/1998	
NMDS - Admitted patient mental health care	01/07/1998	
NMDS - Community mental health care	01/07/2000	

Comments: This data element was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the Community-based residential care sector. The data element is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Urgency of admission

Identifying and Definitional Attributes

Knowledgebase ID: ***000425*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis.

An emergency admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.

An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours. Admissions for which an urgency status is usually not assigned are:

- admissions for normal delivery (obstetric)
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient
- statistical admissions
- planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N(.N)

Minimum size: 1

Maximum size: 3

Data domain:

1	Urgency status assigned – emergency
2	Urgency status assigned – elective
3	Urgency status not assigned
9	Not known/not reported

Guide for use: Emergency admission:

The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation or

- suffering from suspected acute organ or system failure or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened or
- suffering from a drug overdoes, toxic substance or toxin effect or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment or
- suffering gynaecological or obstetric complications or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

Elective admissions:

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions:

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists:

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an Urgency of admission category, which may or may not be elective.

- Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see data domain value 1 in data element Reason for removal) will be assigned an Urgency of admission code of 2. In that case, their Clinical urgency category could be regarded as further detail on how urgent their admission was.
- Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see data domain value 2 in data element Reason for removal), will be assigned an Urgency of admission code of 1.

Admissions for which an urgency status is usually not assigned:

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

Use of code 9.

The not known/not reported category is to be used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

Verification rules:

Collection methods:

Related metadata: relates to the data element Clinical urgency vers 2
relates to the data element concept Elective care vers 1

Administrative Attributes

Source document:

Source organisation: Emergency Definition Working Party
National Health Data Committee

Information model link:

NHIM Assessment event

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

Comments:

Supporting data elements and data element concepts

Acute care episode for admitted patients

Identifying and Definitional Attributes

Knowledgebase ID: ***000004*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

Definition: An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following:

- 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 illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions
- perform diagnostic or therapeutic procedures.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Care type vers 4

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and Territories.

Admission

Identifying and Definitional Attributes

Knowledgebase ID: ***000007*** ***Version No: 3***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

Definition: Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.

Formal admission:

The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.

Statistical admission:

The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: This treatment and/or care provided to a patient following admission occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Admission vers 3

relates to the data element Admission date vers 4

relates to the data element Admission time vers 2

relates to the data element concept Admitted patient vers 3

relates to the data element concept Episode of care vers 1

relates to the data element concept Separation vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

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

Comments:

Admitted patient

Identifying and Definitional Attributes

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

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

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

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

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: This data element concept should be used in conjunction with the definition of same-day patient in the data element Same-day patient.

Part 2 of Schedule 3 of the *National Health Act* (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients.

All babies born in hospital are admitted patients.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Admitted patient vers 2

relates to the data element Care type vers 4

relates to the data element Newborn qualification status vers 2

relates to the data element Number of qualified days for newborns vers 2

relates to the data element Patient days vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Recipient role

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

Comments:

This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Health Care Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care
- remains in hospital without its mother
- is admitted to the hospital without its mother.

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

Diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: ***000398*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/98

Definition: A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient.

Context: Health services:

Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Additional diagnosis vers 4
relates to the data element Complication of labour and delivery vers 2
relates to the data element Complications of pregnancy vers 2
relates to the data element Congenital malformations vers 2
relates to the data element External cause – admitted patient vers 4
relates to the data element Maternal medical conditions vers 2
relates to the data element Neonatal morbidity vers 2
relates to the data element Postpartum complication vers 2
relates to the data element Principal diagnosis vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Physical wellbeing

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

Comments: Classification systems which enable the allocation of a code to the diagnostic information:
International Classification of Diseases – Tenth Revision – Australian Modification (ICD-10-AM)
British Paediatric Association Classification of Diseases
North America Nursing Diagnosis Association
International Classification of Primary Care
International Classification of Impairments, Disabilities and Handicaps
International Classification of Functioning

Episode of care

Identifying and Definitional Attributes

Knowledgebase ID: ***000445*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

Definition: The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: This treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Verification rules:

Collection methods:

Related metadata: relates to the data element concept Admission vers 3

relates to the data element concept Admission date vers 4

relates to the data element concept Admitted patient vers 3

relates to the data element Care type vers 4

relates to the data element concept Separation vers 3

relates to the data element Separation date vers 5

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments:

Establishment number

Identifying and Definitional Attributes

Knowledgebase ID: ***000377*** ***Version No:*** ***4***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: An identifier for an establishment, unique within the State or Territory.

Context: All health services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Identification number

Representational layout: NNNNN

Minimum size: 5

Maximum size: 5

Data domain: Valid establishment number

Guide for use:

Verification rules:

Collection methods:

Related metadata: is a composite part of Establishment identifier vers 4

supersedes previous data element Establishment number vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisation characteristic

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

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

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

Establishment sector

Identifying and Definitional Attributes

Knowledgebase ID: ***000379*** ***Version No:*** ***3***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: A section of the health care industry with which a health care establishment can identify.

Context:

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain: 1 Public

2 Private

Guide for use:

Verification rules:

Collection methods:

Related metadata: is a composite part of Establishment identifier vers 4

supersedes previous data element Establishment sector vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisational setting

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

Comments:

Hospital

Identifying and Definitional Attributes

Knowledgebase ID: ***000064*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/94

Definition: A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.

Context: Admitted patient care, admitted patient palliative care, admitted patient mental health care and public hospital establishments.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Establishment sector vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service delivery setting

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

Comments: A hospital thus defined may be located at one physical site or may be a multicampus hospital. A multicampus hospital treats movements of patients between sites as ward transfers.

For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital.

This definition includes, but is not limited to, hospitals as recognised under Australian Health Care Agreements.

Residential aged care services as approved under the *National Health Act 1953* (Commonwealth) or equivalent State legislation are excluded from this definition.

This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).

Hospital boarder

Identifying and Definitional Attributes

Knowledgebase ID: ***000065*** ***Version No:*** ***1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/94

Definition: A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder.

Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

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

Comments:

Hospital-in-the-home care

Identifying and Definitional Attributes

Knowledgebase ID: ***000633*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/01

Definition: Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

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

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

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

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

Verification rules:

Collection methods:

Related metadata: relates to the data element Admitted patient vers 3

relates to the data element concept Episode of care vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments:

Live birth

Identifying and Definitional Attributes

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

Metadata type: Data Element Concept

Admin. status: Current

01/07/94

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

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

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

Administrative Attributes

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

Source organisation: National Health Data Committee

National Perinatal Data Development Committee

National Perinatal Data Advisory Committee

Information model link:

NHIM Birth event

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

Comments:

Neonate

Identifying and Definitional Attributes

Knowledgebase ID: ***000103*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

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

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document: International Classification of Diseases and Related Health Problems, Tenth Revision – WHO, 1992

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

Information model link:

NHIM Person characteristic

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

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

Newborn qualification status

Identifying and Definitional Attributes

Knowledgebase ID: ***000343*** ***Version No: 2***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

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

Context: Admitted patient care:

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

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

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

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

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care
- is admitted to, or remains in hospital without its mother.

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

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

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

Verification rules:

Collection methods:

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

is used in conjunction with Care type vers 4

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

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

supersedes previous data element Qualification status vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments:

All babies born in hospital are admitted patients.

The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.

The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000117*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

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

Context: Admitted patient care and public hospital establishments.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

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

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

Region code

Identifying and Definitional Attributes

Knowledgebase ID: ***000378*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: An identifier for location of health services in a defined geographic or administrative area.

Context: All health services.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: AN

Minimum size: 1

Maximum size: 2

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

Guide for use: Domain values are specified by individual States/Territories.

Regions may also be known as Areas or Districts.

Verification rules:

Collection methods:

Related metadata: is a composite part of Establishment identifier vers 4

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisation characteristic

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

Comments:

Same-day patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000146*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/94

Definition: A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Ac*t 1953 (Commonwealth)
- that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

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

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

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

Data on same-day patients are derived by a review of admission and separation dates.

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

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

Comments:

Separation

Identifying and Definitional Attributes

Knowledgebase ID: ***000148*** ***Version No: 3***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

Definition: Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical.

Formal separation:

The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

Statistical separation:

The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Verification rules:

Collection methods:

Related metadata: relates to the data element concept Admission vers 3

relates to the data element concept Admitted patient vers 3

relates to the data element Care type vers 4

supersedes previous data element Separation vers 2

relates to the data element Separation date vers 5

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Exit/leave from service event

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

Comments: While this concept is also applicable to non-Admitted patient care and welfare services, terminology different from 'separation' is often used in these other care settings.

State/Territory identifier

Identifying and Definitional Attributes

Knowledgebase ID: ***000380*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: An identifier for Australian State or Territory.

Context: Public health care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Address type vers 1

relates to the data element Australian postcode vers 1

relates to the data element Postal delivery point identifier vers 1

is a composite part of Establishment identifier vers 4

supersedes previous data element State identifier vers 2

relates to the data element Suburb/town/locality vers 1

Administrative Attributes

Source document: Adapted from Australian Standard Geographic Classification, Australian Bureau of Statistics, Catalogue No. 1216.0

Source organisation: National Health Data Committee

Information model link:

NHIM Address element

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

Comments: