National Health Data Dictionary
Version 12

Volume 1

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

National Health Data Dictionary
Version 12

Volume 1

National Health Data Committee

2003

Australian Institute of Health and Welfare
Canberra

AIHW cat. no. HWI 43

A complete list of the Institute's publications is available from the Media and Publishing Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's web site at http://www.aihw.gov.au.

ISBN Volume 1 1 74024 268 8
ISBN (set) 1 74024 267 X
ISSN 1329-4555

Suggested citation

National Health Data Committee 2003. *National Health Data Dictionary*. Version 12. AIHW cat. no. HWI 43. 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

Printed by Elect Printing

Foreword

The Australian Institute of Health and Welfare is pleased to produce the twelfth version of the *National Health Data Dictionary* (NHDD), which is a vital tool for use in ensuring the quality of Australian health data.

It is only through the cooperation and consensus of Australia's health sector that it is possible to produce in the Dictionary a set of core definitions and data items for use in all Australian health data collections. All Australian health departments, the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, the National Centre for Classification in Health, the Department of Veterans' Affairs, the Australian Private Hospitals Association, representatives of the private health insurance industry and the Health Insurance Commission cooperate in this endeavour.

With significant Commonwealth electronic health initiatives such as Health*Connect* and Health Online it is imperative that the health care community maintains the ability to standardise the terminology definitions used in the collection, transmission and analysis of health information. In 2002 the Australian Health Ministers Advisory Council endorsed the Dictionary as the authoritative source of national standard definitions for use in clinical care delivery. This twelfth version of the Dictionary contains nationally endorsed definitions for use in the clinical management of cardiovascular disease and diabetes mellitus. Enhancements have also been made to definitions related to body mass index to include measurements related to child and adolescent overweight and obesity.

In order to maintain the ability of the Dictionary to perform its main function in this ever-changing environment the decision has been taken to publish the hard copy in a new format and to significantly upgrade the prominence of the electronic metadata registry, the Knowledgebase, on the Institute's web site.

The Knowledgebase has been updated to incorporate this twelfth version of the Dictionary and is accessible via the Institute's Internet home page (http://www.aihw.gov.au). In coming months the web site will be undergoing some changes in order to enhance the prominence of the Knowledgebase and to significantly expand its functionality.

Version 12 of the Dictionary will take advantage of recent international developments in relation to the administration of metadata registries by incorporating some of the format based on the ISO/IEC Draft International Standard 11179-3:2002. Version 13 will continue with a full implementation of this International Standard. The standard definitions in this publication identify their alignment to entities in the National Health Information Model (Draft Version 2).

Use of the Dictionary will help ensure that data elements are collected uniformly by all services and jurisdictions throughout Australia and thereby improve the quality of health care and the information available for community discussion and public policy debate on health issues in Australia.

Thanks are due to David Neilsen, Trish Ryan, Robyn Kingham Edwards and Diana Ekeroth (Institute staff who have prepared the material for this twelfth edition) and to all members of the National Health Data Committee who have overseen its preparation.

The Dictionary's content is expanding beyond institutional health care into other sectors of health care. It goes beyond standards primarily derived to support statistical analyses into standards directly related to clinical care. Future developments will include integration of definitions across the health and community services sectors, reflecting the public focus on service integration and realities of the contemporary health care delivery environment.

I urge all collectors of health-related data in Australia and those involved in developing standards for the recording and transmission of data related to clinical care to use the Dictionary.

Richard Madden
Director
Australian Institute of Health and Welfare

How to use this book

Format of publication

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

Volume 1

- Full Contents list for both volumes
- Introduction
- Summary of changes since Versions 10 and 11

  Contains a summary of all changes since Version 10 and 11 of the *National Health Data Dictionary*, including changes to National Minimum Data Sets and data elements, new data elements and data elements retired from the Dictionary.
- National Health Information Model

  Contains background information to the National Health Information Model Version 2 (Draft) and an index of the data elements and model entities.
- Data elements: A to M in alphabetical order
- Full Index for both volumes

Volume 2

- Full Contents list for both volumes
- Data elements: N to Z in alphabetical order the
- Data Set Specifications

  Contains a full description of all data set specifications for National Minimum Data Sets and other data set specifications.
- Appendixes
- Full Index for both volumes

Formatting conventions

- Only metadata items with an Admin. status of CURRENT are published in this book.
- Each metadata item is divided into three sections:
  - Identifying and Definitional Attributes
    - used to identify the metadata item in the Registry; and
    - used to provide a definition, the context in which the definition is valid and any relevant comments that help in defining the metadata item
  - Relational and representational attributes
    - used to record what such a data item would look like and how it is used.
  - Administrative attributes
    - the attributes of the metadata item that are relevant to the Registry.
- Links to the National Health Information Model are identified in each data element.

Not all attributes have instances of information.

CONTENTS

Volume 1

Volume 2

Introduction

The *National Health Data Dictionary* was first published as *the National Minimum Data Set—Institutional Health Care* in September 1989. In March 1993 the *National Health Data Dictionary—Institutional Health Care (Version 2.0)* was published. Since the establishment of the first National Health Information Agreement in June 1993 there have been many changes in the development and management of national health information resulting in the expansion of both the scope and content of the seven subsequent versions of the *National Health Data Dictionary*. The National Health Information Agreement was renewed in 1998 for a further five-year term. Arrangements for a further continuation of the agreement are currently under consideration.

Under the National Health Information Agreement and the National Health Information Standards Plan for Australia, the *National Health Data Dictionary* is the authoritative source of health data definitions used in Australia where national consistency is required. For further details, see:

- the Health Online web site of the National Health Information Standards Plan at www.health.gov.au/healthonline
- A Report to the Australian Health Ministers' Conference from Australian Health Care Agreement Reference Groups September 2002 at www.health.gov.au/haf/ahca.htm
- The National Health Information Agreement Process at www.aihw.gov.au/html/NHIAproc.htm

The Dictionary is designed to improve the comparability of data across the health field. It is also designed to make data collection activities more efficient by reducing duplication of effort in the field, and more effective by ensuring that information to be collected is appropriate to its purpose.

The objectives of the *National Health Data Dictionary* are to:

- establish a core set of uniform definitions relating to the full range of health services and a range of population parameters (including health status and determinants);
- promote uniformity, availability, reliability, validity, consistency and completeness in the data;
- accord with nationally and internationally agreed protocols and standards, wherever possible;
- promote the national standard definitions by being readily available to all individuals and organisations involved in the generation, use and/or development of health and health services information;
- facilitate and promote the development of good data definitions across the health sector.

The National Health Data Committee is responsible for coordinating the development and revision of the *National Health Data Dictionary*.

The National Health Data Committee

The National Health Data Committee is a standing committee of the National Health Information Management Group—a body established under the National Health Information Agreement to oversee implementation of the Agreement. All data element definitions to be included in the *National Health Data Dictionary* require endorsement by the National Health Information Management Group.

The primary role of the National Health Data Committee is to assess data definitions proposed for inclusion in the *National Health Data Dictionary* and to make recommendations

to the National Health Information Management Group on revisions and additions to each successive version of the Dictionary. In particular, the Committee's role is to ensure that the *National Health Data Dictionary* definitions comply with endorsed standards for the definition of data elements and that all data definitions being considered for the Dictionary have undergone sufficient national consultation with recognised experts and stakeholders in the relevant field.

The rules applied to each data element definition are designed to ensure that each definition is clear, concise, comprehensive and provides sufficient information to ensure that all those who collect, provide, analyse and use the data understand its meaning.

All definitions in the *National Health Data Dictionary* are presented in a format that is described in more detail at Appendix B.

The National Health Data Committee comprises representatives of:

- The Commonwealth Department of Health and Ageing
- Each State and Territory government health authority
- The Australian Institute of Health and Welfare
- The Australian Bureau of Statistics
- The Australian Private Hospitals' Association
- The private health insurance industry (through Lysaght's Hospital and Medical Club)
- The Department of Veterans' Affairs
- The National Centre for Classification in Health;
- The Health Insurance Commission
- Other members designated by the National Health Information Management Group.

The National Health Information Management Group appoints the Chair of the National Health Data Committee, currently Dr Ching Choi of the Australian Institute of Health and Welfare.

A list of Committee members and their contact details (as at 1 January 2003) is provided at Appendix A.

The National Health Data Committee does not normally develop data definitions directly. Rather, it provides a channel through which standards emerging from nationally-focussed data development work are documented and endorsed by the National Health Information Management Group for implementation in national data collections and made more widely available to stakeholders in the national health information arena. The range and relevance of the data definitions included in the *National Health Data Dictionary* are dependent, to a significant extent, on the material submitted to the National Health Data Committee by the expert working groups that are actively developing data in the health field.

More information about the National Health Data Committee and its processes is available from the Secretariat (see the address at the end of this section).

The Knowledgebase

The Knowledgebase—Australia's Health, Community Services and Housing Metadata Registry is an electronically accessible registry of national data definitions. The Knowledgebase was designed and created by the Australian Institute of Health and Welfare on behalf of the National Health Information Management Group. Organisations that may place data definitions into the Knowledgebase are given the status of 'Registration Authority'. The organisation authorised to register *National Health Data Dictionary* data definitions in the Knowledgebase is the National Health Information Management Group. The organisation authorised to register *National Community Services Data Dictionary* data

definitions in the Knowledgebase is the National Community Services Information Management Group. The Knowledgebase is also a registry for other Registration Authorities that are approved by the relevant national information management groups. These other groups are allowed to have data definitions with 'DRAFT' status only. DRAFT definitions are not available in print form.

The Knowledgebase integrates and presents information about:

- the *National Health Data Dictionary*
- National Minimum Data Set (NMDS) agreements
- National Health Performance Indicators
- the National Health Information Model
- the National Community Services Information Model
- the *National Community Services Data Dictionary*
- proposed data sets under development
- related data dictionaries from other organisations.

The integrating features of the Knowledgebase enable information managers and policy developers to query and view information in ways not possible with traditional paper-based records, repositories, dictionaries or manuals. It is envisaged that, over time, access to the *National Health Data Dictionary* will be primarily electronic—via the Knowledgebase.

The Knowledgebase is an Internet application, accessible through any Browser compatible with HTML version 3.2 or later. It has been written using Oracle's Webserver technology.

The Internet address for the Knowledgebase—Australia's Health, Community Services and Housing Metadata Registry is
www.aihw.gov.au

Select **Knowledgebase** from the 'Choose a portal' drop down list.

National Health Data Dictionary

All data definitions that are included in the latest version of the *National Health Data Dictionary* as well as all previous versions of those data definitions are available on the Knowledgebase**.** DRAFT data definitions under development by the National Health Data Committee are also available on the Knowledgebase under the National Health Data Committee as Registration Authority.

National Health Data Dictionary, Version 12

The publication format for Version 12 differs from all other versions in that:

- It is presented as two volumes due to the number of definitions.
- Data definitions are presented in alphabetical order.
- For the first-time, data definitions are referred to using the updated International Standard ISO 11179-3: 2002. This standard introduces the terms metadata, metadata item, metadata set, metadata type and steward. Appendix B provides definitions of some of these terms used in this publication.
- It introduces, for the first-time, a new product called Data Set Specification (DSS) as a generic name for groups of metadata (metadata sets) that are intended for collection as a set. NMDSs are a special type of DSS because of the mandatory nature of their collection. Three DSS have been introduced in this version.

This hard copy publication of Version 12 contains only data elements that are CURRENT as at 1 January 2003 i.e. they are available for use as a nationally endorsed standard. Data elements that are included in NMDSs are active in those collections from 1 July 2003.

All data elements including those that have been superseded by new data elements or new versions of data elements or rendered obsolete are available on the Knowledgebase. An 'Advanced Search' facility is available from the *National Health Data Dictionary* page or select by alphabet.

Version 12 comprises:

- the addition of 87 new data elements
- the modification of 25 data elements requiring a version change
- the modification of 13 data elements that did not require a version change
- the retirement of 3 obsolete data elements concepts
- the introduction of a new NMDS for Non-admitted patient emergency department care
- changes to the NMDS for Alcohol and other drug treatment services
- three new types of metadata set; Data Set Specifications (DSS) for Cardiovascular disease (clinical), Diabetes (clinical) and Health care client identification.

These modifications have been endorsed by the National Health Information Management Group.

The full version of the Dictionary is also available from the Publications portal on the AIHW web site at www.aihw.gov.au/publications/index.cfm . Also available on the Publications portal are individual NMDSs and their associated data elements as well as other DSSs and their associated data elements.

Summary of changes

National Minimum Data Sets

- Modification to NMDS – Alcohol and other drug treatment services:
  - 2 new data elements: Geographical location of service delivery outfit, Service delivery outlet

  - change to Client type-alcohol and other drug treatment services;
  - change to Injecting drug use
  - change to Other drugs of concern
  - change to Principal drug of concern
  - change to Source of referral to alcohol and other drug treatment service.
- New NMDS – Non-admitted patient emergency department care.
- New DSS – Cardiovascular disease (clinical).
- New DSS – Diabetes (clinical).
- New DSS – Health care client identification.
- In some cases a data element may be included in more than one Data Set Specification. See Appendix D for a table presenting a cross tabulation of data elements by NMDS.

Data elements

Modified in version 12

- The following Body Mass Index definitions have been changed so that they no longer refer only to adults. Appropriate changes have been made to the wording to reflect this. The following name changes and other relevant changes have been made:
  - *Body mass index – classification* (formerly Adult body mass index – classification)
  - *Body mass index* (formerly Adult body mass index)
  - *Height – self-reported* (formerly Adult height – self-reported)
  - *Height – measured* (formerly Adult height – measured)
  - *Hip circumference measured* (formerly Adult hip circumference – measured)
  - *Waist circumference – measured* (formerly Adult abdominal circumference measured)
  - *Waist to hip ratio* (formerly Adult abdomen to hip ratio)
  - *Weight – measured* (formerly Adult weight – measured)
  - *Weight – self-reported* (formerly Adult weight – self-reported).
- *Carer availability*
  - changes were made to align with the National Community Services Data Dictionary.
- *Client type – alcohol and other drug treatment services*:
  - the term 'contact' is replaced by the term 'treatment episode'.
- *Indigenous status*:
  - change to the Definition such that it is consistent with what is actually measured by the standard Indigenous Status question; and
  - an explanation about how this differs from the Commonwealth working definition has been added to Comments section.
- *Injecting drug use*:
  - wording in the Data Domain was amended to allow for the correct capture of clients who may have injected precisely three months or 12 months ago.
- *Principal drug of concern*:
  - the Data Domain was updated to ensure that the correct title and catalogue number is listed for the Australian Classifications of Drugs of Concern

  - one wording changes made to the definition and additional information has been included under Collection methods, Related data and Guide for use.
- *Other drugs of concern*:
  - similar changes were made as Principal drug of concern.
- *Source of referral to alcohol and other drug treatment service*:
  - the Data domain and the Guide for use were revised to more accurately capture the most common sources of referral and to make the categories mutually exclusive.
- Changes were made to the wording in the following data elements in order to reflect their inclusion in the new NMDS – Non-admitted patient emergency department care and the new Data Set Specifications – Cardiovascular disease (clinical), Diabetes (clinical) and Health care client identification:

  - *Area of usual residence*
  - *Birth order*
  - *Birth plurality*
  - *Compensable status*
  - *Country of birth*
  - *Date of birth*
  - *Date patient presents*
  - *Department of Veterans' Affairs patient*
  - *Establishment identifier*
  - *Establishment sector*
  - *Estimated date flag*
  - *Height-measured*
  - *Person identifier*
  - *Region code*
  - *Service contact date*
  - *Sex*
  - *State/Territory identifier*
  - *Time patient presents*
  - *Triage category*
  - *Type of visit to emergency department*

New in version 12

- *Address*
- *Address type*
- *Alcohol consumption – concept*
- *Alcohol consumption frequency – self-report*
- *Alcohol consumption in standard drinks per day – self-report*
- *Australian postcode*
- *Behaviour-related risk factor intervention*
- *Behaviour-related risk factor intervention – purpose*
- *Blindness – diabetes complication*
- *Blood pressure – concept*
- *Blood pressure – diastolic measured*
- *Blood pressure – systolic measured*
- *Cardiovascular medication – current*
- *Cataract – history*
- *Centrelink customer reference number*
- *Cerebral stroke due to vascular disease – history*
- *Cholesterol-total – measured*
- *Cholesterol-HDL – measured*
- *Cholesterol-LDL – calculated*
- *Coronary artery disease – history of intervention or procedure*
- *Creatinine serum – measured*
- *CVD drug therapy – condition*
- *Date of diagnosis*
- *Date of referral to rehabilitation*
- *Diabetes status*
- *Diabetes therapy type*
- *Division of General Practice number*
- *Dyslipidaemia – treatment*
- *Emergency department – public hospital*
- *Emergency department arrival mode-transport*
- *Erectile dysfunction*
- *Family name*
- *Fasting status*
- *Foot deformity*
- *Foot lesion – active*
- *Foot ulcer – current*
- *Foot ulcer – history*
- *Formal community support access status*
- *Geographical location of service delivery outlet*
- *Given name(s)*
- *Glycosylated haemoglobin (HbA1c) – measured*
- *Glycosylated haemoglobin (HbA1c) – upper limit of normal range*
- *Health professionals attended – diabetes mellitus*
- *Hypertension – treatment*
- *Hypoglycaemia – severe*
- *Initial visit – diabetes mellitus*
- *Labour force status*
- *Length of non-admitted patient emergency department service episode*
- *Living arrangement*
- *Lower limb amputation due to vascular disease*
- *Microalbumin – units*
- *Microalbumin – upper limit of normal range*
- *Microalbumin/protein – measured*
- *Mother's original family name*
- *Myocardial infarction – history*
- *Name*
- *Name context flag*
- *Name suffix*
- *Name title*
- *Name type*
- *Non-admitted patient emergency department service episode*
- *Ophthalmological assessment – outcome*
- *Ophthalmoscopy – performed*
- *Peripheral neuropathy – status*
- *Peripheral vascular disease in feet – status*
- *Person identifier type – health care*
- *Physical activity sufficiency status*
- *Postal delivery point identifier*
- *Pregnancy – current status*
- *Premature cardiovascular disease family history – status*
- *Proteinuria – status*
- *Referred to ophthalmologist – diabetes mellitus*
- *Renal disease – end stage, diabetes complication*
- *Renal disease therapy*
- *Service delivery outlet*
- *Suburb/town/locality*
- *Telephone number*
- *Telephone number type*
- *Tobacco smoking status – diabetes mellitus*
- *Triglycerides – measured*
- *Vascular history*
- *Vascular procedures*
- *Visual acuity*
- *Waist circumference risk indicator – adults*
- *Year insulin started*
- *Year of diagnosis of diabetes mellitus*

Retired from version 12

- *Adult height (concept)*
- *Adult hip circumference (concept)*
- *Adult weight (concept)*

Knowledgebase

Modifications are made to the Knowledgebase. *National Health Data Dictionary* version 12 is created by downloading all Dictionary definitions with an administrative status of 'CURRENT' as at 01 July 2003 and printing the resulting document. This includes those that are still 'CURRENT' as of that date.

Feedback

Your feedback on this publication, the web site, the Knowledgebase or anything in relation to national heath standards development is more than welcome. Please feel free to contact the Institute by any of the means listed below. There is a Feedback area on the Knowledgebase for your convenience.

Contacts

National Data Development Unit

Further information about the *National Health Data Dictionary* and for any comments and suggestions about national standards development processes can be obtained by contacting the National Data Development Unit at the Australian Institute of Health and Welfare.

Contact: David Neilsen

Phone: (02) 6244 1148
Fax: (02) 6244 1166
e-mail: knowledgebase@aihw.gov.au

Secretariat

For further information about the National Health Data Committee and its processes please contact the National Health Data Committee Secretariat at the Australian Institute of Health and Welfare.

Phone: (02) 6244 1155

Fax: (02) 6244 1111

e-mail: nhdcsec@aihw.gov.au

Postal address: NHDC Secretariat
c/-Australian Institute of Health & Welfare
GPO Box 570
Canberra ACT 2601

National Health Information Model, Version 2

Background information

The National Health Information Model (NHIM) provides a means of structuring and organising information within the health sector. The development of Version 2 of the NHIM marks a change from an Entity-Relationship model in Version 1 to a high-level, relationship-free, multi-business framework. This was in recognition of the NHIM's general acceptance as a high-level framework and the need for multi-layering of the modelling process. That is, the change reflects the importance of the consistent identification of entities at the national level, and the greater importance of relationships or business rules at lower levels.

The NHIM is an 'information model', i.e. it is independent of process. In other words, it is not concerned with 'how' something happens, but rather with the information structure underlying the diverse processes and policies of health care delivery in Australia. By understanding the structure of health information resources, we are better able to exploit the information these resources contain. It is a 'conceptual model' aimed at establishing an agreed high-level structure, thus enabling the identification and description of broad entities and providing a framework for the development of more detailed subordinate models.

As a national framework, the NHIM enables related data elements from the Dictionary to be grouped under a single entity rather than organised alphabetically. Entities are the things that we need to know information or hold data about. Entities may be people, places, objects, events or concepts. The Knowledgebase uses this aspect of the NHIM as the conceptual gateway to locate, identify and download data elements.

The 12 major super-entities of the NHIM can be loosely organised into four categories; Parties and states, State-changing events, Environmental factors and Classifying systems. The coverage and importance of particular entities can be assessed by the population of an entity with data elements. For example, if there are few or no data elements for some model entities, this may be helpful in identifying areas for further development or in reassessment of the structure of the NHIM. Version 2 of the NHIM contains more entities than Version 1 largely because of the development of several sector-specific contextual models such as the National Community Services Information Model, the Disability and Aged Care Model, the Primary and Community Health Services National Information Model, the National Institutional-Based Ambulatory Care Model and the Community Health Information Model.

There is increasing interest in use of the NHIM as the main tool for standardising health and welfare information in Australia. This includes potential use of the NHIM for developing electronic data, designing information systems and as a framework for the consistent collection, storage and transmission of data. The next 3 to 5 years are expected to prove a watershed for the NHIM, with significant national health information development projects, including electronic health records, being actively pursued. There are a number of current developments that could see the application of the NHIM as an overall model for context-specific models, such as the HL7 Reference Information Model, the Good Electronic Health Record (GEHR), as well as forming the basis of other health information developments such as Health Online and Health*Connect*, and the work of the National Electronic Health Records Task Force. The NHIM will have to continue to prove its worth and utility in these projects, and will need to continue to learn from and develop with them in order to remain at the forefront of this work.

The development of Version 2 represents a significant period of consolidation and maturity for the NHIM, allowing it to progress from an initial concept and design to a better-proven and more robust architecture. The likelihood is that this pressure for enhancement and development will need to continue at a more rapid pace in the near future. Greater alignment between the projects under the Health and Community Services Information Management Groups will highlight the need for common information structures. The NHIM could act as a tool for building consensus, assisting business planning, providing logical frameworks and influencing application development across human service sectors.

Although models can improve information resource use and management in many ways, they are not substitutes for sound data development practice and management. Equally, there is no single best model for health or for any business activity. The best conceptual models continue to be challenged and supported by contextual level models while accommodating the technical and semantic diversity that generates them.

The Model diagram

The following page is a diagrammatic portrayal of the National Health Information Model, Version 2.

This page is to be replaced with NHIM diagram A3

Model entity index of data elements

Business factors

Business program:

Health and welfare program element:

Program evaluation:

Business statement:

Health and welfare policy/plan element:

Performance indicator:

Enabling factors

Resource:

Aggregate resource:

Specific resource:

Financial resource:

Event

Person event:

Birth event:

Death event:

Life event:

Crisis event:

Injury event:

Health and welfare service event:

Assessment event:

Exit/leave from service event:

Planning event:

Request for/entry into service event:

Service provision event:

Surveillance/monitoring event:

Expenditure

Capital expenditure:

Recurrent expenditure:

Location

Location element:

Address element:

Setting:

Organisational setting:

Other setting:

Service delivery setting:

Party characteristics

Person characteristic:

Accommodation characteristic:

Demographic characteristic:

Insurance/benefit characteristic:

Labour characteristic:

Legal characteristic:

Lifestyle characteristic:

Physical characteristic:

Social characteristic:

State of health and wellbeing:

Health status:

Physical wellbeing:

Data elements
A – N

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: Admitted patients:

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.

Non-admitted patients:

To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of activity being undertaken by the person when injured, on the basis of the information available at the time it is recorded. If two or more categories

are judged to be equally appropriate, select the one that comes first in the code list.

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

Actual place of birth

Identifying and Definitional Attributes

Knowledgebase ID: ***000003*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: The actual place where the birth occurred.

Context: Perinatal statistics:

Used to analyse the risk factors and outcomes by place of birth. While most deliveries occur within hospitals, an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of delivery was planned.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Hospital
2	Birth centre, attached to hospital
3	Birth centre, free-standing
4	Home
8	Other
9	Not stated

Guide for use: This is to be recorded for each baby the mother delivers from this pregnancy.

Verification rules:

Collection methods:

Related metadata: is a qualifier of Intended place of birth vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Other setting

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

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

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***
NMDS - Admitted patient mental health care	01/07/1995	

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

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:

Address

Identifying and Definitional Attributes

Knowledgebase ID: ***000799*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/01/03

Definition: The set of descriptors identifying the geographic location of a person, organisation, and/or object place.

Context: May be used to map to the Australian Bureau of Statistics' publication – Australian Standard Geographical Classifications using the National Localities Index (also produced by the ABS). This information can then be used to compare aggregate data to other information on a Statistical Local Area basis, for example. Similarly postcode can be obtained from Address for comparison with other information available on a postcode basis.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: Multiple addresses may be recorded as required. Each address must have an Address type to indicates the form/type of address (e.g. residential, mailing or business).

Multiple addresses may be held. Each address must be attributed to either one PARTY or to one PARTY IN A ROLE or to one ACTUAL SETTING.

Verification rules:

Collection methods:

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

relates to the data element Postal delivery point identifier vers 1

relates to the data element State/Territory identifier vers 3

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

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Address element

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

Comments:

Address type

Identifying and Definitional Attributes

Knowledgebase ID: ***000801*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A code representing a type of person or organisation address.

Context:

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Code

Representational layout: A

Minimum size: 1

Maximum size: 1

Data domain:

B	Business or office
M	Mailing or postal
R	Residential
T	Temporary residential
U	No fixed address/unknown/not stated

Guide for use: Multiple addresses may be recorded as required. This field can be a multiple occurring field, each address must have an Address type.

Verification rules:

Collection methods: Health care establishments should always collect the residential address of a person who is a health care client when an occasion of service or admission is provided. In addition, the establishment may also need to record other addresses for the person including:

- a mail postal address (for correspondence)
- temporary residential or accommodation address (such as for a person from rural Australia who is visiting an oncology centre for a course of treatment, or a person who usually resides overseas)
- business or office address (for specific correspondence purposes)
- unknown address where the person has no fixed address or does not wish to have their residential or a correspondence address recorded

At least one address must be recorded (this may be an unknown Address type).

If more than one of the above categories applies to any one address, use that which is listed highest.

Overseas health care clients:

Record the overseas address as the 'residential address' and record a 'temporary residential address' as their contact address in Australia.

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

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Address element

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

Comments:

Administrative expenses

Identifying and Definitional Attributes

Knowledgebase ID: **000244** ***Version No:*** **1**

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: All expenditure incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation).

Context: Health expenditure:

Considered to be a sufficiently significant element of non-salary recurrent expenditure as to be separately identified at the national level and also readily and easily collectable.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars. Rounded to nearest whole dollar.

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments:

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:

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:

Admission time

Identifying and Definitional Attributes

Knowledgebase ID: ***000358*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: Time at which an admitted patient commences an episode of care.

Context: Admitted patient care:

Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Time

Representational layout: HHMM

Minimum size: 4

Maximum size: 4

Data domain: Expressed as hours and minutes using 24-hour clock

Guide for use:

Verification rules:

Collection methods:

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

is used in conjunction with Admission date vers 4

supersedes previous data element Admission time vers 1

relates to the data element concept Admitted patient vers 3

relates to the data element Emergency department departure status vers 2

relates to the data element Type of visit to emergency department 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***

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.

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:

Age-standardised rate

Identifying and Definitional Attributes

Knowledgebase ID: ***000769*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/02

Definition: A method of adjusting the crude rate to eliminate the effect of differences in population age structures when comparing crude rates for different periods of time, different geographic areas and/or different population sub-groups (e.g. between one year and the next and/or States and Territories, Indigenous and non-Indigenous populations).

Adjustments are usually undertaken for each of the comparison populations against a standard population (rather than adjusting one comparison population to resemble another). Sometimes a comparison population is referred to as a study population.

Context: Population health and health services research:

For valid comparisons of rates in different populations, such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNNN.N

Minimum size: 1

Maximum size: 8

Guide for use: Formula:

Direct method	*Indirect method*
$SR = \frac{\sum(r_i P_i)}{\sum P_i}$	$SR = \frac{C}{\sum(R_i p_i)} \times R$

Where:

SR is the age-standardised rate for the population being studied

r_i is the age-group specific rate for age group *i* in the population being studied

P_i is the population of age group *i* in the standard population

C is the observed number of events* in the population being studied

$\sum R_i p_i$ is the expected number of events in the population being studied

R_i is the age-group specific rate for age group *i* in the standard population

p_i is the population for age group *i* in the population being studied

R is the crude rate in the standard population

* 'Events' can include deaths, incident or prevalent cases of disease or other conditions, or health care utilisation occurrences.

For the purposes of comparisons of population rates for Australia over time and/or populations within Australia (e.g. States and Territories, Indigenous and non-Indigenous) the standard population to be used is the final 30 June estimated Australian resident total population (males plus females) for the most recent year ending in 1 (e.g. 1991, 2001).

There are two methods (namely direct and indirect) of calculating age-standardised rates:

- The **direct method** is generally used for comparisons between study groups.
- The **indirect method** is recommended when the age-specific rates for the population being studied are not known but the total number of events is known or when calculating rates for small populations where fluctuations in age-specific rates can affect the reliability of rates calculated using the direct method.

The standard population used for purposes of international comparisons is generally the World Standard Population as recommended by the World Health Organization or the European Standard Population.

Five-year age groups should normally be used, with the age group 0–4 separated into 0 and 1 to 4, and ages over 85 years combined, thus 0, 1–4, 5–9, 10–14, ……., 80–84, 85+. If these age groups are not used, the actual age groups should be detailed in notes accompanying the age standardised population rate information.

Standardisation separately for males and females is not usually undertaken but may be appropriate for some applications, for example, hospitalisation rates for caesarean section is best undertaken using a female standard population rather than a standard population for both sexes. If standardisation is undertaken in this way this should be detailed in notes accompanying the age standardised population rate information.

When indirect age standardisation is undertaken for comparisons with or between Indigenous populations, the latest available rates could be used as the standard. In addition, age groups older than 70–74 years could be excluded. This is as recommended in the National Performance Indicators for Aboriginal and Torres Strait Islander Health Technical Specifications.

Collection methods:

Related metadata: relates to the data element Crude rate vers 1

Administrative Attributes

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

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Program evaluation

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

Comments: Standardised rates are generally multiplied by 1,000 or 100,000 to avoid small decimal fractions. They are then called standardised rates per 1,000 or 100,000 population.

The **indirect** method is also used to calculate **standardised mortality ratios (SMRs)** and other standardised ratios, for example for health service utilisation. These ratios express the overall experience of a comparison population in terms of the standard population by calculating the ratio of observed to expected deaths in the comparison population:

Formula:

$$SMR = \frac{C}{\sum(R_i p_i)}$$

The standard population used to calculate SMRs can be any population to which the comparison population is being compared. For example, if death rates for birthplace groups are compared to those of the Australian-born population using SMRs, the standard population would be the Australian-born population.

Sometimes the SMR is multiplied by 100 to express the ratio as a %age, although this is not universally accepted. Not multiplying by 100 has the benefit of being able to say that the SMR was, for example, 2.3 times that expected rather than 130% higher.

Standardised ratios for hospitalisations and other events can be calculated using similar techniques.

Alcohol consumption – concept

Identifying and Definitional Attributes

Knowledgebase ID: ***000802*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/01/03

Definition: The ethyl alcohol (ethanol) consumed by a person in alcoholic beverages such as beer, cider, wine, spirits and mixed drinks.

Alcohol consumption is usually measured in standard drinks.

An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol.

Context: Public health, health care and clinical settings.

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: Australian Alcohol Guidelines: Health Risks and Benefits, NH&MRC, October 2001

Source organisation: CV-Data Working Group

Information model link:

NHIM Lifestyle characteristic

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

Comments:

Alcohol consumption frequency – self report

Identifying and Definitional Attributes

Knowledgebase ID: ***000803*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A person's self-reported frequency of alcohol consumption.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Every day/7 days per week
02	5 to 6 days per week
03	3 to 4 days per week
04	1 to 2 days per week
05	2 to 3 days per month
06	Once per month
07	7 to 11 days in the past year
08	4 to 6 days in the past year
09	2 to 3 days in the past year
10	Once in the past year
11	Never drank any alcoholic beverage in the past year
12	Never in my life
99	Not reported

Guide for use:

Verification rules:

Collection methods: The World Health Organization, in its 2000 *International Guide for Monitoring Alcohol Consumption and Related Harm* document, suggests that in assessing alcohol consumption patterns a 'Graduated Quantity Frequency' method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences. This information can be collected (but not confined to) the following ways:

- in a clinical setting with questions asked by a primary health care professional
- as a self-completed questionnaire in a clinical setting
- as part of a health survey
- as part of a computer aided telephone interview.

It should be noted that, particularly in telephone interviews, the question(s) asked may not be a direct repetition of the data domain; yet they may still yield a response that could be coded to the full data domain or a collapsed version of the domain.

Related metadata: relates to the data element concept Alcohol consumption – concept vers 1

is used in conjunction with Alcohol consumption in standard drinks per day – self report vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: The Australian Alcohol Guidelines: Health Risk and Benefits endorsed by the National Health and Medical Research Council in October 2001

Source organisation: CV-Data Working Group

Information model link:

NHIM Lifestyle characteristic

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

Comments: DSS – Cardiovascular disease (clinical):

These data can be used to help determine the overall health profile of an individual or of a population. Certain patterns of alcohol consumption can be associated with a range of social and health problems. These problems include:

- social problems such as domestic violence, unsafe sex
- financial and relationship problems
- physical conditions such as high blood pressure, gastrointestinal problems, pancreatitis
- an increased risk of physical injury.
- Alcohol can also be a contributor to acute health problems.

Evidence from prospective studies indicates that heavy alcohol consumption is associated with increased mortality and morbidity from coronary heart disease and stroke (Hanna et al. 1992). However, there is some evidence to suggest that alcohol appears to provide some protection against heart disease (both illness and death) for both men and women from middle age onwards. Most, if not all, of this benefit is achieved with 1–2 standard drinks per day for men and less than 1 standard drink for women (the National Health and Medical Research Council's *Australian Alcohol Guidelines*, October 2001).

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that, in surveys of alcohol consumption, data on age, sex, and other socio-demographic variables also be collected where it is possible and desirable to do so. It is recommended that, when alcohol consumption is investigated in relation to health, data on other risk factors including overweight and obesity, smoking, high blood pressure and physical inactivity should be collected.

The *Australian Alcohol Guidelines: Health Risk and Benefits* endorsed by the National Health and Medical Research Council in October 2001 have defined risk of harm in the short term and long term based on patterns of drinking.

The table below outlines those patterns.

The alcohol consumption shown in the tables is not recommended for people who:

- have a condition made worse by drinking
- are on medication
- are under 18 years of age
- are pregnant
- are about to engage in activities involving risk or a degree of skill (e.g. driving, flying, water sports, skiing, operating machinery).

Risk of harm in the short term			
	Low risk (standard drinks)	Risky (standard drinks)	High risk (standard drinks)
Males (on a single occasion)	Up to 6	7 to 10	11 or more
Females (on a single occasion)	Up to 4	5 to 6	7 or more

Source: *NH&MRC Australian Alcohol Guidelines: Health Risk and Benefits* 2001.

Risk of harm in the long term			
	Low risk (standard drinks)	Risky (standard drinks)	High risk (standard drinks)
Males (on an average day)	Up to 4	5 to 6	7 or more
Overall weekly level	Up to 28 Per week	29 to 42 Per week	43 or more Per week
Females (on an average day)	Up to 2	3 to 4	5 or more
Overall weekly level	Up to 14 Per week	15 to 28 Per week	29 or more Per week

Source: *NH&MRC Australian Alcohol Guidelines: Health Risk and Benefits* 2001.

Alcohol consumption in standard drinks per day – self report

Identifying and Definitional Attributes

Knowledgebase ID: ***000648*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A person's self-reported usual number of alcohol-containing standard drinks on a day when they consume alcohol.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Count of consumption in Standard drinks per day

00

01

…. etc

99 Consumption not reported

Guide for use: This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the National Health and Medical Research Council, consumed per day. One standard drinks contains 10 grams alcohol.

The following gives the NH&MRC examples of a standard drink:

- Light beer (2.7%):
  - 1 can or stubbie = 0.8 a standard drink
- Medium light beer (3.5%):
  - 1 can or stubbie = 1 standard drink
- Regular Beer – (4.9% alcohol):
  - 1 can = 1.5 standard drinks
  - 1 jug = 4 standard drinks
  - 1 slab (cans or stubbies) = about 36 standard drinks
- Wine (9.5% – 13% alcohol):
  - 750-ml bottle = about 7 to 8 standard drinks
  - 4-litre cask = about 30 to 40 standard drinks
- Spirits:
  - 1 nip = 1 standard drink
  - Pre-mixed spirits (around 5% alcohol) = 1.5 standard drinks

When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g. 2.4 = 3).

Verification rules:

Collection methods: The World Health Organization's 2000 *International Guide for Monitoring Alcohol Consumption and Related Harm* document suggests that in assessing alcohol consumption patterns a 'Graduated Quantity Frequency' method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences. The CATI-TRG has not yet ratified a set of standard questions that addresses alcohol consumption.

Related metadata: relates to the data element concept Alcohol consumption – concept vers 1

is used in conjunction with the data element Alcohol consumption frequency – self report vers 1

is used in conjunction with the data element Behaviour-related risk factor intervention vers 1

is used in conjunction with the data element Behaviour-related risk factor intervention – purpose vers 1

is used in conjunction with the data element Service contact date vers 1

Administrative Attributes

Source document: The Australian Alcohol Guidelines: Health Risk and Benefits endorsed by the National Health and Medical Research Council in October 2001.

Source organisation: CV-Data Working Group

Information model link:

NHIM Lifestyle characteristic

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

Comments: DSS – Cardiovascular disease (clinical):

These data are used to help determine the overall health profile of an individual. Certain patterns of alcohol consumption can be associated with a range of social and health problems. These problems include:

- social problems such as domestic violence, unsafe sex
- financial and relationship problems
- physical conditions such as high blood pressure, gastrointestinal problems, pancreatitis
- an increased risk of physical injury.

Alcohol can also be a contributor to acute health problems.

Evidence from prospective studies indicates that heavy alcohol consumption is associated with increased mortality and morbidity from coronary heart disease and stroke (Hanna et al. 1992).

However, there is some evidence to suggest that alcohol appears to provide some protection against heart disease (both illness and death) for both men and women from middle age onwards. Most if not all of this benefit is achieved with 1–2 standard drinks per day for men and less than 1 standard drink for women (the National Health and Medical Research Council's *Australian Alcohol Guidelines*, October 2001).

Anaesthesia administered during labour

Identifying and Definitional Attributes

Knowledgebase ID: ***000013*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Anaesthesia administered for the operative delivery of the baby (caesarean, forceps or vacuum extraction).

Context: Perinatal statistics:

Anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	None
2	Local anaesthetic to perineum
3	Pudendal
4	Epidural or caudal
5	Spinal
6	General
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data are tabulated.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with the data element Apgar score at 1 minute vers 1

is used in conjunction with the data element Apgar score at 5 minutes vers 1

is used in conjunction with the data element Method of birth vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Service provision event

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

Comments:

Analgesia administered during labour

Identifying and Definitional Attributes

Knowledgebase ID: ***000014*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Agents administered to the mother by injection or inhalation to relieve pain during labour and delivery.

Context: Perinatal statistics:

Analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	None
2	Nitrous oxide
3	Intra-muscular narcotics
4	Epidural/caudal
5	Spinal
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data will be tabulated.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with the data element Method of birth vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Service provision event

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

Comments:

Anticipated patient election status

Identifying and Definitional Attributes

Knowledgebase ID: ***000631*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: Accommodation chargeable status nominated by the patient when placed on an elective surgery waiting list.

Context: Elective surgery waiting times.

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: The election status nominated by the patient at the time of being placed on an elective surgery waiting list, to be treated as either:

- a public patient or
- a private patient.

This item is independent of patient's hospital insurance status. The definitions of a public and private patient are those in the 1998– 2003 Australian Health Care Agreements:

1. Public patient:

An eligible person who receives or elects to receive a public hospital service free of charge.

2. Private patient:

An eligible person who elects to be treated as a private patient; and elects to be responsible for paying fees of the type referred to in clause 57 (clause 58 of the Northern Territory Agreement) of the Australian Health Care Agreements. Clause 57 states that 'Private patients and ineligible persons may be charged an amount for public hospital services as determined by the State'.

Patients whose charges are to be met by the Department of Veterans' Affairs are regarded as private patients.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Planning event

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

Comments: Anticipated election status may be used for the management of elective surgery waiting lists, but the term is not defined under the 1998–2003 Australian Health Care Agreements. Under the Australian Health Care Agreements, patients are required to elect to be treated as a public or private patient, at the time of, or as soon as practicable after admission. Therefore, the anticipated patient election status is not binding on the patient and may vary from the election the patient makes on admission.

Apgar score at 1 minute

Identifying and Definitional Attributes

Knowledgebase ID: ***000344*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Numerical score to evaluate the baby's condition at 1 minute after birth.

Context: Perinatal statistics:

Required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Apgar score (00–10) or

99 Not stated/inadequately described

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Apgar score vers 1

is a qualifier of Status of the baby vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

Apgar score at 5 minutes

Identifying and Definitional Attributes

Knowledgebase ID: ***000345*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Numerical score to evaluate the baby's condition at 5 minutes after birth.

Context: Perinatal statistics:

Required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Apgar score (00–10)

99 Not stated/inadequately described

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Apgar score vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

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:

Australian postcode

Identifying and Definitional Attributes

Knowledgebase ID: ***000788*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.

Context:

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

Data domain: Valid Australia Post Postal Code or blank.

Guide for use: Postcode may be used as a means of coding a person's area of usual residence or where an agency or organization is usually located. It can be mapped to Australian Standard Geographical Codes using an Australian Bureau of Statistics' (ABS) concordance to determine Statistical Local Area (SLA).

Verification rules: This data should be verified against the Australia Post Postcode File (web site www.auspost.com.au/postcodes). Alternatively, contact State or Territory health authorities for Postcode files.

Collection methods: Leave Postcode blank for any overseas address for:

- Overseas health care clients
- Unknown person address
- No fixed address.

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

relates to the data element Postal delivery point identifier vers 1

is used in conjunction with Labour force status vers 1

relates to the data element State/Territory identifier vers 3

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

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Address element

Data Set Specifications:	***Start date***	***End date***
DSS – Cardiovascular disease (clinical)	01/01/2003	
DSS – Health care client identification	01/01/2003	

Comments:

Australian administered territories and islands each have an Australia Post postcode:

Jervis Bay 2540

Lord Howe Island 2898

Norfolk Island 2899

Christmas Island 6798

Cocos (Keeling) Islands 6799

Macquarie Island 7151

Postal addresses may be different from where a person actually resides, or a service is actually located. As many postcodes have more than one SLA, postcode alone is not a sufficient basis for accurate coding of SLA in many cases.

DSS – Cardiovascular disease (clinical):

Postcode can also be used in association with the ABS Socio-Economic Indexes for Areas (SEIFA) (on CD-ROM Latest Issue: Aug 1996 was released on 30/10/1998) to derive socio-economic disadvantage, which is associated with cardiovascular risk.

People from lower socio-economic groups are more likely to die from cardiovascular disease than those from higher socio-economic groups. In 1997, people aged 25– 64 living in the most disadvantaged group of the population died from cardiovascular disease at around twice the rate of those living in the least disadvantaged group (Australian Institute of Health and Welfare 2001. Heart, stroke and vascular diseases – Australian facts 2001.). This difference in death rates has existed since at least the 1970s.

Behaviour-related risk factor intervention

Identifying and Definitional Attributes

Knowledgebase ID: ***000806*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The intervention taken to modify or manage the patient's behaviour-related risk factor(s).

Context: Public health, health care and clinical settings:

To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked to information on risk factors. The recording of Clinician's management interventions is critical information for health service monitoring, planning and patient outcomes. It is a major descriptor of the care provided throughout an episode of care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	No intervention
02	Information and education (not including written regimen)
03	Counselling
04	Pharmacotherapy
05	Referral provided to a health professional
06	Referral to a community program, support group or service
07	Written regimen provided
08	Surgery
98	Other
99	Not stated/inadequately defined

Guide for use: More than one code can be recorded.

Code 01 Refers to no intervention taken with regard to the 'Behaviour-related risk factor intervention – purpose'.

Code 02 Refers to where there is no treatment provided to the patient for a 'Behaviour-related risk factor intervention – purpose' other than information and education.

Code 03 Refers to any method of individual or group counselling directed towards the 'Behaviour-related risk factor intervention – purpose'. This code excludes counselling activities that are part of referral options as defined in code 5 and 6.

Code 04 Refers to pharmacotherapies that are prescribed or recommended for the management of the 'Behaviour-related risk factor intervention – purpose'.

Code 05 Refers to a referral to a health professional who has the expertise to assist the patient manage the 'Behaviour-related risk factor intervention – purpose'.

Code 06 Refers to a referral to community program, support group or service that has the expertise and resources to assist the patient manage the 'Behaviour-related risk factor intervention – purpose'.

Code 07 Refers to the provision of a written regimen (nutrition plan, exercise prescription, smoking contract) given to the patient to assist them with the management of the 'Behaviour-related risk factor intervention – purpose'.

Code 08 Refers to a surgical procedure undertaken to assist the patient with the management of the 'Behaviour-related risk factor intervention – purpose'.

Code 99 Not stated/inadequately defined

Verification rules:

Collection methods:

Related metadata: relates to the data element Alcohol consumption frequency – self report vers 1

is used in conjunction with Behaviour-related risk factor intervention – purpose vers 1

relates to the data element Physical activity sufficiency status vers 1

is used in conjunction with Service contact date vers 1

relates to the data element Tobacco smoking status vers 1

relates to the data element Waist circumference – measured vers 2

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments:

Behaviour-related risk factor intervention – purpose

Identifying and Definitional Attributes

Knowledgebase ID: ***000807*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The behaviour-related risk factor(s) associated with an intervention(s).

Context: Public health, health care and clinical settings:

The presence of one or more behaviour-related risk factors can be used to help determine the risk of future adverse health events and the development of chronic diseases.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Smoking
2	Nutrition
3	Alcohol misuse
4	Physical inactivity
8	Other
9	Not stated/inadequately described

Guide for use: More than one code can be selected.

Verification rules:

Collection methods:

Related metadata: relates to the data element Alcohol consumption frequency – self report vers 1

is used in conjunction with the data element Behaviour-related risk factor intervention vers 1

relates to the data element Physical activity sufficiency status vers 1

is used in conjunction with the data element Service contact date vers 1

relates to the data element Tobacco smoking status vers 1

relates to the data element Waist circumference – measured vers 2

Administrative Attributes

Source document: SNAP Framework – Commonwealth Department of Health and Ageing – June 2001.

AIHW 2002. Chronic Diseases and associated risk factors in Australians, 2001; Canberra.

Source organisation: CV-Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments:

DSS – Cardiovascular disease (clinical):

Behaviour-related risk factors include tobacco smoking, nutrition patterns that are high in saturated fats and excessive energy (calories /kilojoules) (National Heart Foundation of Australia – A review of the relationship between dietary fat and cardiovascular disease, AJND, 1999. 56 (Supp) S5-S22), alcohol misuse and physical inactivity.

The importance of behaviour-related risk factors in health has become increasingly relevant in recent times because chronic diseases have emerged as the principal threat to the health of Australians. Most of the chronic diseases have their roots in these risk-taking behaviours (Chronic Diseases and associated risk factors in Australians, 2001; AIHW 2002 Canberra).

SNAP initiative:

Smoking, Nutrition, Alcohol, Physical Activity (SNAP) Framework for General Practice is an initiative of the Joint Advisory Group (JAG) on General Practice and Population Health.

The lifestyle-related behavioural risk factors of smoking, poor nutrition (and associated overweight and obesity) and harmful and hazardous alcohol use and declining levels of physical activity have been identified as significant contributors to the burden of disease in Australia, and particularly towards the National Health Priority Areas (NHPAs) of diabetes, cardiovascular disease, some cancers, injury, mental health and asthma. The NHPAs represent about 70% of the burden of illness and injury in Australia. Substantial health gains could occur by public health interventions that address these contributory factors.

Around 86% of the Australian population attends a general practice at least once a year. There is therefore substantial opportunity for general practitioners to observe and influence the lifestyle risk behaviours of their patients. Many general practitioners already undertake risk factor management with their patients. There are also a number of initiatives within general practices, Divisions of General Practice, State/Territory and Commonwealth governments and peak non-government organisations aimed at reducing disease related to these four behavioural risk factors. Within the health system, there is potential for greater collaboration and integration of approaches for influencing risk factor behaviour based on system-wide roll-out of evidence-based best practice interventions.

The aim of the SNAP initiative is to reduce the health and socioeconomic impact of smoking, poor nutrition, harmful and hazardous alcohol use and physical inactivity on patients and the community through a systematic approach to behavioural interventions in primary care. This will provide an opportunity to make better use of evidence-based interventions and to ensure adoption of best practice initiatives widely through general practice.

Birth order

Identifying and Definitional Attributes

Knowledgebase ID: ***000019*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The sequential order of each baby of a multiple birth.

Context: NMDS – Perinatal:

Required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low birthweight, and a higher perinatal death rate.

DSS – Health care client identification:

While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Singleton or first of a multiple birth
2	Second of a multiple birth
3	Third of a multiple birth
4	Fourth of a multiple birth
5	Fifth of a multiple birth
6	Sixth of a multiple birth
8	Other
9	Not stated

Guide for use: Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be recorded as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).

Verification rules:

Collection methods: This data should be collected routinely for persons aged 28 days or less.

Related metadata: supersedes previous data element Birth order vers 1

is a qualifier of the data element Birth plurality vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: National Perinatal Data Development Committee
Standards Australia

Information model link:

NHIM Birth event

Data Set Specifications:	***Start date***	***End date***
NMDS – Perinatal	01/07/1997	
DSS – Health care client identification	01/01/2003	

Comments:

Birth plurality

Identifying and Definitional Attributes

Knowledgebase ID: ***000020*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.

Context: NMDS – Perinatal:

Multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality.

DSS – Health care client identification:

While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other
9	Not stated

Guide for use: Plurality of a pregnancy is determined by the number of live births or by the number of foetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only live births of any birthweight or gestational age, or foetuses weighing 400 grams or more, are taken into account in determining plurality. Foetuses aborted before 20 completed weeks or foetuses compressed in the placenta at 20 or more weeks are excluded.

Verification rules:

Related metadata: is qualified by the data element Birth order vers 2

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

Data Set Specifications:	***Start date***	***End date***
NMDS – Perinatal	01/07/1997	
DSS – Health care client identification	01/01/2003	

Comments:

Birthweight

Identifying and Definitional Attributes

Knowledgebase ID: ***000021*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/96

Definition: The first weight of the foetus or baby obtained after birth. The World Health Organization further defines the following categories:

- extremely low birthweight – less than 1,000 g (up to and including 999 g)
- very low birthweight – less than 1,500 g (up to and including 1,499 g)
- low birthweight – less than 2,500 g (up to and including 2,499 g).

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, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

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

Comments: The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).

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 gram 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.

Blindness – diabetes complication

Identifying and Definitional Attributes

Knowledgebase ID: ***000808*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual has become legally blind in either or both eyes. Legally, blindness is defined as less than 6/60 vision in the better eye with glasses.

Vision 6/60 is the ability to see only at 6 metres what the normal eye can see at 60 metres.

Context: Diabetes mellitus specific data element.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Blindness – (< 6/60) occurred in either or both eyes in the last 12 months
2	Blindness – (< 6/60) occurred in either or both eyes prior to the last 12 months
3	Blindness – (< 6/60) occurred in one eye within 12 months and in the other eye prior to the last 12 months
4	No blindness
9	Not stated/inadequately described

Guide for use: Blindness can be diagnosed in one eye within 12 months even though it has been previously diagnosed on the other eye (refers to code 3).

Verification rules:

Collection methods: Ask the individual if he/she has been diagnosed as legally blind (< 6/60) in both or either eye. If so record whether it has occurred within or prior to the last 12 months.

Alternatively determine blindness from appropriate documentation obtained from an ophthalmologist or optometrist.

Related metadata: relates to the data element Health professionals attended – diabetes mellitus vers 1

relates to the data element Cataract – history vers 1

relates to the data element Ophthalmological assessment – outcome vers 1

relates to the data element Ophthalmoscopy – performed vers 1

relates to the data element Referred to ophthalmologist – diabetes mellitus vers 1

relates to the data element Visual acuity vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

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

Diabetic retinopathy is a leading cause of blindness. Retinopathy is characterised by proliferation of the retina's blood vessels, which may project into the vitreous, causing vitreous haemorrhage, proliferation of fibrous tissue and retinal detachment. It is often accompanied by microaneurysms and macular oedema, which can express as blurred vision. The prevalence of retinopathy increases with increasing duration of diabetes. In the early stage, retinopathy is asymptomatic. Up to 20% of people with diabetes Type 2 have retinopathy at the time of diagnosis of diabetes. The cumulative prevalence of proliferation diabetic retinopathy and macular oedema after 20 years of Type 1 diabetes is about 40%. The Diabetic Retinopathy Study Group showed that panretinal photocoagulation reduces the risk of severe loss of vision by 50%.

Although diabetes retinopathy cannot totally be prevented, better control of blood sugar level slows the onset and progression of retinopathy (The Diabetes Control and Complications Trial – DCCT). Cataract and glaucoma are also associated diabetic eye problems that could lead to blindness.

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

According to the NSW Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, a comprehensive ophthalmological examination should be carried out:

- At diagnosis and then every 1–2 years for patients whose diabetes onset was at age 30 years or more.
- Within five years of diagnosis and then every 1–2 years for patients whose diabetes onset was at age less than 30 years.

If retinopathy is detected, review diabetes control and improve if necessary.

References:

Vision Australia, No. 2, 1997–8; University of Melbourne.

The Diabetic Retinopathy Study Research Group. Photocoagulation treatment of proliferative diabetic retinopathy.

Clinical application of Diabetic Retinopathy Study (DRS) finding, DRS Report Number 8. Ophthalmology. 1981; 88:583–600).

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

Blood pressure – concept

Identifying and Definitional Attributes

Knowledgebase ID: ***000809*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/01/03

Definition: The pressure exerted by blood against the walls of the blood vessels i.e. arteries, capillaries or veins.

Context:

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 Blood pressure – diastolic measured vers 1

relates to the data element Blood pressure – systolic measured vers 1

Administrative Attributes

Source document: Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases – Australian facts 2001. Canberra: AIHW, National Heart Foundation of Australia, National Stroke Foundation of Australia.

Source organisation: CV-Data Working Group

Information model link:

NHIM Service provision event

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

Comments:

Blood pressure – diastolic measured

Identifying and Definitional Attributes

Knowledgebase ID: ***000649*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The person's measured diastolic blood pressure.

Context: Public health, health care and clinical settings:

High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 2

Maximum size: 3

Data domain: Measured pressure head in millimetres of mercury (mm Hg)

999 Not collected

Guide for use: The diastolic pressure is recorded as phase V Korotkoff (disappearance of sound) however phase IV Korotkoff (muffling of sound) is used if the sound continues towards zero but does not cease.

If Blood pressure – diastolic is not collected or not able to be collected, code 999.

Verification rules:

Collection methods: Measurement protocol for resting blood pressure:

The diastolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the minimum pressure to which the arteries are exposed.

- The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.
- Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).
- Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.
- Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the velcro on the cuff is not totally attached, the cuff is probably too small.
- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being

measured.

- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2–3 mm Hg/beat (2–3 mm Hg/sec) or less.
- Recording the diastolic pressure use phase V Korotkoff (disappearance of sound). Use phase IV Korotkoff (muffling of sound) only if sound continues towards zero but does not cease. Wait 30 seconds before repeating the procedure in the same arm. Average the readings.
- If the first two readings differ by more than 4 mmHg diastolic or if initial readings are high, take several readings after five minutes of quiet rest.

Related metadata: is used in conjunction with Blood pressure – systolic measured vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: The National Heart Foundation Blood Pressure Advisory Committee's 'Guidelines for the Management of Hypertension – 1999' which are largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO-SH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17:151–83).

Australian Bureau of Statistics 1998. National Nutrition Survey User's Guide 1995. Cat. No. 4801.0. Canberra: ABS. (p. 20).

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

Source organisation: CV-Data Working Group

National Diabetes Data Working Group

Information model link:

NHIM Service provision event

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

Comments: The pressure head is the height difference a pressure can raise a fluid's equilibrium level above the surface subjected to pressure. (Blood pressure is usually measured as a head of Mercury, and this is the unit of measure nominated for this data element.)

The current (2002) definition of hypertension is based on the level of blood pressure above which treatment is recommended, and this depends on the presence of other risk factors, e.g. age, diabetes etc. (NHF 1999 Guide to Management of Hypertension).

DSS – Cardiovascular disease (clinical):

In the primary care setting, blood pressure on both arms should be measured at the first visit, particularly if there is evidence of peripheral vascular disease.

Variation of up to 5 mm Hg in blood pressure between arms can be acceptable. In certain conditions (e.g. chronic aortic dissection, subclavian artery stenosis) all blood pressure recordings should be taken from the arm with the highest reading.

Measure sitting and standing blood pressures in elderly and diabetic patients or in other situations in which orthostatic hypotension might be suspected.

Measure and record heart rate and rhythm. Note: Atrial fibrillation in a patient with hypertension indicates increased risk of stroke.

In all patients, consideration should be given to obtaining blood pressure measurements outside the clinic setting either by self-measurement of blood pressure at home or by non-invasive ambulatory blood pressure monitoring.

Target-organ damage and cardiovascular outcome relate more closely to blood pressures measured outside the clinic, particularly with ambulatory monitoring. An accurate, reliable machine and technique are essential if home blood pressure monitoring is to be used. In up to 30% of patients who are hypertensive in the clinic, blood pressure outside the clinic is within acceptable limits ('white coat' hypertension).

High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure (Ashwell 1997; DHSH 1994b; Whelton 1994; Kannel 1991). The higher the blood pressure, the higher the risk of both stroke and coronary heart disease. The dividing line between normotension and hypertension is arbitrary.

Both systolic and diastolic blood pressures are predictors of heart, stroke and vascular disease at all ages (Kannel 1991), although diastolic blood pressure is a weaker predictor of death due to coronary heart disease (Neaton & Wentworth 1992).

The risk of disease increases as the level of blood pressure increases. When blood pressure is lowered by 4–6 mmHg over two to three years, it is estimated that the risk reduces by 14% in patients with coronary heart disease and by 42% in stroke patients (Collins et al. 1990; Rose 1992.) When high blood pressure is controlled by medication, the risk of cardiovascular disease is reduced, but not to the levels of unaffected people.

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

DSS – Diabetes (clinical):

The United Kingdom Prospective Diabetes Study (1987 to 1998) showed major benefit from lowering blood pressure in preventing diabetes complications.

A target for blood pressure for people who suffer from diabetes is 130/85 mm Hg or less; recommended by the Australian Diabetes Society (if proteinuria is detected it is less than 125/75 mm Hg) Australian Medicines Handbook: last modified February, 2001).

Following the NSW Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus for patients who suffer from hypertension, if pharmacological intervention is required, ACE inhibitors are the preferred agents for treating hypertension in people with diabetes (unless contraindicated).

References:

'Guidelines for the Management of Hypertension – 1999' largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO) J Hypertension 1999; 17: 151–83.).

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

UKPDS 38 Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UK Prospective Diabetes Study Group. British Medical Journal (1998); 317: 703–713.

Blood pressure – systolic measured

Identifying and Definitional Attributes

Knowledgebase ID: ***000650*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The person's measured systolic blood pressure.

Context: Public health, health care and clinical settings:

High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 2

Maximum size: 3

Data domain: Measured pressure head in millimetres of mercury (mm Hg)

999 Not collected

Guide for use: For recording the systolic reading, use phase I Korotkoff (the first appearance of sound).

If Blood pressure – systolic is not collected or not able to be collected, code 999.

Verification rules:

Collection methods: Measurement protocol for resting blood pressure:

The systolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the maximum pressure to which the arteries are exposed.

- The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.
- Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).
- Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.-Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the Velcro on the cuff is not totally attached, the cuff is probably too small.
- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.

- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2–3 mm Hg/beat (2–3 mm Hg/sec) or less.
- For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). Wait 30 seconds before repeating the procedure in the same arm. Average the readings. If the first two readings differ by more than 6 mm Hg systolic or if initial readings are high, take several readings after five minutes of quiet rest.

Related metadata: is used in conjunction with Blood pressure – diastolic measured vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: The National Heart Foundation Blood Pressure Advisory Committee's 'Guidelines for the Management of Hypertension – 1999' which are largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO-ISH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17:151–83).

Australian Bureau of Statistics 1998. National Nutrition Survey User's Guide 1995. Cat. No. 4801.0. Canberra: ABS. (p. 20).

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

Source organisation: CV-Data Working Group

National Diabetes Data Working Group

Information model link:

NHIM Service provision event

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

Comments: The pressure head is the height difference a pressure can raise a fluid's equilibrium level above the surface subjected to pressure. (Blood pressure is usually measured as a head of Mercury, and this is the unit of measure nominated for this data element.)The current (2002) definition of hypertension is based on the level of blood pressure above which treatment is recommended, and this depends on the presence of other risk factors, e.g. age, diabetes etc.(NHF 1999 Guide to Management of Hypertension).

DSS – Cardiovascular disease (clinical):

In the primary care setting, blood pressure on both arms should be measured at the first visit, particularly if there is evidence of peripheral vascular disease.

Variation of up to 5 mm Hg in blood pressure between arms can be acceptable. In certain conditions (e.g. chronic aortic dissection, subclavian artery stenosis) all blood pressure recordings should be taken from the arm with the highest reading.

Measure sitting and standing blood pressures in elderly and diabetic patients or in other situations in which orthostatic hypotension might be suspected.

Measure and record heart rate and rhythm. Note: Atrial fibrillation in a patient with hypertension indicates increased risk of stroke.

In all patients, consideration should be given to obtaining blood pressure measurements outside the clinic setting either by self-measurement of blood pressure at home or by non-invasive ambulatory blood pressure monitoring.

Target-organ damage and cardiovascular outcome relate more closely to blood pressures measured outside the clinic, particularly with ambulatory monitoring. An accurate, reliable machine and technique are essential if home blood pressure monitoring is to be used. In up to 30% of patients who are hypertensive in the clinic, blood pressure outside the clinic is within acceptable limits ('white coat' hypertension).

High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure (Ashwell 1997; DHSH 1994b; Whelton 1994; Kannel 1991). The higher the blood pressure, the higher the risk of both stroke and coronary heart disease. The dividing line between normotension and hypertension is arbitrary.

Both systolic and diastolic blood pressures are predictors of heart, stroke and vascular disease at all ages (Kannel 1991), although diastolic blood pressure is a weaker predictor of death due to coronary heart disease (Neaton & Wentworth 1992).

The risk of disease increases as the level of blood pressure increases. When blood pressure is lowered by 4–6 mm Hg over two to three years, it is estimated that the risk reduces by 14 per cent in patients with coronary heart disease and by 42 per cent in stroke patients (Collins et al. 1990; Rose 1992.) When high blood pressure is controlled by medication, the risk of cardiovascular disease is reduced, but not to the levels of unaffected people.

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

DSS – Diabetes (clinical):

The United Kingdom Prospective Diabetes Study (1987 to 1998) showed major benefit from lowering blood pressure in preventing diabetes complications.

A target for blood pressure for people who suffer from diabetes is 130/85 mm Hg or less; recommended by the Australian Diabetes Society (if proteinuria is detected it is less than 125/75 mm Hg) Australian Medicines Handbook: last modified February, 2001).

Following the NSW Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus for patients who suffer from hypertension, if pharmacological intervention is required, ACE inhibitors are the preferred agents for treating hypertension in people with diabetes (unless contraindicated).

References:

'Guidelines for the Management of Hypertension – 1999' largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO) J Hypertension 1999; 17: 151–83.).

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

UKPDS 38 Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UK Prospective Diabetes Study Group. British Medical Journal (1998); 317: 703–713.

Bodily location of main injury

Identifying and Definitional Attributes

Knowledgebase ID: ***000086*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance:

The injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. The data element Nature of main injury – non-admitted patient together with data element Bodily location of main injury indicates the diagnosis.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Head (excludes face [02])
02	Face (excludes eye)
03	Neck
04	Thorax
05	Abdomen
06	Lower back (includes loin)
07	Pelvis (includes perineum, anogenital area and buttocks)
08	Shoulder
09	Upper arm
10	Elbow
11	Forearm
12	Wrist
13	Hand (include fingers)
14	Hip
15	Thigh
16	Knee
17	Lower leg
18	Ankle
19	Foot (include toes)
20	Unspecified bodily location
21	Multiple injuries (involving more than one bodily location)
22	Bodily location not required

Guide for use: If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis).

If any code from 01 to 12 or 26 to 29 in the data element Nature of main injury has been selected, the body region affected by that injury must be specified.

Select the category that best describes the location of the injury. If two or more categories are judged to be equally appropriate, select the one that comes first on the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'. Bodily location of main injury code is not required with other Nature of main injury codes (code 22 may be used as a filler to indicate that a specific body region code is not required).

Verification rules:

Collection methods:

Related metadata: is used in conjunction with the data element Nature of main injury – non-admitted patient vers 1

Administrative Attributes

Source document:

Source organisation: National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Injury surveillance	01/07/1996	

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

Body mass index

Identifying and Definitional Attributes

Knowledgebase ID: ***000367*** ***Version No: 2***

Metadata type: Derived Data Element

Admin. status: Current

01/07/03

Definition: A measure of a person's weight (body mass) relative to height used to assess the extent of weight deficit or excess in adults and excess only in children and adolescents.

Context: Public health and health care:

Body mass index (BMI) is used as an indicator of underweight, normal or healthy weight, and overweight and obesity in adults, and overweight and obesity in children and adolescents. On a population basis there is a strong association between BMI and health risks such as coronary heart disease, non-insulin-dependent diabetes mellitus and high blood pressure in adults. In population based surveys, BMI may be used:

- to indicate the prevalence of thinness and overweight and their sociodemographic distribution (problem identification)
- to evaluate health promotion and disease prevention programs (assessment of interventions)
- to monitor progress towards National public health policy
- to ascertain determinants and consequences of thinness and overweight
- in nutrition and physical activity surveillance and long-term planning.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN.NN*/NN.N**

Minimum size: 4

Maximum size: 5

Data domain: Calculated ratio for body mass index

888.8 Unknown

999.9 Not collected

Guide for use: Formula:

$$\text{BMI} = \frac{\text{weight (kg)}}{\text{height squared}(m^2)}$$

Body mass index is a continuous variable.

Code body mass index to one or two decimal places (i.e. 99.99 or 99.9).

If any component necessary for its calculation (i.e. weight or height for adults and weight, height, sex or date of birth for children and adolescents) is unknown or has not been collected (i.e. is coded to 888.8, 999.9).

Verification rules:

Collection methods:

*NN.NN for BMI calculated from measured height and weight.

**NN.N for BMI calculated from self-reported height and/or self-reported weight

BMI calculated from measured height and weight should be distinguished from BMI calculated from self-reported height and/or weight. When either self-reported height or self-reported weight is used in the calculation, BMI should be recorded as self-reported BMI. Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all.

BMI should be derived after the data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.

Related metadata:

supersedes previous data element Adult body mass index vers 1

is used in the derivation of Body mass index – classification vers 2

relates to the data element Date of birth vers 4

is calculated using the data element Height – measured vers 2

is calculated using the data element Height – self-reported vers 2

relates to the data element Sex vers 3

is calculated using the data element Weight – measured vers 2

is calculated using the data element Weight – self-reported vers 2

Administrative Attributes

Source document:

Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Cole TJ, Bellizi MC, Flegal KM, Bietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240–1243

Source organisation:

The World Health Organization and the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children's Hospital at Westmead on behalf of the Commonwealth Department of Health and Ageing.

Information model link:

NHIM Physical wellbeing

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

Comments:

This data element applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the US Centers for Disease Control 2000 BMI-for-age chart in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th %ile would be classified as overweight, while a BMI greater than the 95th %ile would be classified as obese. These %iles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as magnetic resonance imaging and dual x-ray absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering

good reliability.

Overweight and obesity, as defined by WHO for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups . Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

BMI can be calculated from measured height and weight, or self-reported height and weight, however, for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, BMI tends to be underestimated when based on self-reported, rather than measured, height and weight. This is due to the fact that, on average, height tends to be overestimated and weight tends to be underestimated when self-reported by respondents.

There are many individuals for whom BMI is an inappropriate measure of body fatness. These are individuals whose high body mass is due to excess muscle rather than fat (e.g. body builders or others in whom the level of physical activity promotes an increase in muscle mass); or in those with osteoporosis who will have a lower than usual BMI; or those who have a different body build (e.g. individuals with unusually long or short legs or a different body fat distribution) (WHO Expert Committee 1995).

This is particularly important when assessing individuals but should also be taken into account in interpreting data from populations in which there are sub-groups with genetic or environmental differences in body build, composition, skeletal proportions or body fat distribution. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

Thinness (low BMI) is also an indicator of health risk, often being associated with general illness, anorexia, cigarette smoking, drug addiction and alcoholism. Low BMI is consistently associated with increased risk of osteoporosis and fractures in the elderly.

Body mass index – classification

Identifying and Definitional Attributes

Knowledgebase ID: ***000368*** ***Version No: 2***

Metadata type: Derived Data Element

Admin. status: Current

01/07/03

Definition: The category of weight deficit or excess in adults and weight excess only in children and adolescents.

Context: Public health and health care:

Body mass index (BMI) is used as an indicator of underweight, normal or healthy weight and overweight and obesity in adults and of overweight and obesity in children and adolescents. On a population basis there is a strong association between BMI and health risk. In order to correctly categorise adults and children/adolescents, please refer to the categorisation protocol described under Guide for Use.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N*/N.N**

Minimum size: 1

Maximum size: 3

Data domain:

Classification		BMI	Risk of comorbidities
1	Not overweight or obese	< 25.00	
1.1	Underweight	< 18.50	Low (but risk of other clinical problems increased)
1.2	Normal range	18.50 – 24.99	Average
2	Overweight	> or = 25.00	
2.1	Overweight	> or = 25.00	
2.2	Pre Obese	25.00 – 29.99	Increased
3	Obese	> or = 30	
3.1	Obese class 1	30.00 – 34.99	Moderate
3.2	Obese class 2	35.00 – 39.99	Severe
3.3	Obese class 3	> or = 40.00	Very severe
9	Not stated/inadequately described		

Guide for use: Adults:

BMI for adults cannot be calculated if components necessary for its calculation (weight or height) is unknown or has not been collected (i.e is coded to 888.8 or 999.9).

BMI for adults is categorised according to the range it falls within as indicated by codes 1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3 or 9.9. For consistency, when the sample includes children and adolescents, adults can be analysed under the broader categories of 1, 2, 3 or 9 as used for categorising children and adolescents.

Children/adolescents:

BMI for children and adolescents aged 2 to 17 years cannot be calculated if components necessary for its calculation (date of birth, sex, weight or height) is unknown or has not been collected (i.e is coded to 888.8, 999.9 or 9).

Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all.

To determine overweight and obesity in children and adolescents, compare the derived BMI against those recorded for the relevant age and sex of the subject to be classified, against Table 1: Classification of BMI for children and adolescents, based on BMI cut-points developed by Cole et al.(see below). For example, an 11-year-old boy with a BMI of 21 would be considered overweight (i.e coded as 2), or a 7-year-old girl with a BMI of 17.5 would be considered not overweight or obese (i.e coded as 1).

Using this method, children and adolescents can only be coded as 1, 2, 3 or 9.

Table 1: Classification of overweight and obesity for children and adolescents

Age (years)	BMI equivalent to 25 kg/m²		BMI equivalent to 30 kg/m²	
	Males	Females	Males	Females
2	18.41	18.02	20.09	19.81
2.5	18.13	17.76	19.80	19.55
3	17.89	17.56	19.57	19.36
3.5	17.69	17.40	19.39	19.23
4	17.55	17.28	19.29	19.15
4.5	17.47	17.19	19.26	19.12
5	17.42	17.15	19.30	19.17
5.5	17.45	17.20	19.47	19.34
6	17.55	17.34	19.78	19.65
6.5	17.71	17.53	20.23	20.08
7	17.92	17.75	20.63	20.51
7.5	18.16	18.03	21.09	21.01
8	18.44	18.35	21.60	21.57
8.5	18.76	18.69	22.17	22.18
9	19.10	19.07	22.77	22.81
9.5	19.46	19.45	23.39	23.46
10	19.84	19.86	24.00	24.11
10.5	20.20	20.29	24.57	24.77
11	20.55	20.74	25.10	25.42
11.5	20.89	21.20	25.58	26.05
12	21.22	21.68	26.02	26.67
12.5	21.56	22.14	26.43	27.24
13	21.91	22.58	26.84	27.76
13.5	22.27	22.98	27.25	28.20
14	22.62	23.34	27.63	28.57
14.5	22.96	23.66	27.98	28.87
15	23.29	23.94	28.30	29.11
15.5	23.60	24.17	28.60	29.29
16	23.90	24.37	28.88	29.43
16.5	24.19	24.54	29.14	29.56
17	24.46	24.70	29.41	26.69
17.5	24.73	24.85	29.70	29.84
18	25.00	25.00	30.00	30.00

Collection methods: *N for BMI category determined (1, 2, 3 or 9) for persons (children and adolescents) aged 2 to 17 years.

**N.N for BMI category determined (1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3 or 9.9) for persons aged 18 years or older.

Standard definitions of overweight and obesity in terms of BMI are used to derive age-specific and age-adjusted indicators of overweight and obesity for reporting progress towards national public health policy.

Related metadata: supersedes previous data element Adult body mass index – classification vers 1

is used in conjunction with data element Body mass index vers 2

Administrative Attributes

Source document: Obesity: Preventing and Managing the Global Epidemic (Report of a WHO Consultation: World Health Organization 2000)

Cole TJ, Bellizi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240–1243

Source organisation: World Health Organization (see also Comments) and the consortium to develop an Australian standard definition of child/adolescent overweight and obesity at the Children's Hospital at Westmead on behalf of the Commonwealth Department of Health & Ageing

Information model link:

NHIM Physical wellbeing

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

Comments: This data element applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the US Centers for Disease Control 2000 BMI-for-age chart in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th %ile would be classified as overweight, while a BMI greater than the 95th %ile would be classified as obese. These %iles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults. BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity. The robust nature of the measurements and the widespread routine inclusion of weights and heights in clinical and population health surveys mean that a more selective measure of adiposity, such as skinfold thickness measurements, provides additional rather than primary information. BMI can be used to estimate the prevalence of obesity within a population and the risks associated with it, but does not, however, account for the wide variation in the nature of obesity between different individuals and populations (WHO 2000).

BMI values for adults are age-independent and the same for both sexes.

However, BMI values for children and adolescents aged 2 to 17 years are age- and sex-specific and are classified by comparing against the above table, Table 1: Classification of BMI for children and adolescents.

For adults and children and adolescents BMI may not correspond to the same degree of fatness in different populations due, in part, to differences in body proportions. The classification table shows a simplistic relationship between BMI and the risk of comorbidity, which can be affected by a range of factors, including the nature of the diet, ethnic group and activity level. The risks associated with increasing BMI are continuous and graded and begin at a BMI of 25 (or equivalent to 25 for children and adolescents). The interpretation of BMI grades in relation to risk may differ for different populations. Both BMI

and a measure of fat distribution (waist circumference or waist: hip ratio in adults) are important in calculating the risk of obesity comorbidities. The corresponding cut-off points for children and adolescents are arbitrary while those for adults relate to morbidity.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

Presentation of data:

A BMI of 30 or more is now widely accepted as denoting obesity. In some studies, however, other BMI cut off points both above and below 30 have been used. Differences in cut-off points have a major impact on estimates of the prevalence of obesity. For meaningful comparisons between or within populations it is advisable to use the single BMI cut off points recommended below (WHO 2000).

Caution is required in relation to BMI cut-off points when used for different ethnic groups because of limited outcome data for some ethnic groups, e.g. Aboriginal and Torres Strait Islander peoples. As with overweight the cut-off points for a given level of risk are likely to vary with body build, genetic background and physical activity.

The classification above is different from ones that have been used in the past and it is important that in any trend analysis consistent definitions are used.

BMI should not be rounded before categorisation to the classification above.

Capital expenditure

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/89

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

Context: Health expenditure:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

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

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

Calculate separately for each type described below:

1 Land and buildings:

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

2 Computer equipment/installations:

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

3 Major medical equipment:

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

4 Plant and (other) equipment:

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

5 Expenditure in relation to intangible assets:

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

6 Other capital expenditure:

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

Verification rules: Must be in Currency format

Collection methods:

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

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

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Capital expenditure

Data Set Specifications:	***Start date***	***End date***
NMDS – Public hospital establishments	01/07/1998	

Comments:

Capital expenditure – gross (accrual accounting)

Identifying and Definitional Attributes

Knowledgebase ID: ***000325*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Expenditure in a period on the acquisition or enhancement of an asset (excluding financial assets).

Context: Health expenditure:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

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

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

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

Calculate separately for each type of capital expenditure described below:

1 Land:

A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.

2 Buildings and building services (including plant):

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

3 Constructions (other than buildings):

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

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

4-7 Equipment:

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

4 Information technology:

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

5 Major medical equipment:

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

6 Transport:

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

7 Other equipment:

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

8 Intangible:

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

Verification rules: Must be in currency format

Collection methods:

Related metadata: supersedes previous data element Capital expenditure vers 1

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

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Capital expenditure

Data Set Specifications:	***Start date***	***End date***
NMDS – Public hospital establishments	01/07/1997	

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

Capital expenditure – net (accrual accounting)

Identifying and Definitional Attributes

Knowledgebase ID: ***000396*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Gross capital expenditure less trade-in values of replaced items and receipts from the sale of replaced or otherwise disposed items.

Context: Health expenditure:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

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

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

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

Calculate separately for each type of capital expenditure described below:

1 Land:

A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.

2 Buildings and building services (including plant):

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

3 Constructions (other than buildings):

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

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

4-7 Equipment:

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

4 Information technology:

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

5 Major medical equipment:

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

6 Transport:

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

7 Other equipment:

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

8 Intangible:

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

Verification rules: Must be in Currency format

Collection methods:

Related metadata: supersedes previous data element Capital expenditure vers 1

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

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Capital expenditure

Data Set Specifications:	***Start date***	***End date***
NMDS – Public hospital establishments	01/07/1997	

Comments:

Cardiovascular medication – current

Identifying and Definitional Attributes

Knowledgebase ID: ***000810*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual is taking some of the following cardiovascular medications:

- Angiotensin converting enzyme (ACE) inhibitors
- Angiotensin II (A2) antagonists
- Beta blockers
- Calcium antagonists

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 4

Data domain:

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

Guide for use: A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be recorded sequentially.

Code 1 ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril).

Code 2 Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan).

Code 3 Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol).

Code 4 Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil).

Example 1: If a person takes one of the ACE inhibitors and a Beta blocker, the code recorded would be 13.

Example 2: If a person takes one of the ACE inhibitors, an Angiotensin II receptor blocker and a Beta blocker, the code recorded would be 123.

Code 8 is used when none of the listed medications is being taken by the person.

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

Verification rules:

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

Are you currently taking any medication for a cardiovascular condition?
___Yes ___No

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

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

Ace Inhibitors	___Yes ___No
Angiotensin II receptor blockers	___Yes ___No
Beta blockers	___Yes ___No
Calcium antagonists	___Yes ___No

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

Related metadata: relates to the data element Blood pressure – diastolic measured vers 1

relates to the data element Blood pressure – systolic measured vers 1

relates to the data element Date of birth vers 4

relates to the data element Hypertension – treatment vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Request for/entry into service event

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

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.

Carer availability

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/01/03

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

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

Context: Personal and social support, clinical settings:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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

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

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

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

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

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

Verification rules:

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

Related metadata: supersedes previous data element Carer availability vers 2

relates to the data element Formal support access status vers 1

relates to the data element Living arrangement vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: HACC Data Dictionary Version 1.0, 1998

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Request for/entry into service event

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

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

DSS – Cardiovascular disease (clinical):

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

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

Cataract – history

Identifying and Definitional Attributes

Knowledgebase ID: ***000811*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Cataract currently present or has been previously removed from the right eye
2	Cataract currently present or has been previously removed from the left eye
3	Cataract currently present or has been previously removed from both eyes
4	No cataract present or has not been previously removed from either eye
9	Not stated/inadequately described

Guide for use:

Verification rules:

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

Ask the individual if he/she has a cataract in either or both eyes or has had a Cataract removed from either or both eyes previously. Alternatively obtain information from an ophthalmologist or optometrist or from appropriate documentation.

Related metadata: relates to the data element Health professionals attended – diabetes mellitus vers 1

relates to the data element Blindness – diabetes complication vers 1

relates to the data element Ophthalmological assessment – outcome vers 1

relates to the data element Ophthalmoscopy – performed vers 1

relates to the data element Referred to ophthalmologist – diabetes mellitus vers 1

relates to the data element Visual acuity vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

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

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

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

Category reassignment date

Identifying and Definitional Attributes

Knowledgebase ID: ***000391*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of clinical review for the awaited procedure, or is assigned to a different patient listing status category ('ready for care' or 'not ready for care').

Context: Elective surgery:

This date is necessary for the calculation of Waiting time at removal from elective surgery waiting list and Waiting time at a census date.

Relational and Representational Attributes

Datatype: Numeric

Representational form: DATE

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use: The date needs to be recorded each time a patient's urgency classification or listing status changes.

Verification rules:

Collection methods:

Related metadata: relates to the data element Clinical review vers 1

is used in conjunction with Clinical urgency vers 2

is used in conjunction with Patient listing status vers 3

supersedes previous data element Urgency reassignment date vers 1

is used in the calculation of Waiting time at a census date vers 2

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

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Assessment event

Data Set Specifications:	***Start date***	***End date***
NMDS – Elective surgery waiting times	01/07/1997	30/06/2002

Comments:

Census date

Identifying and Definitional Attributes

Knowledgebase ID: ***000174*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.

Context: Elective surgery:

This data element is necessary for the calculation of the waiting time until a census.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use: This date is recorded when a census is done of the patients on a waiting list.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Census date vers 1

is used in the calculation of Waiting time at a census date vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Surveillance/monitoring event

Data Set Specifications:	***Start date***	***End date***
NMDS – Elective surgery waiting times	01/07/1997	

Comments:

Centrelink customer reference number

Identifying and Definitional Attributes

Knowledgebase ID: ***000797*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A personal identifier assigned by Centrelink for the purposes of identifying people (and organisations) eligible for specific services, including some public health care services, such as oral health services.

Context: All Health services.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Identification number

Representational layout: NNNNNNNNNA

Minimum size: 0

Maximum size: 10

Data domain: The reference number comprises 9 numeric characters and one alphabetic character.

Guide for use: The Centrelink Customer Reference Number should only be collected from persons eligible to receive health services that are to be funded by Centrelink. The number may be reported to a Centrelink agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.

Verification rules:

Collection methods: The Centrelink Customer Reference Number is provided on 'Health Care Cards' and 'Pensioner Concession Cards'.

Related metadata:

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Recipient role

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

Comments: When a person accesses health services on the basis of being a Centrelink Customer, collection of the Centrelink Customer Reference Number is usually necessary. This data should not be collected and recorded if it is not needed to support the provision of such health services.

Cerebral stroke due to vascular disease – history

Identifying and Definitional Attributes

Knowledgebase ID: ***000812*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual has had a cerebral stroke due to vascular disease.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Cerebral stroke – occurred in the last 12 months
2	Cerebral stroke – occurred prior to the last 12 months
3	Cerebral stroke – occurred both in and prior to the last 12 months
4	No history of cerebral stroke due to vascular disease
9	Not stated/inadequately described

Guide for use:

Verification rules:

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

Related metadata: relates to the data element Blood pressure – diastolic measured vers 1

relates to the data element Blood pressure – systolic measured vers 1

relates to the data element Hypertension – treatment vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments: Cerebral stroke is a medical emergency condition with a high mortality rate, which is often recognised as a vascular complication of diabetes mellitus.

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

References:

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

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

Cessation of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: ***000422*** ***Version No: 2***

Metadata type: Data Element Concept

Admin. status: Current

01/07/01

Definition: Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.

Context: Alcohol and other drug treatment services.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: A client is identified as ceasing a treatment episode if one or more of the following apply:

- their treatment plan is completed
- they have had no contact with the treatment provider for a period of three months, nor is there a plan in place for further contact
- their 'principal drug of concern for alcohol and other drugs' has changed
- their 'main treatment type for alcohol and other drugs' has changed
- their 'treatment delivery setting for alcohol and other drugs' has changed
- their treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice, transferred to another service provider, died etc).

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Cessation of treatment vers 1

relates to the data element Date of cessation of treatment episode for alcohol and other drugs vers 2

relates to the data element Reason for cessation of treatment episode for alcohol and other drugs vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Exit/leave from service event

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

Comments:

Cholesterol-HDL – measured

Identifying and Definitional Attributes

Knowledgebase ID: ***000651*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A person's measured high-density lipoprotein cholesterol (HDL-C).

Context: Public health, health care and clinical settings:

The evidence is strong that HDL-C has a direct protective effect against the development of arteriosclerosis.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: N.NN

Minimum size: 2

Maximum size: 3

Data domain: Measurement in mmol/L to 2 decimal places

9.99 Not measured/inadequately described

Guide for use: When reporting, record whether or not the measurement of HDL Cholesterol was performed in a fasting specimen.

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

DSS – Diabetes (clinical):

When reporting, record absolute result of the most recent HDL Cholesterol measurement in the last 12 months to the nearest 0.01 mmol/L.

Verification rules:

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

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

Related metadata: is used in the calculation of Cholesterol-LDL calculated vers 1

relates to the data element Cholesterol-total – measured vers 1

relates to the data element Dyslipidaemia – treatment vers 1

is used in conjunction with Fasting status vers 1

is used in conjunction with Service contact date vers 1

relates to the data element Triglycerides – measured vers 1

Administrative Attributes

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

Source organisation: CV-Data Working Group

National Diabetes Data Working Group

Information model link:

NHIM Service provision event

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

Comments:

DSS – Cardiovascular disease (clinical):

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

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

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

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

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

DSS – Diabetes (clinical):

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

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

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

and the target is:

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

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

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

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

References:

National Heart Foundation of Australia – Lipid Management Guidelines 2001.

Cholesterol-LDL – calculated

Identifying and Definitional Attributes

Knowledgebase ID: ***000652*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/01/03

Definition: A person's calculated low-density lipoprotein cholesterol (LDL-C).

Context: Public health, health care and clinical setting.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN.N

Minimum size: 2

Maximum size: 3

Data domain: Calculated value recorded in mmol/L to one decimal place

Guide for use: Formula:

LDL-C = (plasma total cholesterol) - (high-density lipoprotein cholesterol) - (fasting plasma triglyceride divided by 2.2).

Verification rules:

Collection methods: The LDL-C is usually calculated from the Friedwald Equation (Friedwald et al. 1972), which depends on knowing the blood levels of the total cholesterol and high-density lipoprotein cholesterol and the fasting level of the triglyceride.

Note that the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L.

Note also that while cholesterol levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 6 weeks after an event.

- Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.
- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Related metadata: is calculated using Cholesterol-HDL – measured vers 1

is calculated using Cholesterol-total – measured vers 1

is calculated using Fasting status vers 1

is used in conjunction with Service contact date vers 1

is calculated using Triglycerides – measured vers 1

Administrative Attributes

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

Source organisation: CV-Data Working Group

Information model link:

NHIM Service provision event

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

Comments:

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

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

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

DSS – Cardiovascular disease (clinical):

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

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

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

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

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

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

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

Cholesterol-total – measured

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/01/03

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

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN.N

Minimum size: 3

Maximum size: 4

Data domain: Measurement in mmol/L to one decimal place

99.9 Not stated/Inadequately described

Guide for use: Record the absolute result of the TC measurement. When reporting, record whether or not the measurement of Cholesterol-total – measured was performed in a fasting specimen.

DSS – Diabetes (clinical):

When reporting, record absolute result of the most recent Cholesterol-total - measured in the last 12 months to the nearest 0.1 mmol/L.

Verification rules:

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

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

Related metadata: relates to the data element Cholesterol-HDL – measured vers 1

is used in the calculation of Cholesterol-LDL calculated vers 1

relates to the data element Dyslipidaemia – treatment vers 1

is used in conjunction with Fasting status vers 1

is used in conjunction with Service contact date vers 1

relates to the data element Triglycerides – measured vers 1

Administrative Attributes

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

National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra.

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

Source organisation: CV-Data Working Group

Information model link:

NHIM Service provision event

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

Comments:

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

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

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

DSS – Cardiovascular disease (clinical):

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

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

Several generalisations can be made from these cholesterol lowering trials:

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

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

DSS – Diabetes (clinical):

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

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

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

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

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

Classification of health labour force job

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/95

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

Context: Health labour force:

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

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

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN

Minimum size: 3

Maximum size: 3

Data domain:

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

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

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:	***Start date***	***End date***
NMDS – Health labour force	01/07/1995	

Comments:

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

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

Client type – alcohol and other drug treatment services

Identifying and Definitional Attributes

Knowledgebase ID: ***000426*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person.

Context: Alcohol and other drug treatment services:

Required to differentiate between clients according to whether the treatment episode concerns their own alcohol and/or other drug use or that of another person to provide a basis for description of the people accessing alcohol and other drug treatment services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Own alcohol or other drug use

2 Other's alcohol or other drug use

Guide for use: Code 1 A client who receives treatment or assistance concerning their own alcohol and/or other drug use.

Code 2 A client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person.

Where a client is receiving treatment or assistance for both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person code to 1.

Verification rules:

Collection methods: To be collected on commencement of a treatment episode with a service.

For clients covered under code 2, exclude the collection of the following data elements: Principal drug of concern, Other drugs of concern, Injecting drug use and Method of use for principal drug of concern.

Related metadata: supersedes previous data element Client type – alcohol and other drug treatment services vers 2

is a qualifier of Injecting drug use status vers 2

is a qualifier of Method of use for principal drug of concern vers 1

is a qualifier of Other drug of concern vers 2

is a qualifier of Principal drug of concern vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Alcohol and other drug treatment services	01/07/2003	

Comments:

Clinical intervention

Identifying and Definitional Attributes

Knowledgebase ID: ***000399*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/99

Definition: An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.

Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.

Invasive:

(a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device)

(b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).

Non-invasive:

Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).

Cognitive:

An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

Context: Health services:

Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments:

Clinical review

Identifying and Definitional Attributes

Knowledgebase ID: ***000024*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

Definition: The examination of a patient by a clinician after the patient has been added to the waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.

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 Clinical urgency vers 2

Administrative Attributes

Source document:

Source organisation: Hospital Access Program Waiting List Working Group

National Health Data Committee

Information model link:

NHIM Assessment event

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

Comments:

Clinical urgency

Identifying and Definitional Attributes

Knowledgebase ID: ***000025*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: A clinical assessment of the urgency with which a patient requires elective hospital care.

Context: Elective surgery:

Categorisation of waiting list patients by clinical urgency assists hospital management and clinicians in the prioritisation of their workloads. It gives health consumers a reasonable estimate of the maximum time they should expect to wait for care. Clinical urgency classification allows a meaningful measure of system performance to be calculated, namely the number or proportion of patients who wait for times in excess of the maximum desirable time limit for their urgency category (data element 'Overdue patient').

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency
2	Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency

Guide for use: The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Category reassignment date vers 2

relates to the data element concept Clinical review vers 1

is a qualifier of Extended wait patient vers 1

is a qualifier of Overdue patient vers 3

is used in conjunction with Patient listing status vers 3

is a qualifier of Waiting time at a census date vers 2

is a qualifier of Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Assessment event

Data Set Specifications:	***Start date***	***End date***
NMDS – Elective surgery waiting times	01/07/1997	

Comments: A patient's classification may change if he or she undergoes clinical review during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

Commencement of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: ***000427*** ***Version No: 2***

Metadata type: Data Element Concept

Admin. status: Current

01/07/01

Definition: Commencement of a treatment episode for alcohol and other drugs is the first service contact when assessment and/or treatment occurs with the treatment provider.

Context: Alcohol and other drug treatment services.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: A client is identified as commencing a treatment episode if one or more of the following apply:

- they are a new client
- they are a client recommencing treatment after they have had had no contact with the treatment provider for a period of three months or had any plan in place for further contact
- their Principal drug of concern for alcohol and other drugs has changed
- their Main treatment type for alcohol and other drugs has changed
- their Treatment delivery setting for alcohol and other drugs has changed.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Commencement of treatment vers 1

relates to the data element Date of commencement of treatment episode for alcohol and other drugs vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Request for/entry into service event

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

Comments:

Compensable status

Identifying and Definitional Attributes

Knowledgebase ID: ***000026*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: A compensable patient is an individual who is entitled to receive or has received a compensation payment with respect to an injury or disease.

A compensable patient is a person who:

- is entitled to claim damages under Motor Vehicle Third Party insurance or
- is entitled to claim damages under worker's compensation or
- has an entitlement to claim under public liability or common law damages.

Context: To assist in the analyses of utilisation and health care funding.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Compensable
2	Non-compensable
9	Not stated/not known

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

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

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Compensable status vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Insurance/benefit characteristic

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

Comments:

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

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

Complication of labour and delivery

Identifying and Definitional Attributes

Knowledgebase ID: ***000027*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.

Context: Perinatal statistics:

Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.NN

Minimum size: 3

Maximum size: 6

Data domain: ICD-10-AM 3rd edition

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

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM

Collection methods:

Related metadata: supersedes previous data element Complication of labour and delivery – ICD-9-CM code vers 1

is used in conjunction with Method of birth vers 1

is used in conjunction with Perineal status vers 2

is used in conjunction with Postpartum complication vers 2

is used in conjunction with Presentation at birth vers 1

Administrative Attributes

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

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

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

Comments:

Complications of pregnancy

Identifying and Definitional Attributes

Knowledgebase ID: ***000028*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal statistics:

Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the foetus and perinatal morbidity.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.NN

Minimum size: 3

Maximum size: 6

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

Guide for use: Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM

Collection methods:

Related metadata: supersedes previous data element Complications of pregnancy – ICD-9-CM code vers 1

is used in conjunction with Maternal medical conditions vers 2

Administrative Attributes

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

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

Congenital malformations

Identifying and Definitional Attributes

Knowledgebase ID: ***000030*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Admitted patient care:

Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and Representational Attributes

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: Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see the data element Congenital malformations – BPA classification).

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Congenital malformations – ICD-9-CM code vers 1

is used in conjunction with Neonatal morbidity vers 2

Administrative Attributes

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

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

Congenital malformations – BPA code

Identifying and Definitional Attributes

Knowledgebase ID: ***000029*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Perinatal statistics:

Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: ANNNN

Minimum size: 5

Maximum size: 5

Data domain: British Paediatric Association (BPA) Classification of Diseases (1979)

Guide for use: Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients.

NMDS – Perinatal:

Use of BPA codes is preferred as this is more detailed.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Neonatal morbidity vers 2

Administrative Attributes

Source document: British Paediatric Association Classification of Diseases (1979)

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

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

Contract establishment identifier

Identifying and Definitional Attributes

Knowledgebase ID: ***000416*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The establishment identifier of the other hospital involved in the contracted care.

Context: Admitted patient care and public hospital establishments.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: NNANNN

Minimum size: 6

Maximum size: 6

Data domain: Valid list of establishment numbers

Guide for use: The contracted hospital will record the establishment identifier of the contracting hospital.

The contracting hospital will record the establishment identifier of the contracted hospital.

Verification rules:

Collection methods:

Related metadata: relates to the data element Contract procedure flag vers 1

relates to the data element Contract role vers 1

relates to the data element Contract type vers 1

relates to the data element Contracted care commencement date vers 1

relates to the data element Contracted care completion date vers 1

relates to the data element Contracted hospital care vers 1

relates to the data element Establishment identifier vers 4

relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Request for/entry into service event

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

Comments:

Contract procedure flag

Identifying and Definitional Attributes

Knowledgebase ID: ***000417*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Contracted admitted procedure

2 Contracted non-admitted procedure

Otherwise blank

Guide for use: Procedures performed at another hospital under contract (Hospital B) are recorded by both hospitals, but flagged by the contracting hospital only (Hospital A). This flag is to be used by the contracting hospital to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service.

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

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate. Some jurisdictions may require these to be separately identified and they could be distinguished from contracted hospital procedures through the use of an additional code in the contract procedure flag data item.

Verification rules:

Collection methods:

Related metadata: relates to the data element Contract establishment identifier vers 1

relates to the data element Contract role vers 1

relates to the data element Contract type vers 1

relates to the data element Contracted care commencement date vers 1

relates to the data element Contracted care completion date vers 1

relates to the data element Contracted hospital care vers 1

relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Request for/entry into service event

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

Comments:

Contract role

Identifying and Definitional Attributes

Knowledgebase ID: ***000418*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital).

Context: Admitted patient care and public hospital establishments.

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Code

Representational layout: A

Minimum size: 1

Maximum size: 1

Data domain:

A Hospital A

B Hospital B

Guide for use: Hospital A is the contracting hospital (purchaser).

Hospital B is the contracted hospital (provider).

Verification rules:

Collection methods:

Related metadata: relates to the data element Contract establishment identifier vers 1

relates to the data element Contract procedure flag vers 1

relates to the data element Contract type vers 1

relates to the data element Contracted care commencement date vers 1

relates to the data element Contracted care completion date vers 1

relates to the data element Contracted hospital care vers 1

relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisation role

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

Comments:

Contract type

Identifying and Definitional Attributes

Knowledgebase ID: ***000419*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: Contract type describes the contract arrangement between the contractor and the contracted hospital. Contract types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.

Context: Admitted patient care and public hospital establishments.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Contract type B
2	Contract type ABA
3	Contract type AB
4	Contract type (A)B
5	Contract type BA

Guide for use: The contracting hospital (purchaser) is termed Hospital A.

The contracted hospital (provider) is termed Hospital B.

1 Contract type B:

A health authority/other external purchaser contracts hospital B for admitted service which is funded outside the standard funding arrangements.

2 Contract type ABA:

Patient admitted by Hospital A.

Hospital A contracts Hospital B for admitted or non-admitted patient service.

Patient returns to Hospital A on completion of service by Hospital B.

For example, a patient has a hip replacement at Hospital A, then receives aftercare at Hospital B, under contract to Hospital A. Complications arise and the patient returns to Hospital A for the remainder of care.

3 Contract type AB:

Patient admitted by Hospital A.

Hospital A contracts Hospital B for admitted or non-admitted patient service.

Patient does not return to Hospital A on completion of service by Hospital B.

For example, a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.

4 Contract type (A)B:

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

5 Contract type BA:

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

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

Verification rules:

Collection methods:

Related metadata: relates to the data element Contract establishment identifier vers 1

relates to the data element Contract procedure flag vers 1

relates to the data element Contract role vers 1

relates to the data element Contracted care commencement date vers 1

relates to the data element Contracted care completion date vers 1

relates to the data element Contracted hospital care vers 1

relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisation role

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

Comments:

Contracted care commencement date

Identifying and Definitional Attributes

Knowledgebase ID: ***000420*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The date the period of contracted care commenced.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use: This item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

Verification rules:

Collection methods:

Related metadata: relates to the data element Contract establishment identifier vers 1

relates to the data element Contract procedure flag vers 1

relates to the data element Contract role vers 1

relates to the data element Contract type vers 1

relates to the data element Contracted care completion date vers 1

relates to the data element Contracted hospital care vers 1

relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Request for/entry into service event

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

Comments:

Contracted care completion date

Identifying and Definitional Attributes

Knowledgebase ID: ***000428*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The date the period of contracted care is completed.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use: This item is to be used by the contracting hospital to record the date of completion of the contracted hospital care and will be the separation date for the contracted hospital.

Verification rules:

Collection methods:

Related metadata: relates to the data element Contract establishment identifier vers 1

relates to the data element Contract procedure flag vers 1

relates to the data element Contract role vers 1

relates to the data element Contract type vers 1

relates to the data element Contracted care commencement date vers 1

relates to the data element Contracted hospital care vers 1

relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Exit/leave from service event

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

Comments:

Contracted hospital care

Identifying and Definitional Attributes

Knowledgebase ID: ***000337*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

Definition: Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

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

Contracted hospital care must involve all of the following:

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

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

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

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

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

Verification rules:

Collection methods:

Related metadata: relates to the data element Contract establishment identifier vers 1
relates to the data element Contract procedure flag vers 1
relates to the data element Contract role vers 1
relates to the data element Contract type vers 1
relates to the data element Contracted care commencement date vers 1
relates to the data element Contracted care completion date vers 1
relates to the data element Inter-hospital same-day contracted patient vers 2
relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments:

Coronary artery disease – history of intervention or procedure

Identifying and Definitional Attributes

Knowledgebase ID: ***000813*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	CABG, angioplasty or stent – undertaken in last 12 months
2	CABG, angioplasty or stent – undertaken prior to the last 12 months
3	CABG, angioplasty or stent – both within and prior to the last 12 months
4	No CABG, angioplasty or stent undertaken
9	Not stated/inadequately described

Guide for use:

Verification rules:

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

Related metadata: relates to the data element Blood pressure – diastolic measured vers 1

relates to the data element Blood pressure – systolic measured vers 1

relates to the data element Cerebral stroke due to vascular disease – history vers 1

relates to the data element Hypertension – treatment vers 1

relates to the data element Myocardial infarction – history vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

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

Angioplasty is an elective surgery technique of blood vessels reconstruction.

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

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

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

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

Country of birth

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: The country in which the person was born.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

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

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

Verification rules: DSS – Health care client identification:

Country of birth for newborn babies should be 'Australia'.

Collection methods:

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

Administrative Attributes

Source document: ABS Catalogue No. 1269.0 (1998)

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Demographic characteristic

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

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

Creatinine serum – measured

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A person's measured serum creatinine.

Context: Clinical settings and population survey:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNN

Minimum size: 2

Maximum size: 4

Data domain: Measured in µmol/L (micromoles per litre)

Guide for use: Record the absolute result of the most recent serum creatinine measurement.

Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.

Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/function. The calculation uses the Cockcroft-Gault formula.

DSS – Diabetes (clinical):

Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre)

Verification rules:

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

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

Related metadata: is used in conjunction with Date of birth vers 4

relates to the data element Diabetes status vers 1

is used in conjunction with Renal disease – end stage, diabetes complication vers 1

is used in conjunction with Service contact date vers 1

is used in conjunction with Sex vers 3

is used in conjunction with Weight – measured vers 2

Administrative Attributes

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

Source organisation: CV-Data Working Group

National Diabetes Data Working Group

Information model link:

NHIM Service provision event

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

Comments:

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

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

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

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

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

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

To determine chronic renal impairment

GFR > 90 ml/min: normal

GFR > 60 – 90 ml/min: mild renal impairment

GFR > 30 – 60 ml/min: moderate renal impairment

GFR 0 – 30 ml/min: severe renal impairment

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

In general, patients with GFR < 30 ml/min are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure.

Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required.

Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (ie. hypertensive, proteinuric (> 1 g/24 hours), significant comorbid illness) should be considered for referral to a nephrologist well before function declines to less than 30 ml/min. (CARI Guidelines 2002. Australian Kidney Foundation). Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

Crude rate

Identifying and Definitional Attributes

Knowledgebase ID: ***000770*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/02

Definition: The ratio of the number of events in the population being studied during a certain time period to the estimated population size midway through that time period.

Context: Population health and health services research:

Required to calculate population rates, such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN.N

Minimum size: 1

Maximum size: 4

Data domain:

Guide for use: Formula:

R =d/n

Where:

R is the crude rate for the population being studied

d is the number of events for that population group

n is the total population for that population group

Verification rules:

Collection methods:

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

Administrative Attributes

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

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Program evaluation

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

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

CVD drug therapy – condition

Identifying and Definitional Attributes

Knowledgebase ID: ***000664*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Describes the condition(s) for which drug therapy is being used for the prevention or long-term treatment of cardiovascular disease.

Context: Public health, health care and clinical settings:

Its main use is to enable categorisation of drug management regimens used in the community for the long-term care of patients with or at increased risk of vascular disease.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Heart failure
02	Ischaemic heart disease
03	Hypertension
04	Atrial fibrillation (AF)
05	Other dysrhythmia or conductive disorder
06	Dyslipidaemia
07	Peripheral vascular disease (PVD)
08	Renal vascular disease
09	Stroke
10	Transient ischaemic attack (TIA)
97	Other
98	No CVD drugs prescribed
99	Not recorded

Guide for use: More than one code can be recorded.

The categorisations may be made using the most recent version of the Australian Modification of the appropriate International Classification of Diseases codes.

Verification rules:

Collection methods:

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

relates to the data element Vascular history vers 1

Administrative Attributes

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

Source organisation: CV-Data Working Group

Information model link:

NHIM Physical wellbeing

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

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

Date of birth

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The date of birth of the person.

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

National Minimum Data Sets:

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

NMDS – Perinatal:

Requires the collection of the date of birth for the mother and the baby(s).

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.

National Minimum Data Sets:

For 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.

NMDS – Perinatal:

Data collection systems must be able to differentiate between the date of birth of the mother and the baby(s). This is important in the Perinatal data collection as the date of birth of the baby is used to determine the antenatal length of stay and the postnatal length of stay.

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.

DSS – Cardiovascular disease (clinical):

Age is an important non-modifiable risk factor for cardiovascular conditions. The prevalence of cardiovascular conditions increases dramatically with age. For example, more than 60% of people aged 75 and over had a cardiovascular condition in 1995 compared with less than 9% of those aged under 35. Aboriginal and Torres Strait Islander peoples are more likely to have cardiovascular conditions than other Australians across almost all age groups. For example, in the 25–44 age group, 23% of Indigenous Australians reported cardiovascular conditions compared with 16% among other Australians (Heart, Stroke and Vascular Diseases: Australian Facts 2001. AIHW).

DSS – Diabetes (clinical):

Age over 45 is one of the predisposing factors for developing Type 2 diabetes and age over 35 in individuals of Aboriginal and Torres Strait Islander and certain other ethnic origins. The prevalence of diabetes increases with age, approaching 25% among those over 75.

References:

National Institute of Aging U. S. Department of Health and Human Services

NHMRC Evidence Based Guidelines for Case Detection and Diagnosis of Type 2 Diabetes

Date of cessation of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: ***000424*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: Date on which a treatment episode for alcohol and other drugs ceases.

Context: Alcohol and other drug treatment services:

Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

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: Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used. Refer to data element concept Cessation of treatment episode for alcohol and other drugs to determine when a treatment episode ceases.

Verification rules: Must be later than or the same as the Date of commencement of treatment for alcohol and other drugs.

Collection methods:

Related metadata: relates to the data element concept Cessation of treatment episode for alcohol and other drugs vers 2

supersedes previous data element Date of cessation of treatment vers 1

relates to the data element Reason for cessation of treatment episode for alcohol and other drugs vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS – WG

Information model link:

NHIM Exit/leave from service event

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

Comments:

Date of change to qualification status

Identifying and Definitional Attributes

Knowledgebase ID: ***000342*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: The date, within a newborn episode of care, on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa.

Context:

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: Record the date or dates on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa.

If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status.

Verification rules: Must be greater than or equal to admission date

Collection methods:

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

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

is used in conjunction with Newborn qualification status vers 2

is used in conjunction with Care type vers 4

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments:

Date of commencement of service event

Identifying and Definitional Attributes

Knowledgebase ID: ***000356*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: The day on which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client's care.

Context: Hospital non-admitted patient care and public health care.

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: For the emergency departments the date of triage is recorded separately. In an emergency department the service event commences when the medical officer (or, if no medical officer is on duty in the emergency department, a treating nurse) provides treatment or diagnostic service. The commencement of a service event does not include contact associated with triage.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Date of service event vers 1

relates to the data element Date of triage vers 1

relates to the data element Date patient presents vers 2

relates to the data element Emergency department waiting time to admission vers 1

relates to the data element Emergency department waiting time to service delivery vers 2

relates to the data element concept Patient presentation at emergency department vers 1

relates to the data element Time of commencement of service event vers 2

relates to the data element Time of triage vers 1

relates to the data element Time patient presents vers 2

Administrative Attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Emergency department waiting times	01/07/2001	

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.

Date of commencement of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: ***000430*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: Date on which a treatment episode for alcohol and other drugs commences.

Context: Alcohol and other drug treatment services:

Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

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: The first date of the treatment episode is the first service contact within the treatment episode when assessment and/or treatment occurs.

Verification rules: Must be earlier than or the same as the Date of cessation of treatment episode for alcohol and other drugs.

Collection methods:

Related metadata: relates to the data element concept Commencement of treatment episode for alcohol and other drugs vers 2

supersedes previous data element Date of commencement of treatment vers 1

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Request for/entry into service event

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

Comments:

Date of completion of last previous pregnancy

Identifying and Definitional Attributes

Knowledgebase ID: ***000037*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Date on which the pregnancy preceding the current pregnancy was completed.

Context: Perinatal statistics:

Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low birthweight.

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: Estimate day of month (DD), if first day is unknown.

Verification rules:

Collection methods:

Related metadata: is qualified by Outcome of last previous pregnancy vers 1

is a qualifier of Previous pregnancies vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

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

Date of diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: ***000666*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The date a disease or condition is diagnosed.

Context: Health services and clinical setting:

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

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:

Collection methods:

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

relates to the data element concept Diagnosis vers 1

is used in conjunction with Service contact date vers 1

relates to the data element Vascular history vers 1

relates to the data element Vascular procedures vers 1

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Service provision event

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

Comments: Classification systems, which enable the allocation of a code to the diagnostic information, can be used in conjunction with this data element.

Date of diagnosis of cancer

Identifying and Definitional Attributes

Knowledgebase ID: ***000771*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).

Context: Patient administration systems, cancer notification systems, population cancer statistics, research.

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: Date of diagnosis must be:

>= Date of birth

<= Date of death

Diagnosis of cancer after death:

If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate.

Incidental diagnosis of cancer:

If a patient is admitted for another condition (e.g. a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.

Verification rules:

Collection methods: Reporting rules:

The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:

Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.

Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.

Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Related metadata: relates to the data element Date of birth vers 4

relates to the data element Estimated date flag vers 1

Administrative Attributes

Source document: Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Source organisation: International Agency for Research on Cancer

World Health Organization

International Association of Cancer Registries.

Information model link:

NHIM Request for/entry into service event

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

Comments:

Date of first contact

Identifying and Definitional Attributes

Knowledgebase ID: ***000039*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.

The definition includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home
- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home
- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

This applies irrespective of whether the person is present or not.

The definition excludes:

- first visits where the visit objective is not met, such as first visit made where no one is home.

Context: To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This data element enables the capture of the commencement of care irrespective of the setting in which the activities took place.

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: This should occur after a previous Date of last contact of a previous care episode and prior to or on the same as Date of first delivery of service.

Collection methods: The Date of first contact can be the same as Date of first delivery of service and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date.

Related metadata: supersedes previous data element Date of first contact with the community nursing service vers 1

relates to the data element Date of last contact vers 2

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Request for/entry into service event

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

Comments: This item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

Date of first delivery of service

Identifying and Definitional Attributes

Knowledgebase ID: ***000038*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: The date of first delivery of service to a person in a non-institutional setting.

The definition excludes:

- visit made to persons in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service, with the intent of planning for the future delivery of community-based services
- first visits where there is no contact with the person, such as a first visit where no-one is at home
- telephone, letter or other such contacts made with the person prior to the first home visit.

In situations where the first delivery of service determines that no future visit needs to be made, the Date of first delivery of service and the Date of last delivery of service will be the same.

Context: The Date of first delivery of service is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.

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: This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Date of first contact.

Collection methods: As long as contact is made with the person in a non-institutional setting, the Date of first delivery of service must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.

Related metadata: supersedes previous data element Date of first community nursing visit vers 1

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Request for/entry into service event

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

Comments: This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing hospital-in-the-home services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

Date of last contact

Identifying and Definitional Attributes

Knowledgebase ID: ***000040*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Date of the last contact between a staff member of the community service and a person in any setting.

The definition includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;
- bereavement visits in any setting;
- visits made to the person's home to complete the service, including the collection of equipment.

The definition excludes:

- visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.

Context: To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.

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: This could be the same as the date of discharge.

Verification rules: May occur after or on the same day as Date of last delivery of service

Collection methods:

Related metadata: relates to the data element Date of first contact vers 2

supersedes previous data element Date of last community service contact with client/family vers 1

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Exit/leave from service event

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

Comments: If service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.

Date of procedure

Identifying and Definitional Attributes

Knowledgebase ID: ***000772*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: The date on which a procedure commenced during an inpatient episode of care.

Context: Admitted patient care:

Required to provide information on the timing of the procedure in relation to the episode of care

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use: Admitted patients:

Record date of procedure for all procedures undertaken during an episode of care in accordance with ICD-10-AM 3rd edition.

Verification rules:

Collection methods: Right justified and zero filled (e.g. 1 May 2001 should read 01052001)

Date of procedure >= admission date

Date of procedure <= separation date

Related metadata: relates to the data element Procedure vers 5

Administrative Attributes

Source document:

Source organisation: National Centre for Classification in Health

Information model link:

NHIM Service provision event

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

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

Reference: Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998–1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Date of referral to rehabilitation

Identifying and Definitional Attributes

Knowledgebase ID: ***000656*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The date on which a person is referred to a rehabilitation service.

Context: Clinical settings.

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 referral is not known then provision should be made to collect month and year as a minimum, using 01 as DD if only the month and year are known.

Verification rules:

Collection methods: To be collected at the time of commencement of rehabilitation.

Related metadata: relates to the data element Date of diagnosis vers 1

relates to the data element Vascular history vers 1

relates to the data element Vascular procedures vers 1

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Service provision event

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

Comments: Required to derive those referred to a rehabilitation service from those eligible to attend and who actually attend. This data element can be used to determine the time lag between referral and commencement of rehabilitation.

Date of triage

Identifying and Definitional Attributes

Knowledgebase ID: ***000353*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: The day on which the patient is triaged.

Context: Admitted patient care:

Required to identify the commencement of the service and calculation of waiting times.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Emergency department waiting time to service delivery vers 2

relates to the data element concept Patient presentation at emergency department vers 1

relates to the data element Time of triage vers 1

Administrative Attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group

National Health Data Committee

Information model link:

NHIM Assessment event

Data Set Specifications:	***Start date***	***End date***
NMDS – Emergency department waiting times	01/07/1999	

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

Date patient presents

Identifying and Definitional Attributes

Knowledgebase ID: ***000350*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: The day on which the patient/client presents for the delivery of a service.

Context: Admitted patient care.

Community health care.

Hospital non-admitted patient care:

Required to identify commencement of a visit and for calculation of waiting times.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use: For community health care, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences.

The time of patient presentation at the emergency department is the earliest occasion of being registered clerically or triaged.

The date that the patient presents is not necessarily:

- the listing date for care (see Listing date for care data element concept), nor
- the date on which care is scheduled to be provided, nor
- the date on which commencement of care actually occurs (for admitted patients see Admission date, for hospital non-admitted patient care and community health care see Date of commencement of service event).

Verification rules:

Collection methods:

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

relates to the data element Date of commencement of service event vers 2

relates to the data element Date of triage vers 1

supersedes previous data element Date patient presents vers 1

relates to the data element Emergency department waiting time to admission vers 1

relates to the data element Emergency department waiting time to service delivery vers 2

relates to the data element concept Patient presentation at emergency department vers 2

relates to the data element Time of commencement of service event vers 2

relates to the data element Time of triage vers 1

relates to the data element Time patient presents vers 2

relates to the data element Triage category vers 2

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

Administrative Attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group

National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Emergency department waiting times	01/07/2001	
NMDS – Non-admitted patient emergency department care	01/07/2003	

Comments: This data element is required to identify commencement of a visit and for calculation of waiting times. It supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS – Emergency department waiting times.

Day program attendances

Identifying and Definitional Attributes

Knowledgebase ID: ***000211*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/89

Definition: A count of the number of patient/client visits to day centres. Each individual is to be counted once for each time they attend a day centre. Where an individual is referred to another section of the hospital/centre and returns to the day centre after treatment only one visit is to be recorded.

Context: Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain: Number of attendances

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Service provision event

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

Comments: Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

This data element is derived from data elements that are not currently specified in the *National Health Data Dictionary*, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Department of Veterans' Affairs file number

Identifying and Definitional Attributes

Knowledgebase ID:	***000204***	***Version No: 2***
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	A unique number issued to a veteran by the Department of Veterans' Affairs.	
Context:	This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.	

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Identification number
Representational layout:	AAANNNNNA
Minimum size:	9
Maximum size:	9
Data domain:	Valid identification number
Guide for use:	All veterans and veteran community clients are issued with a DVA File Number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA File Number. The DVA File Number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to the appropriate government agency to reconcile payment for the service provided. 1st character is the State Code (an alpha) – N, V, Q, W, S or T for the appropriate State/Territory. ACT is included in NSW (N) and NT with SA (S). Next 7 characters are the File Number, made up of: War Code + numeric digits, where: if War Code is 1 alpha character, add 6 digits (ANNNNNN) if War Code is 2 alpha characters, add 5 digits (AANNNNN) if War Code is 3 alpha characters, add 4 digits (AAANNNN) 9th character is the Segment Link (an alpha) which represent members related to the veteran. The alpha code is generated in the order that cards are issued. For example A, B, C, D etc. CAUTIONARY NOTE: For Veterans the 9th character is left blank. Note that Veterans may have a Medicare Card Number and a Department of Veterans' Affairs (DVA) Number or only a DVA Number. DVA card number: This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the Gold and White cards may be used in conjunction with the data element an imprinter. This method records the DVA

file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA File Number for data linking unless specifically authorised by law.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Department of Veterans' Affairs file number vers 1

relates to the data element Department of Veterans' Affairs patient vers 1

Administrative Attributes

Source document:

Source organisation: Department of Veterans' Affairs

Information model link:

NHIM Recipient role

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

Comments: DVA has three (3) types of health cards:

- Gold Card
- White Card
- Repatriation Pharmaceutical Benefits Card.

Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.

The Gold Card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.

The White Card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post-traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.

The White Card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.

A White Card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war-related.

When a Gold/White Card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare Card Number is not required or relevant.

It should be noted that there are a number of Gold Card holders who do not have a Medicare Card.

The Repatriation Pharmaceutical Benefits Card is an orange coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Department of Veterans' Affairs patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000421*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: An eligible person whose charges for this hospital admission are met by the Department of Veterans' Affairs (DVA).

Context: Health services:

To assist in analyses of utilisation and health care funding.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain: 1 Yes

2 No

Guide for use: Refer to the *Veterans' Entitlements Act 1986* for details of eligible DVA beneficiaries.

Verification rules:

Collection methods: Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.

Related metadata: relates to the data element Department of Veterans' Affairs file number vers 2

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 – Non-admitted patient emergency department care	01/07/2003	
NMDS – Admitted patient care	01/07/2000	30/06/2001
NMDS – Admitted patient mental health care	01/07/2000	30/06/2001

Comments:

Eligible veterans and war widow/widowers can receive free treatment at any public hospital, former Repatriation Hospitals (RH) or a Veteran Partnering (VP) contracted private hospital as a private patient in a shared ward, with the doctor of their choice. Admission to a public hospital does not require prior approval from the DVA.

When treatment cannot be provided within a reasonable time in the public health system at a former RH or a private VP hospital, there is a system of contracted non-VP private hospitals which will provide care.

Admission to a contracted private hospital requires prior financial authorisation from DVA. Approval may be given to attend a non-contracted private hospital when the service is not available at a public or contracted non-VP private hospital.

In an emergency a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to DVA.

If an eligible veteran or war widow/widower chooses to be treated under Veterans' Affairs arrangements, which includes obtaining prior approval for non-VP private hospital care, DVA will meet the full cost of their treatment.

Dependency in activities of daily living

Identifying and Definitional Attributes

Knowledgebase ID: ***000309*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: An indicator of a person's ability to carry out activities of daily living without assistance.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding. The following is an example of the minimum items, which are indicative of dependency.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain:

a) Mobility* 1 2 3 4
b) Toileting 1 2 3 4
c) Transferring 1 2 3 4 5
d) Bathing 1 2 3 4
e) Dressing 1 2 3 4
f) Eating 1 2 3 4 5
g) Bed mobility 1 2 3 4 5
h) Bladder continence 1 2 3 4 5 6
i) Bowel continence 1 2 3 4 5
j) Extra surveillance* 1 2 3 4 5 6 7
k) Technical care** not required, or time in minutes

Guide for use: Services may elect to adopt the measures as defined in this item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

All items must be completed.

Select the appropriate code from the options provided for activities a) to g)

when:

1 = Independent

2 = Requires observation or rare physical assistance

3 = Cannot perform the activity without some assistance

4 = Full assistance required (totally dependent); for bed mobility – a hoist is used

5 = For transferring – person is bedfast; for eating – tube-fed only; for bed mobility – 2 persons physical assist is required

* applies to walking, walking aid or wheelchair

Select the appropriate code for h) Bladder continence when:

1 = Continent of urine (includes independence in use of device)

2 = Incontinent less than daily

3 = Incontinent once per 24 hour period

4 = Incontinent 2 – 6 times per 24 hour period

5 = Incontinent more than 6 times per 24 hour period

6 = Incontinent more than once at night only

Select the appropriate code for I) Bowel continence when:

1 = Continent of faeces (includes independence in use of device)

2 = Incontinent less than daily

3 = Incontinent once per 24 hour period

4 = Incontinent regularly, more than once per 24 hour period

5 = Incontinent more than once at night only

Select the appropriate code for j) Extra surveillance* when:

1 = No additional attention required

2 = Less than 30 minutes individual attention per day

3 = More than 30 and more than or equal to 90 minutes individual attention per day

4 = Requires at least two hours intervention per week on an episodic basis

5 = More than 90 minutes but less than almost constant individual attention

6 = Requires almost constant individual attention

7 = Cannot be left alone at all

* Extra surveillance refers to behaviour, which requires individual attention and/or planned intervention. Some examples of extra surveillance are:

- aggressiveness
- wandering
- impaired memory or attention
- disinhibition and other cognitive impairment.

Select the appropriate code for k) Technical care** not required, or time in minutes, when:

1 = No technical care requirements

or

____ = Daytime technical (minutes per week)

____ = Evening technical (minutes per week)

____ = Night-time technical (minutes per week)

____ = Infrequent technical (minutes per month)

** Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some

of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)
- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Verification rules:

Collection methods: Commencement of Care episode. (There may be several visits in which assessment data are gathered.)

Related metadata: supersedes previous data element Client dependency vers 1

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Functional wellbeing

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

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The CNMDSA recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The data domain specified in this item consists of a number of standard elements, which can be used to map to and/or score from the majority of them.

Depreciation

Identifying and Definitional Attributes

Knowledgebase ID: ***000246*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.

Context: Health expenditure:

This item has been retained for national minimum data sets because of its significance for the private sector. Current period depreciation charges form a significant component of expenditure for any health establishment whose financial statements are based on accrual accounting.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars. Rounded to nearest whole dollar.

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments: With the long-term trend towards accrual accounting in the public sector, this item will ultimately become significant for public sector establishments. Public sector establishments in some States have adopted modified accrual accounting identifying depreciation only, before reaching full accrual accounting. Depreciation is now reported for most public sector establishments and should be reported as a separate recurrent expenditure.

Depreciation should be identified separately from other recurrent expenditure categories.

Diabetes status

Identifying and Definitional Attributes

Knowledgebase ID: ***000654*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Identifies a person with or at risk of diabetes.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Type 1 diabetes
02	Type 2 diabetes
03	Gestational diabetes mellitus (GDM)
04	Other (secondary diabetes)
05	Previous gestational diabetes mellitus (GDM)
06	Impaired fasting glucose (IFG)
07	Impaired glucose tolerance (IGT)
08	Not diagnosed with diabetes
09	Not assessed
99	Not stated/inadequately described

Guide for use: Note that where there is a GDM or Previous GDM (i.e. data domains 3 & 5) and a current history of Type 2 diabetes then record 'Code 2' Type 2 diabetes.

This same principle applies where a history of either IFG (impaired fasting glycaemia) or IGT (impaired glucose tolerance) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.

Code 01 Type 1 diabetes:

Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with this Type can be identified at earlier clinical stages than 'diabetes mellitus'.

Code 02 Type 2 diabetes:

Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

Code 03 Gestational diabetes mellitus (GDM):

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition

applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy. Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines.

Code 04 Other (Secondary diabetes):

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.

Code 05 Previous GDM:

Where the person has a history of GDM.

Code 06 Impaired fasting glycaemia (IFG):

IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.

Code 07 Impaired glucose tolerance (IGT):

IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.

Code 08 Not diagnosed with diabetes:

The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).

Code 09 Not assessed:

The subject has not had their diabetes status assessed.

Code 99 is for unknown or information unavailable.

Verification rules:

Collection methods: The diagnosis is derived from and must be substantiated by clinical documentation.

DSS – Diabetes (clinical):

A type of diabetes should be recorded and coded for each episode of patient care.

Related metadata: relates to the data element Date of diagnosis vers 1

relates to the data element Diabetes therapy type vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a WHO Consultation (Alberti & Zimmet 1998).

Source organisation: CV-Data Working Group

National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

DSS – Cardiovascular disease (clinical):

People with diabetes have two to five times increased risk of developing heart, stroke and vascular disease (Zimmet & Alberti 1997). Cardiovascular disease is the most common cause of death in people with diabetes.

Diabetes is also an important cause of stroke, and people with diabetes may have a worse prognosis after stroke.

Heart, stroke and vascular disease and diabetes share common risk factors, but also diabetes is an independent risk factor for heart, stroke and vascular disease.

During the 1995 National Health Survey, about 15 per cent of those with diabetes reported having heart disease, at almost six times the rate noted among people without diabetes. In 1996–97, almost one in six hospital separations, with coronary heart disease as any listed diagnosis, also had diabetes recorded as an associated diagnosis. Heart disease appears earlier in life and is more often fatal among those with diabetes.

Diabetes may accentuate the role of elevated blood pressure in stroke. The incidence and prevalence of peripheral vascular disease in those with diabetes increase with the duration of the diabetes.

Mortality is increased among patients with peripheral vascular disease and diabetes, in particular if foot ulcerations, infection or gangrene occur. There is limited information on whether the presence of heart, stroke and vascular disease promotes diabetes in some way.

High blood pressure, high cholesterol and obesity are often present along with diabetes. As well as all being independent cardiovascular risk factors, when they are in combination with glucose intolerance (a feature of diabetes) and other risk factors such as physical inactivity and smoking, these factors present a greater risk for heart, stroke and vascular disease.

Evidence is accumulating that high cholesterol and glucose intolerance, which often occur together, may have a common aetiological factor. Despite these similarities, trends in cardiovascular mortality and diabetes incidence and mortality are moving in opposite directions.

While the ageing of the population following reductions in cardiovascular mortality may have contributed to these contrasting trends, the role of other factors also needs to be clearly understood if common risk factor prevention strategies are to be considered (from Commonwealth Department of Health & Ageing and Australian Institute of Health and Welfare (1999) National Health Priority Areas Report: Cardiovascular Health).

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

DSS – Diabetes (clinical):

Uncontrolled diabetes leads to a variety of complications, often resulting in limitation of activity, disability, illness and premature mortality. Therefore ongoing assessment is required to identify people at risk of developing complications so that early preventive strategies can be applied. Although there is no cure for diabetes, with modern treatment most people can lead a full and active life and avoid long-term complications.

Aetiological classifications contained in the scientific paper 'Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a WHO Consultation' (Alberti & Zimmet 1998).

Diabetes therapy type

Identifying and Definitional Attributes

Knowledgebase ID: ***000668*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The type of diabetes therapy the person is currently receiving.

Context: Public health, health care and clinical setting:

Its main use is to enable categorisation of management regimes against best practice for diabetes.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Diet and exercise only
02	Oral hypoglycaemic – sulphonylurea only
03	Oral hypoglycaemic – biguanide (e.g. metformin) only
04	Oral hypoglycaemic – alpha-glucosidase inhibitor only
05	Oral hypoglycaemic – thiazolidinedione only
06	Oral hypoglycaemic – meglitinide only
07	Oral hypoglycaemic – combination (e.g. biguanide and sulphonylurea)
08	Oral hypoglycaemic – other
09	Insulin only
10	Insulin plus oral hypoglycaemic
98	Nil – not currently receiving diabetes treatment
99	Not stated/inadequately described

Guide for use:

Code 01 includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates; low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.

Code 98 no current diet, tablets or insulin therapy(ies)

Code 99 missing information

Verification rules:

Collection methods: To be collected at the commencement of treatment and at each review.

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

relates to the data element Renal disease therapy vers 1

is used in conjunction with Service contact date vers 1

relates to the data element Vascular history vers 1

relates to the data element Year insulin started vers 1

Administrative Attributes

Source document:

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

Information model link:

NHIM Physical wellbeing

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

Comments:

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

DSS – Diabetes (clinical):

The objectives and priorities of treatment must be tailored to the individual considering age, sex, weight and individual health status.

An individual management plan for each patient should include the following:

- establishment of targets of treatment
- healthy eating plan
- education in self-monitoring
- adjustment of treatment and in approaches to coping with emergencies
- exercise program
- risk factor reduction, e.g. smoking cessation
- use of oral hypoglycaemic agents, if required
- use of insulin, if required
- screening for and treatment of complications of diabetes.

In addition to glycaemic control, management of diabetes of either type requires close attention to other risk factors for the development of complications, and the impact of lifestyle changes on blood glucose levels should be monitored. In patients with Type 2 diabetes, an increase in physical activity is essential in management of lipids and glucose level. Increased physical activity has been recognised as perhaps the most feasible way of modifying glucose intolerance, a risk factor for developing diabetes and macrovascular disease (Guest & O'Dea 1992).

References:

Berkow R, editor. The Merck Manual. 16th ed. Rahway (New Jersey, USA): Merck Research Laboratories; 1992.

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

Diagnosis onset type

Identifying and Definitional Attributes

Knowledgebase ID: ***000773*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: A qualifier for each coded diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care

Context: Health services:

Improved analysis of diagnostic information, especially in relation to patient safety and adverse event monitoring

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Primary condition

2 Post-admit condition

9 Unknown or uncertain

Guide for use: Assign the relevant diagnosis type flag to all of the ICD-10-AM disease codes recorded in the hospital morbidity system. Specific guidelines for correct assignment of diagnosis flag type are in ICD-10-AM Australian Coding Standards, Third Edition 1 July 2002.

The following rules only apply to:

- diagnoses which meet the criteria in the Australian Coding Standards (ACS) 0001 Principal diagnosis and ACS 0002 Additional diagnoses or a specialty standard which requires the use of an additional code(s).
- hospital morbidity data
- 'episode of care' refers to hospital or day procedure episodes of care

1 Primary condition

- a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status. In the case of neonates, the condition(s) present at birth.
- a previously existing condition not diagnosed until the current episode of care
- in delivered obstetric cases, all conditions which arise from the beginning of labour to the end of second stage

2 Post-admit condition

- a condition which arises during the current episode of care and would not have been present on admission

9 Unknown or uncertain

- a condition where the documentation does not support assignment to 1 or 2

Explanatory Notes:

The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

The flag on morphology codes should match that on the corresponding neoplasm code.

Conditions meeting the criteria of principal diagnosis may, in some cases, have a flag of 2.

Verification rules:

Collection methods: A diagnosis onset type should be recorded and coded upon completion of an episode of admitted patient care.

Related metadata: relates to the data element Activity when injured vers 2

relates to the data element Additional diagnosis vers 4

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

relates to the data element Place of occurrence of external cause of injury vers 5

relates to the data element Principal diagnosis vers 3

Administrative Attributes

Source document:

Source organisation: National Centre for Classification in Health

Information model link:

NHIM Request for/entry into service event

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

Comments:

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.

Division of General Practice number

Identifying and Definitional Attributes

Knowledgebase ID: ***000669*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The Division of General Practice number as designated by the Commonwealth Government of Australia. Each separately administered Division of General Practice has a unique identifying number.

Context: Public health and health care:

To facilitate outcomes focused collection, linkage, pooling, analysis, reporting and feedback of aggregated data, which could potentially be linked to other health initiatives.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNN

Minimum size: 3

Maximum size: 3

Data domain: Codes defined in the Commonwealth Department of Health and Ageing: General Practice in Australia: 2000. First Edition May 2000.

Guide for use: Divisions of General Practice are geographically based networks of general practitioners. In geographical terms, each Division of General Practice can be described by the postcodes that fall within its jurisdiction.

Verification rules:

Collection methods:

Related metadata: relates to the data element Person identifier vers 1

Administrative Attributes

Source document: Commonwealth Department of Health and Ageing: General Practice in Australia: 2000. First Edition May 2000.

Source organisation: CV-Data Working Group

Information model link:

NHIM Service provider role

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

Comments:

Domestic services

Identifying and Definitional Attributes

Knowledgebase ID: ***000241*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: The costs of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars. Rounded to nearest whole dollar.

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments: The possibility of separating fuel, light and power from domestic services which would bring the overall non-salary recurrent expenditure categories closer to the old Hospitals and Allied Services Advisory Council categories was briefly considered by the Resources Working Party but members did not hold strong views in this area.

Drug supplies

Identifying and Definitional Attributes

Knowledgebase ID: ***000238*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: The cost of all drugs including the cost of containers. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure:

This is a significant element of non-salary recurrent expenditure and also national level data on drug expenditure in hospitals is of considerable interest in its own right to a wide range of persons and organisations.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars. Rounded to nearest whole dollar.

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments:

Dyslipidaemia – treatment

Identifying and Definitional Attributes

Knowledgebase ID: ***000814*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether an individual is currently treated for dyslipidaemia (abnormal lipid levels) using anti-lipid medication.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Yes – currently treated for dyslipidaemia using anti-lipid medication
2	No – not currently treated for dyslipidaemia using anti-lipid medication
9	Not stated/inadequately described

Guide for use: Record as code 1 if on drug treatment for dyslipidaemia.

Verification rules:

Collection methods: Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Related metadata: relates to the data element Cholesterol-HDL – measured vers 1

relates to the data element Cholesterol-total – measured vers 1

relates to the data element Fasting status vers 1

relates to the data element Triglycerides – measured vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments: Dyslipidaemia is an excessive accumulation of one or more of the major lipids transported in plasma. Plasma lipid levels may be reduced by a variety of

agents having different mechanisms of action. They also have different effects on the plasma lipid profile.

Dyslipidaemia is associated with many health problems including diabetes and hypertension. It is often related to overweight and obesity. Usually caused by inappropriate diet and sedentary lifestyle, dyslipidaemia has been reaching epidemic proportions. Active lifestyle and low calorie diets are the best way of prevention, however sometimes for the treatment of dyslipidaemia the use of pharmacotherapy is required. Abnormal levels of blood lipids are associated with increased risk of developing coronary health disease especially in diabetic patients.

The risk of coronary and other macrovascular disorders is 2–5 times higher in people with diabetes than in non-diabetic subjects and increases in parallel with the degree of dyslipidaemia. Diabetes mellitus greatly modifies the significance of lipoprotein levels, particularly when associated with smoking, hypertension and family history of cardiovascular disease. Poor metabolic control of diabetes seems to have impact on abnormal lipoprotein level.

Primary dyslipidaemia, due to genetic and environmental (especially dietary) factors, is diagnosed if secondary causes have been excluded (hypothyroidism, nephrotic syndrome, cholestasis, anorexia nervosa, diabetes mellitus Type 2, renal impairment).

Elective care

Identifying and Definitional Attributes

Knowledgebase ID: ***000348*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

Definition: Care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours.

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 Waiting list category vers 3

Administrative Attributes

Source document:

Source organization: Hospital Access Program Waiting List Working Group

National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments:

Elective surgery

Identifying and Definitional Attributes

Knowledgebase ID: ***000046*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

Definition: Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians.

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 Waiting list category vers 3

Administrative Attributes

Source document:

Source organisation: Hospital Access Program Waiting List Working Group

National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments:

Emergency department – public hospital

Identifying and Definitional Attributes

Knowledgebase ID: ***000815*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/03

Definition: The dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care.

The emergency department must be part of a hospital and be licensed or otherwise recognised as an emergency department by the appropriate State or Territory authority.

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

Context: Emergency department care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element concept Non-admitted patient emergency department service episode vers 1

Administrative Attributes

Source document:

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

Information model link:

NHIM Service delivery setting

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

Comments: This data element concept has been defined to support the NMDS – Non-admitted patient emergency department care. It is not intended as a definitive statement of the role or purpose of an emergency department.

The national definition of an emergency department and the care that is provided in an emergency department is characterised by jurisdictional and local differences. For example, there is no national agreement on the identification and classification of emergency department-related settings such as observation units, short-stays units, or the use of 'admitted patient beds' located in an emergency department setting.

Emergency department is therefore defined as a concept, and not necessarily as a physical premises, setting or site.

Emergency department arrival mode – transport

Identifying and Definitional Attributes

Knowledgebase ID: ***000816*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The mode of transport by which the person arrives at the emergency department.

Context: Emergency department care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Ambulance, air ambulance or helicopter rescue service
2	Police/correctional services vehicle
8	Other
9	Not stated/unknown

Guide for use: Code 8 (Other) includes patients who walked in, came by private transport, public transport, community transport, or taxi.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

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

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Non-admitted patient emergency department care	01/07/2003	

Comments:

Emergency department departure status

Identifying and Definitional Attributes

Knowledgebase ID: ***000359*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The status of the patient at the end of the non-admitted patient emergency department service episode

Context: Non-admitted patient emergency department care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Admitted to this hospital (including to units or beds within the emergency department)
2	Non-admitted patient emergency department service episode completed – departed without being admitted or referred to another hospital
3	Referred to another hospital for admission
4	Did not wait to be attended by a health care professional
5	Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed
6	Died in emergency department as a non-admitted patient
7	Dead on arrival, not treated in emergency department

Guide for use: A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

Code 2 includes patients who departed under their own care, under police custody and under the care of a residential aged care facility or other carer. Code 2 excludes those who died in the emergency department, which should be coded to Code 6.

Verification rules:

Collection methods:

Related metadata: relates to the data element Date of commencement of service event vers 2

relates to the data element Date patient presents vers 2

supersedes previous data element Departure status vers 1

relates to the data element concept Emergency department – public hospital vers 1

relates to the data element Emergency department waiting time to admission vers 1

relates to the data element Emergency department waiting time to service delivery vers 2

relates to the data element concept Patient presentation at emergency department vers 1

relates to the data element Time of commencement of service event vers 2

relates to the data element Time patient presents vers 2

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

Administrative Attributes

Source document:

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

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Emergency department waiting times	01/07/2003	
NMDS – Non-admitted patient emergency department care	01/07/2003	

Comments:

Emergency department waiting time to admission

Identifying and Definitional Attributes

Knowledgebase ID: ***000397*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/98

Definition: The time elapsed for each patient from presentation to the emergency department to admission to hospital.

Context: Emergency department care:
This is a critical waiting times data item. This item is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this data item will have many uses including to assist in the planning and management of hospitals and in health care research.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Time

Representational layout: HHMM

Minimum size: 4

Maximum size: 4

Data domain: Count in numbers of hours and minutes

Guide for use: Calculated from admission date and time minus date and time patient presents for those emergency department patients who are admitted.

Verification rules:

Collection methods: To be collected on patients presenting to emergency department for unplanned care in public hospitals with emergency department and private hospitals providing contracted services for the public sector.

Related metadata: is calculated using Admission date vers 4

is calculated using Admission time vers 2

is calculated using Date patient presents vers 2

is calculated using Emergency department departure status vers 2

relates to the data element concept Patient presentation at emergency department vers 1

is calculated using Time patient presents vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

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

Comments:

Emergency department waiting time to service delivery

Identifying and Definitional Attributes

Knowledgebase ID: ***000347*** ***Version No: 2***

Metadata type: Derived Data Element

Admin. status: Current

01/01/00

Definition: The time elapsed for each patient from presentation in the emergency department to commencement of service by a treating medical officer or nurse.

Context: Non-admitted patient emergency department care.

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: MMMMM

Minimum size: 5

Maximum size: 5

Data domain: Time in minutes

Guide for use: Calculated from the date and time of service event minus date and time patient presents. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Emergency department waiting time to service delivery vers 1

relates to the data element concept Emergency department – public hospital vers 1

is calculated using Date of commencement of service event vers 2

is calculated using Date patient presents vers 2

is calculated using Time of commencement of service event vers 2

is calculated using Time patient presents vers 2

Administrative Attributes

Source document:

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

Information model link:

NHIM Performance indicator

Data Set Specifications:	***Start date***	***End date***
NMDS – Emergency department waiting times	01/07/2000	
NMDS – Non-admitted patient emergency department care	01/07/2003	

Comments: It is recognised that at times of extreme urgency or multiple synchronous presentations, or if no medical officer is on duty in the emergency department, this service may be provided by a nurse.

Employment status – acute hospital and private psychiatric hospital admissions

Identifying and Definitional Attributes

Knowledgebase ID: ***000395*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Self-reported employment status of a person, immediately prior to admission to an acute or private psychiatric hospital.

Context: The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be employment status, income, occupation and education.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Unemployed/pensioner

2 Other

Guide for use:

Verification rules:

Collection methods: In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Related metadata: supersedes previous data element Employment status vers 1

relates to the data element Employment status – public psychiatric hospital admissions vers 2

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Labour characteristic

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

Comments:

Employment status – public psychiatric hospital admissions

Identifying and Definitional Attributes

Knowledgebase ID: ***000317*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Self-reported employment status of a person, immediately prior to admission to a public psychiatric hospital.

Context: The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be employment status, income, occupation and education.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Child not at school
2	Student
3	Employed
4	Unemployed
5	Home duties
6	Other

Guide for use:

Verification rules:

Collection methods: In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

What is your/the person's Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

However, for national reporting purposes it is preferable to distinguish these

two data items logically.

Related metadata: supersedes previous data element Employment status vers 1

relates to the data element Employment status – acute hospital and private psychiatric hospital admissions vers 2

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Labour characteristic

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

Comments:

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:

Erectile dysfunction

Identifying and Definitional Attributes

Knowledgebase ID: ***000817*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether a male individual has a history of erection failure or has received treatment to achieve erection sufficient for penetration in the last 12 months and prior.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Erectile dysfunction – developed in the last 12 months
2	Erectile dysfunction – developed prior to the last 12 months
3	No erectile dysfunction
9	Not stated/inadequately described

Guide for use: Record for male patients only.

Verification rules:

Collection methods: Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration. Determine whether this developed within or prior to the last 12 months.

Related metadata: relates to the data element Peripheral neuropathy – status vers 1

relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments: Erectile dysfunction or impotence is defined as inability to achieve or maintain an erection of sufficient rigidity to perform sexual intercourse successfully. It may be due to psychological causes, macrovascular disease or pelvic autonomic neuropathy. An organic cause is more likely in the presence of other macro or micro vascular complications.

Erectile problems occur in up to 50% of men with diabetes who are over 40 years old.

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.

NMDS – Admitted patient care:

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.

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:

Establishment type

Identifying and Definitional Attributes

Knowledgebase ID: ***000327*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment.

Residential establishments are considered to be separately administered if managed as an independent unit in terms of financial, budgetary and activity statistics. The situation where establishment-level data, say for components of an area health service, were not available separately at a central authority was not grounds for treating such a group of establishments as a single establishment unless such data were not available at any level in the health care system.

Non-residential health services are classified in terms of separately administered organisations rather than in terms of the number of sites at which care is delivered. Thus, domiciliary nursing services would be counted in terms of the number of administered entities employing nursing staff rather than in terms of the number of clinic locations used by the staff.

Establishments can cater for a number of activities and in some cases separate staff and financial details are not available for each activity. In the cases it is necessary to classify the establishment according to its predominant residential activity (measured by costs) and to allocate all the staff and finances to that activity. Where non-residential services only are provided at one establishment, that establishment is classified according to the predominant non-residential activity (in terms of costs).

Context: Health services:

Type of establishment is required in order to aggregate establishment-level data into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: AN.N.N

Minimum size: 2

Maximum size: 6

Data domain:

N7.1	Public day centre/hospital
N7.2	Public freestanding day surgery centre
N7.3	Private day centre/hospital
N7.4	Private freestanding day surgery centre
N8.1.1	Public community health centre
N8.1.2	Private (non-profit) community health centre
N8.2.1	Public domiciliary nursing service
N8.2.2	Private (non-profit) domiciliary nursing service

N8.2.3 Private (profit) domiciliary nursing service
R1.1 Public acute care hospital
R1.2 Private acute care hospital
R1.3.1 Veterans' Affairs hospital
R1.3.2 Defence force hospital
R1.3.3 Other Commonwealth hospital
R2.1 Public psychiatric hospital
R2.2 Private psychiatric hospital
R3.1 Private charitable nursing home for the aged
R3.2 Private profit nursing home for the aged
R3.3 Government nursing home for the aged
R3.4 Private charitable nursing home for young disabled
R3.5 Private profit nursing home for young disabled
R3.6 Government nursing home for young disabled
R4.1 Public alcohol and drug treatment centre
R4.2 Private alcohol and drug treatment centre
R5.1 Charitable hostels for the aged
R5.2 State government hostel for the aged
R5.3 Local government hostel for the aged
R5.4 Other charitable hostel
R5.5 Other State government hostel
R5.6 Other Local government hostel
R6.1 Public hospice
R6.2 Private hospice

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

R1 Acute care hospitals:

Establishments which provide at least minimal medical, surgical or obstetric services for inpatient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the State health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

R2 Psychiatric hospitals:

Establishments devoted primarily to the treatment and care of inpatients 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 health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

R3 Nursing homes:

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile inpatients. They must be approved by the Commonwealth Department of Health and Family Services and/or licensed by the State, or controlled by government departments.

Private profit nursing homes are operated by private profit-making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated by or on behalf of a State or Territory government.

R4 Alcohol and drug treatment centres:

Freestanding centres for the treatment of drug dependence on an inpatient basis.

R5 Hostels and residential services:

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Only hostels subsidised by the Commonwealth are included. Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

R6 Hospices:

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

N7 Same-day establishments:

Includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

N8 Non-residential health services:

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

N8.1 Community health centres:

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

N8.2 Domiciliary nursing service:

Public or registered non-profit or profit-making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Organisation characteristic

Data Set Specifications:	***Start date***	***End date***
NMDS – Alcohol and other drug treatment services	01/07/2002	30/06/2003
NMDS – Public hospital establishments	01/07/1989	

Comments:

In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This data element is currently under review by the Organisational Units Working Group of the National Health Data Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Estimated date flag

Identifying and Definitional Attributes

Knowledgebase ID: ***000431*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: An indication of whether any component of a reported date was estimated.

Context: Provision of a date is often a mandatory requirement in data collections. However, at times, the actual date or part thereof is not known (e.g. date of birth or date of injury). This data element is designed to flag the part or parts of a date that have been estimated when a date provided is based on an approximation of the date in question rather than reporting of the actual date. This data element may assist with record linkage processes (for example when the date of birth is a component of the linkage key).

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Code

Representational layout: AAA

Minimum size: 1

Maximum size: 3

Data domain:

A	Date estimated from reported age
D	Day value in date was estimated
DM	Day and month values in date were estimated
DMY	All values (day, month, year) in date were estimated
DY	Day and year values in date were estimated
M	Month value (only) in date was estimated
MY	Month and year values in date were estimated
Null	Date not estimated
Y	Year value (only) in date was estimated

Guide for use: May be used to record an estimated date for date of birth or data elements for other dates such as date of death.

Verification rules:

Collection methods: This data element should be reported in conjunction with a reported date when any part of the date represents an estimate rather than the actual or known date.

Related metadata: is used in conjunction with Date of birth vers 4

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Demographic characteristic

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

Comments:

DSS – Health care client identification:

The use of a code V for a valid date could be useful in the determination of a positive identification of a health care client.

Extended wait patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000400*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/99

Definition: A patient with the lowest level of clinical urgency for an awaited procedure who has been on the waiting list for elective surgery for more than one year.

Context: Elective surgery:
The numbers and proportions of patients with extended waits are measures of hospital performance in relation to patient access to elective hospital care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Extended wait patient

2 Other patient

Guide for use: A patient is classified as an extended wait patient if the patient is clinical urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year.

Verification rules:

Collection methods:

Related metadata: is qualified by Clinical urgency vers 2

is derived from Waiting time at a census date vers 2

is derived from Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

Data Set Specifications:	***Start date***	***End date***
NMDS – Elective surgery waiting times	01/07/1999	

Comments: This data item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an 'Overdue patient' as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.

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.

External cause – human intent

Identifying and Definitional Attributes

Knowledgebase ID: ***000382*** ***Version No: 4***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: The most likely role of human intent in the occurrence of the injury or poisoning as assessed by clinician.

Context: Injury surveillance:

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.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Accident – injury not intended
02	Intentional self-harm
03	Sexual assault
04	Maltreatment by parent
05	Maltreatment by spouse or partner
06	Other and unspecified assault
07	Event of undetermined intent
08	Legal intervention (including police) or operations of war
09	Adverse effect or complications of medical and surgical care
10	Other specified intent
11	Intent not specified

Guide for use: Select the item which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. This item must always be accompanied by an External cause – non-admitted patient code.

This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in emergency departments).

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Activity when injured vers 2
is used in conjunction with Bodily location of main injury vers 1
supersedes previous data element External cause – human intent vers 3
is used in conjunction with Narrative description of injury event vers 1
is used in conjunction with Nature of main injury – non-admitted patient vers 1
is used in conjunction with Place of occurrence of external cause of injury vers 5

Administrative Attributes

Source document:

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

Information model link:

NHIM Injury event

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

Comments:

External cause – non-admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000381*** ***Version No: 4***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Event, circumstance or condition associated with the occurrence of injury, poisoning or adverse effect.

Context: Injury surveillance:

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.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Motor vehicle – driver
02	Motor vehicle – passenger or unspecified occupant
03	Motorcycle – driver
04	Motorcycle – passenger or unspecified
05	Pedal cyclist or pedal cycle passenger
06	Pedestrian
07	Other or unspecified transport-related circumstance
08	Horse-related (includes fall from, struck or bitten by)
09	Fall – low (on same level or < 1 metre or no information on height)
10	Fall – high (drop of 1 metre or more)
11	Drowning, submersion – swimming pool
12	Drowning, submersion – other than swimming pool (excludes drowning associated with water craft [07])
13	Other threat to breathing (including strangling and asphyxiation)
14	Fire, flames, smoke
15	Hot drink, food, water, other fluid, steam, gas or vapour
16	Hot object or substance, not otherwise specified
17	Poisoning – drugs or medicinal substance
18	Poisoning – other substance
19	Firearm
20	Cutting, piercing object
21	Dog-related
22	Animal-related (excluding Horse [08] and Dog [21])

23 (deleted)
24 Machinery in operation
25 Electricity
26 Hot conditions (natural origin) sunlight
27 Cold conditions (natural origins)
28 Other specified external cause
29 Unspecified external cause
30 Struck by or collision with person
31 Struck by or collision with object

Guide for use: This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The External cause – non-admitted patient group must always be accompanied by an External cause – human intent code (see data element External cause – human intent).

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Activity when injured vers 2
is used in conjunction with Bodily location of main injury vers 1
is used in conjunction with External cause – human intent vers 4
supersedes previous data element External cause – major external cause vers 3
is used in conjunction with Narrative description of injury event vers 1
is used in conjunction with Nature of main injury – non-admitted patient vers 1
is used in conjunction with Place of occurrence of external cause of injury vers 5

Administrative Attributes

Source document:

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***

Comments: This item has been developed to cater for the information requirements of the wide range of settings where injury surveillance is undertaken and do not have the capability of recording the complete ICD-10-AM external cause codes. This code list has been derived from the ICD-10-AM external cause classification. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Family name

Identifying and Definitional Attributes

Knowledgebase ID: ***000781*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: That part of a name a person usually has in common with some other members of his/her family, as distinguished from her/his given names.

Context:

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Text

Representational layout: A(40)

Minimum size: 1

Maximum size: 40

Data domain: Text

Guide for use:

Verification rules:

Collection methods: Mixed case should be used.

Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type.

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the health care establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the health care establishment. The person's preferred name may in fact be the name on their Medicare card. The Name type data element can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name? _____

Are you known by any other family names that you would like recorded? If so, what are they? _____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an Alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the Family name field and leave the Given name field blank.

Registering an unidentified health care client:

The default for unknown family name, should be 'Unknown' in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of 'Unknown'.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias name type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (alias name) in addition to the person's Medicare card name.

Baby for adoption:

The word 'Adoption' should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to 'Adoption' in client registers (for names) should also be changed to 'Unknown'. Contact your State or Territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the Family name field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic names:

The Centrelink publication, *Naming Systems for Ethnic Groups*, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Related metadata: relates to the data element Given name(s) vers 1

relates to the data element concept Name vers 1

relates to the data element Name context flag vers 1

relates to the data element Name suffix vers 1

relates to the data element Name title vers 1

relates to the data element Name type vers 1

Administrative Attributes

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

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

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

Comments:

Fasting status

Identifying and Definitional Attributes

Knowledgebase ID: ***000665*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The fasting status of the patient at the time of an examination, test, investigation or procedure.

Context: Public health, health care and clinical setting.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Fasting
2	Non-fasting
9	Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Cholesterol-HDL – measured vers 1

is used in conjunction with Cholesterol-total – measured vers 1

relates to the data element Dyslipidaemia – treatment vers 1

is used in conjunction with Triglycerides – measured vers 1

Administrative Attributes

Source document:

Source organisation: National Diabetes Data Working Group

CV-Data Working Group

Information model link:

NHIM Service provision event

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

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

First day of the last menstrual period

Identifying and Definitional Attributes

Knowledgebase ID: ***000056*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Date of the first day of the mother's last menstrual period (LMP).

Context: Perinatal statistics:

The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid dates or 99999999 if first day is unknown

Guide for use: If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).

Verification rules:

Collection methods:

Related metadata: is used in the calculation of Gestational age vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

Food supplies

Identifying and Definitional Attributes

Knowledgebase ID: ***000240*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: The cost of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars. Rounded to nearest whole dollar.

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments:

Foot deformity

Identifying and Definitional Attributes

Knowledgebase ID: ***000819*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Presence of foot deformity on either foot. Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Yes, foot deformity present

2 No, foot deformity not present

9 Not stated/inadequately described

Guide for use: Record whether or not a foot deformity is present in the person.

Verification rules:

Collection methods: Both feet to be examined for the presence of foot deformity.

Related metadata: relates to the data element Health professionals attended – diabetes mellitus vers 1

relates to the data element Foot lesion – active vers 1

relates to the data element Foot ulcer – history vers 1

relates to the data element Lower limb amputation due to vascular disease vers 1

relates to the data element Peripheral neuropathy – status vers 1

relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads. Foot deformities are frequently the result of diabetic motor neuropathy and diabetic foot disease is the most common cause of hospitalisation in people with diabetes.

Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45–74 years and sevenfold over 75 years. In people with diabetes, amputations are 15 times more common than in people without diabetes and 50% of all amputations occur in people with diabetes (Epidemiology of the diabetic foot; Report of the Diabetic Foot and Amputation Group). All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Specialised foot clinics appear to decrease further episodes of foot ulceration and decrease hospital admissions for amputations.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- feet should be examined every 6 months or at every visit if high-risk foot or active foot problem
- refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present
- ensure that patients with 'high-risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems
- to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of Peripheral neuropathy
- assessment outcome, peripheral vascular disease, or foot deformity or history of previous ulceration.

References:

Lesley V Campbell, Antony R Graham, Rosalind M Kidd, Hugh F Molloy, Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

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

Reiber GE. Epidemiology of the diabetic foot. In: Levin ME, O'Neal LW, Bowker JH, editors. The diabetic foot. 5th ed. St Louis: Mosby Year Book, 1993; 1–5.

Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes Care 1983; 6: 87–91.

Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Foot lesion – active

Identifying and Definitional Attributes

Knowledgebase ID: ***000820*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether an individual has an active foot lesion other than an ulcer on either foot. The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Yes, foot lesion present

2 No, foot lesion not present

9 Not stated/inadequately described

Guide for use: Record whether or not a current active foot lesion other than ulceration is present on either foot in the person.

Verification rules:

Collection methods: Assess whether the individual has an active foot lesion on either foot.

Related metadata: relates to the data element Foot deformity vers 1

relates to the data element Foot ulcer – current vers 1

relates to the data element Foot ulcer – history vers 1

relates to the data element Lower limb amputation due to vascular disease vers 1

relates to the data element Peripheral neuropathy – status vers 1

relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

Early detection and appropriate management of the 'high-risk foot' and active foot problems can reduce morbidity, hospitalisation and amputation in people with diabetes.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers or other problems that may result in the need for amputation. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus foot examination:

- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer
- Ask the patient about current foot problems, neuropathic symptoms, rest pain and intermittent claudication.

Foot ulcer – current

Identifying and Definitional Attributes

Knowledgebase ID: ***000821*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether an individual has a current foot ulcer on either foot.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Yes, foot ulcer present

2 No, foot ulcer not present

9 Not stated/inadequately described

Guide for use: Record whether or not a foot ulcer is present on either foot in the person.

Verification rules:

Collection methods: Assess whether the individual has a current foot ulcer on either foot.

Related metadata: relates to the data element Health professionals attended – diabetes mellitus vers 1

relates to the data element Foot deformity vers 1

relates to the data element Foot lesion – active vers 1

relates to the data element Foot ulcer – history vers 1

relates to the data element Lower limb amputation due to vascular disease vers 1

relates to the data element Peripheral neuropathy – status vers 1

relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

Foot ulcer is usually situated on the edge of the foot or toes because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.

Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.

Assessment

- Ask the patient about previous or current foot problems, neuropathic symptoms, rest pain and intermittent claudication.
- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

The development of ulcers of the feet and lower extremities is a special problem in the diabetic patient, and appears to be due primarily to abnormal pressure distribution secondary to diabetic neuropathy.

Diabetic foot ulceration is a serious problem and the lack of pain does not mean that the ulcer can be ignored or neglected. The absence of pain is very common in people with diabetes due to peripheral neuropathy.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Early detection and appropriate management of the 'high-risk foot' and current foot ulceration can reduce morbidity, hospitalisation and amputation in people with diabetes.

References:

The Diabetic Foot Vol. 3 No. 4 Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Foot ulcer – history

Identifying and Definitional Attributes

Knowledgebase ID: ***000822*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether or not person has a previous history of foot ulceration on either foot.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Yes, history of foot ulceration

2 No, no history of foot ulceration

9 Not stated/inadequately described

Guide for use: Record whether or not the person has a history of foot ulceration.

Verification rules:

Collection methods: Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

Related metadata:

relates to the data element Health professionals attended – diabetes mellitus vers 1

relates to the data element Foot deformity vers 1

relates to the data element Foot lesion – active vers 1

relates to the data element Foot ulcer – current vers 1

relates to the data element Lower limb amputation due to vascular disease vers 1

relates to the data element Peripheral neuropathy – status vers 1

relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments:

Past history of foot ulceration, peripheral neuropathy and foot deformities have been associated with increased risk of foot ulceration and lower limb amputation for patients who suffer from diabetes. The aim is to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, individuals with a 'high-risk foot' or a significant active foot problem should be examined every six months or at every visit.

Assessment

- Ask patient about previous foot problems, neuropathic symptoms, rest pain and intermittent claudication.
- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

Formal community support access status

Identifying and Definitional Attributes

Knowledgebase ID: ***000660*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Identifies a person who is currently accessing a formal community support service or services.

Context: Personal and social support and clinical settings:

This data element provides information about the use of formal community support services by clients.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Currently accessing
2	Currently not accessing
9	Not known/inadequately described

Guide for use: Code 1 The person is currently accessing at least one paid community support service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc.).

Code 2 The person is not currently accessing any paid community support service or services.

Code 9 The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding.

Verification rules:

Collection methods:

Related metadata: relates to the data element Carer availability vers 3

relates to the data element Living arrangement vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments:

Full-time equivalent staff

Identifying and Definitional Attributes

Knowledgebase ID: ***000252*** ***Version No: 2***

Metadata type: Derived Data Element

Admin. status: Current

01/07/97

Definition: Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Context: Health expenditure:

To assist in analyses of the resource use and activity of public hospital establishments. Inclusion of these data, classified by staffing category, allows analysis of costs per unit of labour and analysis of staffing inputs against establishment outputs.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain: Calculated number of staff (full-time equivalents) for each of the staffing categories listed in the Guide for use.

Guide for use: Staffing categories:

C1.1 Salaried medical officers

C1.2 Registered nurses

C1.3 Enrolled nurses

C1.4 Student nurses

C1.5 Trainee/pupil nurses

C1.6 Other personal care staff

C1.7 Diagnostic and health professionals

C1.8 Administrative and clerical staff

C1.9 Domestic and other staff

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary-time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each. (Salary costs should be apportioned on the same basis.)

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Total full-time equivalent staff vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

Data Set Specifications:	***Start date***	***End date***
NMDS – Public hospital establishments	01/07/1997	
NMDS – Community mental health establishments	01/07/1998	

Comments: This metadata item was amended during 1996-97. Until then, both average and end-of-year counts of full-time equivalent staff were included, and the end-of-year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

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:

Geographical location of establishment

Identifying and Definitional Attributes

Knowledgebase ID: ***000260*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Geographical location of the establishment. For establishments with more than one geographical location, the location is defined as that of the main administrative centre.

Context: Health services:

To enable the analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNN

Minimum size: 5

Maximum size: 5

Data domain: *Australian Standard Geographical Classification* (Australian Bureau of Statistics, Cat. No. 1216.0)

Guide for use: The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA) for service delivery outlet.

The ASGC 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 Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including 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 an 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 establishment is used with the Streets Sub-index of the NLI to assign the SLA.

Verification rules:

Collection methods:

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

supersedes previous data element Geographic location vers 1

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 – Alcohol and other drug treatment services	01/07/2002	30/06/2003
NMDS – Public hospital establishments	01/07/1997	
NMDS – Community mental health establishments	01/07/1998	

Comments: The geographical location does not provide direct information on the geographical catchment area or catchment population of the establishment.

Geographical location of service delivery outlet

Identifying and Definitional Attributes

Knowledgebase ID: ***000823*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/03

Definition: Geographical location of a site from which a health/community service is delivered.

Context: Alcohol and other drug treatment services:

To enable the analysis of the accessibility of service provision in relation to demographic and other characteristics of the population of a geographic area.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNN

Minimum size: 5

Maximum size: 5

Data domain: Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0).

Guide for use: The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA) for service delivery outlet.

The Australian Standard Geographical Classification (ASGC) 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 Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including 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 an 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 establishment is used with the Streets Sub-index of the NLI to assign the SLA.

Verification rules:

Collection methods:

Related metadata: relates to the data element Service delivery outlet vers 1

is composed of State/Territory identifier vers 3

Administrative Attributes

Source document: Australian Standard Geographical Classification (ABS Cat. No. 1216.0)

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Address element

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

Comments:

Gestational age

Identifying and Definitional Attributes

Knowledgebase ID: ***000059*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/96

Definition: The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed days or completed weeks (e.g. events occurring 280 to 286 completed days after the onset of the last normal menstrual period are considered to have occurred at 40 weeks of gestation).

The World Health Organization identifies the following categories:

- Pre-term: less than 37 completed weeks (less than 259 days) of gestation
- Term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation
- Post-term: 42 completed weeks or more (294 days or more) of gestation.

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 Gestational age vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

Gestational age

Identifying and Definitional Attributes

Knowledgebase ID: ***000060*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: The estimated gestational age of the baby in completed weeks as determined by clinical assessment.

Context: Perinatal statistics:

The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Number representing the number of completed weeks

99 Not stated/unknown.

Guide for use: This is derived from clinical assessment when accurate information on the date of the last menstrual period (LMP) is not available for this pregnancy.

Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.

Verification rules:

Collection methods:

Related metadata: is calculated using First day of the last menstrual period vers 1

relates to the data element concept Gestational age vers 1

Administrative Attributes

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

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

Given name(s)

Identifying and Definitional Attributes

Knowledgebase ID: ***000782*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The person's identifying name(s) within the family group or by which the person is socially identified.

Context:

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Text

Representational layout: A(40)

Minimum size: 0

Maximum size: 40

Data domain: Text

Guide for use: Health care establishments may record given names (first and other given names) in one field or several fields. This data element definition applies regardless of the format of data recording.

A full history of names is to be retained.

Verification rules:

Collection methods: Given name(s) should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre-) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nickname or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the health care establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Name type data element can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

_____

Are you known by any other given names that you would like recorded?

If so, what are they?

_____

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Do not delete or overwrite a previous given name:

Whenever a person informs the establishment of a change of given name (e.g. prefers to be know by their middle name), the former name should be recorded according to the appropriate Name type.

Example – Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred Given name and record 'Mary' as the Medicare card Given name.

Example – The establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred Given name.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record 'Unknown' in the Given name field and use alias name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of 'Unknown'.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the (preferred) Given name field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a family name and a given name: they have only one name by which they are known. If the person has only one name, record it in the Family name field and leave the Given name blank.

Multiple given names (middle, second, third etc.names):

All of the person's given names should be recorded in the Given name field, leaving a space between each name.

Record complete information:

If the person has many given names and all of them cannot fit in the field, record as many names in full as possible, in preference to recording initials.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as Alias names as appropriate.

Example – The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred Given name and 'Jennifer' as her Medicare card name.

Example – The person's given name is 'Giovanni' but he prefers to be called 'John'. Record 'John' as the preferred Given name and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included.

- hyphen (e.g. Anne-Maree, Mary-Jane)

  Hyphenated names shall be entered with the hyphen. Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces e.g. Jean Claude

  If the person has recorded a given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way.

- e.g. Oscar Peter, Wendy Hilda

  Leave a single space between the person's first name and each of their middle names.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of' . For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the (preferred) Given name field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred Given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple birth. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first-born baby, and 'Twin 2 of Fiona' in the Given name field of the second-born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman numerals (I, II, III .....).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin

  Use Twin i.e. Twin 1 of Fiona
- Triplet

  Use Trip i.e. Trip 1 of Fiona
- Quadruplet

  Use Quad i.e. Quad 1 of Fiona
- Quintuplet

  Use Quin i.e. Quin 1 of Fiona
- Sextuplet

  Use Sext i.e. Sext 1 of Fiona
- Septuplet

  Use Sept i.e. Sept 1 of Fiona

These names should be recorded under the newborn Name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name. Record their current name as the preferred Given name and record their previously recorded given name as an Alias name.

Ethnic names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Appendix A Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Related metadata: relates to the data element Family name vers 1
relates to the data element Name vers 1
relates to the data element Name context flag vers 1
relates to the data element Name suffix vers 1
relates to the data element Name title vers 1
relates to the data element Name type vers 1

Administrative Attributes

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

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

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

Comments:

Glycosylated haemoglobin (HbA1c) – measured

Identifying and Definitional Attributes

Knowledgebase ID: ***000824*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A person's measured glycosylated haemoglobin (HbA1c) level.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN.N

Minimum size: 3

Maximum size: 4

Data domain: Measured in % to 1 decimal point

99.9 Not stated/inadequately described

Guide for use: Record the absolute result of the test (%).

Verification rules:

Collection methods: Test is performed in accredited laboratories.

- A single blood sample is sufficient and no preparation of the patient is required.
- Measure HbA1c ideally using High Performance Liquid Chromatography (HPLC)

Related metadata: relates to the data element Glycosylated haemoglobin (HbA1c) – upper limit of normal range vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Service provision event

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

Comments: The HbAlc along with regular blood glucose monitoring is the best way to see the overall picture of blood glucose levels.

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. The level of HbA1c is proportional to the level of glucose in the blood over a period of approximately two months, because glucose attaches to the haemoglobin (red blood cells) and remains there for the life of the red blood cell, approximately 120 days. The HbA1c gives an average of the blood glucose level over the past 6– 8 weeks and therefore haemoglobin A1c is accepted as an indicator of the mean daily blood glucose concentration over the preceding two months.

HbA1c is formed by the non-enzymatic glycation of the N-terminus of the B-chain of haemoglobin Ao. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions used as a standard for assessing overall blood glucose control.

HbA1c results vary between laboratories; use the same laboratory for repeated testing

When reporting, record absolute result of the most recent HbA1c level in the last 12 months.

Research studies in the United States have found that for every 1% reduction in results of HbA1c blood tests, the risk of developing micro vascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40%.

The maintenance of good glycaemic control (in diabetes Type 1 and Type 20, significantly reduces progression of diabetes-related complications such as retinopathy, nephropathy and neuropathy, as indicated in the 'Diabetes Control and Complications Trial' (DCCT 1993) and the 'United Kingdom Prospective Diabetes Study' (UKPDS 1997).

The target proposed by the Australian Diabetes Society for glycosylated haemoglobin (HbA1c) is 7.0% or less and a doctor may order this test about every 3–6 months.

References:

Koening, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. Diabetes 259 (1976): 230–232.

Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. N. Eng. J. Med. 310 (1984): 341–346.

Glycosylated haemoglobin (HbA1c) – upper limit of normal range

Identifying and Definitional Attributes

Knowledgebase ID: ***000825*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Laboratory standard for the value of glycosylated haemoglobin (HbA1c) that is the upper boundary of the normal reference range.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN.N

Minimum size: 3

Maximum size: 4

Data domain: Measured in %

99.9 Not stated/inadequately described

Guide for use: Record the upper limit of the HbA1c normal reference range from the laboratory result.

Verification rules:

Collection methods: This value is usually notified in patient laboratory results and may vary for different laboratories.

Related metadata: relates to the data element Glycosylated haemoglobin (HbA1c) – measured vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Service provision event

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

Comments: The upper limit of normal range is the laboratory standard for the maximum level of HbA1c, which is still in normal range.

These figures vary between laboratories.

HbA1c results vary between laboratories; use the same laboratory for repeated testing.

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions and is used as a standard for assessing overall blood glucose control. The target is to achieve an HbA1c within 1% of the upper limit of normal or achieve control as near to this target as possible without producing unacceptable hypoglycaemia as recommended from the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

If HbA1c is 2% above the upper limit of normal, explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise and review management:

- review and adjust treatment
- consider referral to diabetes educator
- consider referral to dietitian
- consider referral to endocrinologist or physician or diabetes centre.

Goal of care

Identifying and Definitional Attributes

Knowledgebase ID: ***000111*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current
01/07/98

Definition: The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, which outlines the overall aim of actions planned by a community service and relates to a person's health need. This goal reflects a total care plan and takes into account the possibility that a range of community services may be provided within a specified time frame.

Context: This item focuses on the broad goal which the person and services provider hope to achieve within an expected time period and takes into account the intervention or services provided by a range of community services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Well person for preventative/maintenance/health promotion program
02	Person will make a complete recovery
03	Person will not make a complete recovery, but will rehabilitate to a state where formal on-going service is no longer required
04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home
05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die
06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time
07	For assessment only/not applicable

Guide for use:

01 service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.

02 describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long-term health problems who are normally independent in their management.

Goal 2 service recipient includes:

- post-surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;
- persons recovering from an acute illness and referred from the general practitioner or other community-based facility;

– persons with disability or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

03 refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.

04 refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.

05 refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

06 includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.

– Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in Goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.

07 service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Verification rules: Only one option is permissible and where Code 7 is selected, Code 9 must be used in Nursing interventions.

Collection methods: At time of formal review of the client, the original Goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the Date of first contact with community nursing service and Date of last contact and in this format provides a focussing effect at the time of planning for care.

Related metadata: relates to the data element Date of first contact vers 2
relates to the data element Date of last contact vers 2
relates to the data element Nursing diagnosis vers 2
supersedes previous data element Nursing goal vers 1
relates to the data element Nursing interventions vers 2

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Expected outcome

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

Comments: Agencies who had previously implemented this item should note changes to the code set in data domain.

Group sessions

Identifying and Definitional Attributes

Knowledgebase ID: ***000210*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/89

Definition: The number of groups of patients/clients receiving services. Each group is to count once, irrespective of size or the number of staff providing services.

Context: The resources required to provide services to groups of patients are different from those required to provide services to an equivalent number of individuals. Hence services to groups of non-admitted patients or outreach clients should be counted separately from services to individuals.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNNN

Minimum size: 1

Maximum size: 6

Data domain: Calculated number of group sessions

Guide for use:

Verification rules:

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Related metadata:

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Service provision event

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

Comments: This data element is derived from data elements that are not currently specified in the *National Health Data Dictionary*, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Health labour force

Identifying and Definitional Attributes

Knowledgebase ID: ***000061*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

Definition: All those in paid employment, unpaid contributing family workers, and unpaid volunteers:

- whose primary employment role is to achieve a health outcome for either individuals or the population as a whole, whether this is in clinical, research, education, administrative or public health capacities
- employed in the health industry defined by the Australian Bureau of Statistics using the Australian and New Zealand Standard Industrial Classification, other than those already included.

The health labour force consists of all those persons included in the health work force plus all those persons not currently employed in the health work force who are seeking employment therein. Health professionals registered in Australia but working overseas are excluded from the national health labour force. Health professionals registered in a particular State or Territory but working solely in another State or Territory or overseas are excluded from the health labour force for that State or Territory.

Context: Health labour force statistics 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 Profession labour force status of health professional vers 1

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

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

Comments:

Health outcome

Identifying and Definitional Attributes

Knowledgebase ID: ***000062*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/97

Definition: A change in the health of an individual, or a group of people or a population, which is wholly or partially attributable to an intervention or a series of interventions.

Context: Admitted patient and non-admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Information Management Group

Information model link:

NHIM Stated outcome

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

Comments:

Health outcome indicator

Identifying and Definitional Attributes

Knowledgebase ID: ***000063*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/97

Definition: A statistic or other unit of information which reflects, directly or indirectly, the effect of an intervention, facility, service or system on the health of its target population, or the health of an individual.

- A generic indicator provides information on health, perceived health or a specific dimension of health using measurement methods that can be applied to people in any health condition.
- A condition-specific indicator provides information on specific clinical conditions or health problems, or aspects of physiological function pertaining to specific conditions or problems.

Epidemiological terminology

- An association exists between two phenomena (such as an intervention and a health outcome) if the occurrence or quantitative characteristics of one of the phenomena varies with the occurrence or quantitative characteristics of the other.
- One phenomenon is attributable to another if there is a casual link between the phenomena. Attribution depends upon the weight of evidence for causality.
- Association is necessary (but not sufficient) for attribution. Associations may be fortuitous or causal. The term relationship is to be taken as synonymous with association.

Context: Admitted patient and non-admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Information Management Group

Information model link:

NHIM Stated outcome

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

Comments:

Health professionals attended – diabetes mellitus

Identifying and Definitional Attributes

Knowledgebase ID: ***000804*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The health professionals that a person has attended in the last 12 months in relation to issues arising from diabetes mellitus.

Context: Diabetes (clinical) specific data element.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N(NNNN)

Minimum size: 1

Maximum size: 5

Data domain:

1	Diabetes educator
2	Dietitian
3	Ophthalmologist
4	Optometrist
5	Podiatrist
8	None of the above
9	Not stated/inadequately described

Guide for use: Record a code sequentially for each health professional attended.

A person may have attended several health professionals in the last 12 months, therefore, more than one code can be recorded sequentially.

Example 1: If a person has attended a diabetes educator and a podiatrist in the last twelve months, the code recorded would be 15.

Example 2: If all have been seen, the code recorded would be 12345.

Verification rules:

Collection methods: The person should be asked about each type of health professional in successive questions, as follows:

Have you attended any of the following health professionals in relation to diabetes mellitus in the last 12 months?

Diabetes educator	___Yes ___ No
Dietitian	___Yes ___ No
Ophthalmologist	___Yes ___ No
Optometrist	___Yes ___ No
Podiatrist	___Yes ___No

The appropriate code should be recorded for each health professional attended.

If the person answers 'NO' to all the health professionals specified, then code 8 should be applied.

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

Related metadata: relates to the data element Occupation of person vers 2

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments: The health professional occupations are assigned the following codes at the occupation level of the Australian Standard Classification of Occupations, Second Edition, Australian Bureau of Statistics, 1997, Catalogue No. 1220.0

Diabetic educator 2512-13

Dietitian 2393-11

Ophthalmologist 2312-19

Optometrist 2384-11

Podiatrist 2388-11

Management of diabetes requires a team approach, comprising selected health professionals, to provide services specific to the individual with diabetes.

All patients with diabetes require diet therapy in conjunction with exercise and/or medication to achieve optimal control of blood glucose, body weight and blood lipids. In insulin treated diabetics, diet management aims to restrict variations in the timing, size or composition of meals that could result in hypoglycaemia or postprandial hyperglycaemia. Based on the Healthy Eating Pyramid, meals should be low in saturated fat, and rich in high-fibre carbohydrates with low glycaemic index (GI). Saturated fats have to be replaced with monounsaturated and polyunsaturated fats.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, a comprehensive ophthalmological examination should be carried out:

- at diagnosis and then every 1–2 years for patients whose diabetes onset was at age 30 years or more
- within five years of diagnosis and then every 1–2 years for patients whose diabetes onset was at age less than 30 years.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- foot examination to be performed every 6 months or at every visit if high-risk foot or active foot problem
- refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present
- to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of peripheral neuropathy, peripheral vascular disease, or foot deformity and history of previous ulceration
- ensure that patients with 'high-risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems.

Height – measured

Identifying and Definitional Attributes

Knowledgebase ID: ***000362*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: A person's measured height.

In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.

Context: Public health, health care and clinical settings:

Stature is a major indicator of general body size and of bone length and of nutritional and health status of the individual and the community at large. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all-cause mortality, coronary heart disease mortality in middle-aged men, and of less favourable gestational outcomes in women (Marmot et al. 1984, Kramer 1988).

Measurements of height should be assessed in relation to children and adolescents' age and pubertal status.

Disease, nutritional, genetic and environmental factors all exert an influence on the height of an individual, hence this variable, together with its related variable weight, is of unique value in health surveillance. It enables the calculation of body mass index which requires the measurement of height and weight (body mass) for adults as well as sex and date of birth for children and adolescents.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN.N

Minimum size: 3

Maximum size: 4

Data domain: Measurement in centimetres to one decimal place

999.9 Not able to be measured

Guide for use:

Verification rules:

Collection methods: Measurement protocol:

Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.

The measurement of height requires a vertical metric rule, a horizontal headboard, and a non-compressible flat even surface on which the subject stands. The equipment may be fixed or portable, and should be described and reported.

The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm.

Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject stands on a platform scale is not recommended.

Adults and children who can stand:

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems). The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board. To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base-board.

The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement. If the two measurements disagree by more than 0.5 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured height is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over-reporting (Armitage & Berry 1994). For example, a mean value of 172.25 cm would be rounded to 172.2 cm, while a mean value of 172.35 cm would be rounded to 172.4 cm.

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5–1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the

date be recorded when the change is made from supine to standing height measure.

Validation and quality control measures:

All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level. Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Related metadata: supersedes previous data element Adult height – measured vers 1

is used in the calculation of Body mass index vers 2

Administrative Attributes

Source document: The measurement protocol described below are those recommended by the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996), and the World Health Organization (WHO Expert Committee 1995), which was adapted from Lohman et al. (1988).

Source organisation: International Society for the Advancement of Kinanthropometry

World Health Organization

The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing.

Information model link:

NHIM Physical characteristic

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

Comments: This data element applies to persons of all ages. It is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be

presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men, women, children and adolescents although the range will depend on the population.

Ht < 70 cm

70 cm = Ht < 75 cm

75 cm = Ht < 80 cm

... in 5 cm categories

185 cm = Ht < 190 cm

Ht => 190 cm

Height – self-reported

Identifying and Definitional Attributes

Knowledgebase ID: ***000363*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: A person's self-reported height.

Context: Public health and health care:

Stature is a major indicator of general body size and of bone length and of nutritional and health status of the individual and the community at large. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all cause mortality and coronary heart disease mortality in middle aged men (Marmot et al. 1984) and of less favourable gestational outcomes in women (Kramer 1988). Self-reported or parentally reported height for children and adolescents should be used cautiously if at all. It enables the calculation of body mass index which requires the measurement of height and weight (body mass) for adults.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 2

Maximum size: 3

Data domain: Measurement in centimetres to the nearest centimetre

888 Unknown

999 Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods: The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their height is. For example, the Australian Bureau of Statistics' National Health Survey 1995 included the question 'How tall are you without shoes?'. The data collection form should allow for both metric (to the nearest 1 cm) and imperial (to the nearest 0.5 inch) units to be recorded.

If practical, it is preferable to enter the raw data into the database before conversion of measures in imperial units to metric. However if this is not possible, height reported in imperial units can be converted to metric prior to data entry using a conversion factor of 2.54 cm to the inch.

Rounding to the nearest 1 cm will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 cm. The following rounding conventions are desirable to reduce systematic over-reporting (Armitage & Berry 1994):

nnn.x where x < 5 – round down, e.g. 172.2 cm would be rounded to 172 cm.

nnn.x where x > 5 – round up, e.g. 172.7 cm would be rounded to 173 cm.

nnn.x where x = 5 – round to the nearest even number, e.g. 172.5 cm would be rounded to 172 cm, while 173.5 cm would be rounded to 174 cm.

Related metadata: supersedes previous data element Adult height – self-reported vers 1

is used in the calculation of Body mass index vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Physical characteristic

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

Comments: This data element is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure height.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140–190 cm.

Ht < 140 cm

140 cm = Ht < 145 cm

145 cm = Ht < 150 cm

... in 5 cm categories

185 cm = Ht < 190 cm

Ht => 190 cm

On average, height tends to be overestimated when self-reported by respondents. Data for Australian men and women aged 20–69 years in 1989 indicated that men overestimated by an average of 1.1 cm (sem of 0.04 cm) and women by an average of 0.5 cm (sem of 0.05 cm) (Waters 1993). The extent of overestimation varied with age.

Hip circumference – measured

Identifying and Definitional Attributes

Knowledgebase ID: ***000370*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: A person's hip circumference measured at the level of maximum posterior extension of the buttocks.

In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.

Context: Public health and health care:

Its main use is to enable the calculation of adult Waist-to-hip ratio which requires the measurement of hip circumference and waist circumference.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN.N

Minimum size: 3

Maximum size: 4

Data domain: Measurement in centimetres to the nearest 0.1 cm

999.9 Not able to be measured

Guide for use: As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to collect this item for those aged under 18 years.

Verification rules:

Collection methods: Measurement protocol:

The data collection form should allow for up to three measurements of hip circumference to be recorded in centimetres to 1 decimal place. The data collection form should also have the capacity to record any reasons for the non-collection of hip circumference data.

The measurement of hip circumference requires a narrow (< 7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.

The subject should wear only non-restrictive briefs or underwear, a light smock over underwear or light clothing. Belts and heavy outer clothing should be removed. Hip measurement should be taken over one layer of light clothing only.

The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the

two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement.

All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the data base as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured hip circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting. For example, a mean value of 102.25 cm would be rounded to 102.2 cm, while a mean value of 102.35 cm would be rounded to 102.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1-metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured hip circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Related metadata: supersedes previous data element Adult hip circumference – measured vers 1

is used in the calculation of Waist-to-hip ratio vers 2

Administrative Attributes

Source document: The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995).

Source organisation: World Health Organization (see also Comments)

Information model link:

NHIM Physical characteristic

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

Comments: This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the

errors in waist-to-hip ratio measurements.

Waist-to-hip ratio is therefore no longer a commonly used measure.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present hip circumference data in categories. It is recommended that 5 cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation

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 census

Identifying and Definitional Attributes

Knowledgebase ID: ***000066*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/01/95

Definition: A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.

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 Census date vers 2

relates to the data element Waiting time at a census date vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Surveillance/monitoring event

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

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.

Hospital waiting list

Identifying and Definitional Attributes

Knowledgebase ID: ***000067*** ***Version No: 2***

Metadata type: Data Element Concept

Admin. status: Current

01/07/02

Definition: A register which contains essential details about patients who have been assessed as needing elective hospital care.

Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours.

Patients on waiting lists for elective hospital care can be 'ready for care' or 'not ready for care' (as defined in Patient listing status).

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 concept Elective care vers 1

relates to the data element Patient listing status vers 3

relates to the data element Waiting list category vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Assessment event

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:

Hours on-call (not worked) by medical practitioner

Identifying and Definitional Attributes

Knowledgebase ID: ***000393*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.

Context: Health labour force:

Used in relation to issues of economic activity, productivity, wage rates, working conditions etc.

Used to develop capacity measures relating to total time available.

Assists in analysis of human resource requirements and labour force modelling.

Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 3

Maximum size: 3

Data domain: Total hours, expressed as 000, 001 etc.

999 Not stated / inadequately described

Guide for use: Data element relates to each position (job) held by a medical practitioner.

Verification rules: Value must be less than 169 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours on-call not worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours on-call not worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related metadata: supersedes previous data element Hours worked vers 1

relates to the data element Hours worked by medical practitioner in direct patient care vers 2

relates to the data element Total hours worked by a medical practitioner vers 2

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:	***Start date***	***End date***
NMDS – Health labour force	01/07/1997	

Comments:

Hours worked by health professional

Identifying and Definitional Attributes

Knowledgebase ID: ***000313*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Hours worked is the amount of time a person spends at work in a week in employment/self-employment. It may apply to hours actually worked in a week or hours usually worked per week, and the National Health Labour Force Collection collects hours usually worked. It includes all paid and unpaid overtime less any time off.

It also:

- includes travel to home visits or calls out
- excludes other time travelling between work locations
- excludes unpaid professional and/or voluntary activities.

Total hours worked is the amount of time spent at work in all jobs.

As well as total hours worked, for some professions the National Health Labour Force Collection asks for hours worked in each of the main job, second job and third job. Hours worked for each of these is the amount of time spent at work in each job.

Context: Health labour force:

Important variable in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 3

Maximum size: 3

Data domain: Total hours, expressed as 000, 001 etc.

999 Not stated/inadequately described

Guide for use:

Verification rules: Value must be less than 127 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related metadata: supersedes previous data element Hours worked vers 1

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:	***Start date***	***End date***
NMDS – Health labour force	01/07/1997	

Comments: It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Hours worked by medical practitioner in direct patient care

Identifying and Definitional Attributes

Knowledgebase ID: ***000392*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: The number of hours worked in a week by a medical practitioner on service provision to patients including direct contact with patients, providing care, instructions and counselling, and providing other related services such as writing referrals, prescriptions and phone calls.

Context: Health labour force:

Used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 3

Maximum size: 3

Data domain: Total hours, expressed as 000, 001 etc.

999 Not stated/inadequately described

Guide for use: Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked for all jobs.

Verification rules: Value must be less than 127 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours usually worked per week in direct patient care, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked in direct patient care are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related metadata: relates to the data element Hours on-call (not worked) by medical practitioner vers 2

supersedes previous data element Hours worked vers 1

relates to the data element Total hours worked by a medical practitioner vers 2

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:	***Start date***	***End date***
NMDS – Health labour force	01/07/1997	

Comments: It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Hypertension – treatment

Identifying and Definitional Attributes

Knowledgebase ID: ***000826*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether an individual is currently treated for hypertension (high blood pressure) using antihypertensive medication.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Yes, currently being treated for hypertension using antihypertensive medication
2	No, not currently being treated for hypertension using antihypertensive medication
9	Not stated/inadequately described

Guide for use: Record whether or not on treatment for hypertension.

Only record yes if on an antihypertensive medication for their blood pressure.

Verification rules:

Collection methods: Ask the individual if he/she is currently treated with anti-hypertensive medications. Alternatively obtain the relevant information from appropriate documentation.

Related metadata: relates to the data element Blood pressure – diastolic measured vers 1

relates to the data element Blood pressure – systolic measured vers 1

relates to the data element Cardiovascular medication – current vers 1

relates to the data element Date of birth vers 4

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

Hypertension is probably the most important public health problem in developed countries. It is common, asymptomatic, readily detectable, usually easily treatable, and often leads to lethal complications if left untreated.

Elevated blood pressure (Hypertension) is a recognised risk for microvascular and macro vascular complications of diabetes (coronary, cerebral and peripheral).

Hypertension is elevated arterial blood pressure above the normal range (130 to 139/85 to 89 mm Hg) and values above these are defined as hypertension. Lower levels of target blood pressure should be aimed for in specific groups, e.g. in diabetics aim for blood pressure less than 135/80 mm Hg.

Many diabetics fail to control high blood pressure. Among all the diabetics with high blood pressure, 29% were unaware that they had high blood pressure and only slightly more than half were receiving hypertensive medications as treatment. Numbers of studies have shown that good management of blood pressure is at least as important as good control of blood glucose and the reduction of cholesterol in preventing the complications of diabetes.

Antihypertensives – Australian Medicines Handbook: February, 2001. Tight blood control in diabetes usually requires combination therapy as stated by (Australian Diabetes society) Therapeutic Guidelines Limited (05/04/2002).

People taking antihypertensives are also encouraged to make healthy lifestyle changes, such as quit smoking, lose weight and have regular physical activity. The level of blood pressure should generally be established on at least two to four occasions prior to initiating antihypertensive medication.

Systematic reviews of studies that have reported outcomes in patients with diabetes and hypertension indicate that combination therapy is frequently required and may be more beneficial than monotherapy. In the past multi-drug therapy to control hypertension has not been advocated much, but according to the special report published in the American Journal of Kidney Diseases, if ACE inhibitor therapy alone doesn't achieve good blood pressure control, multi-drug therapy should be implemented. (Heart Center Online)

References:

Pahor M, Psaty BM, Furberg CD. Treatment of hypertensive patients with diabetes. Lancet 1998; 351:689–90.

Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group (erratum appears in Br Med J 1999; 318:29).

Br Med J 1998; 317:703–13. Grossman E, Messerli FH, Goldbourt U, Curb JD, Pressel SL, Cutler JA, Savage PJ, Applegate WB, Black H, et al. Effect of diuretic-based antihypertensive treatment on cardiovascular disease risk in older diabetic patients with isolated systolic hypertension.

Systolic Hypertension in the Elderly Program Cooperative Research Group. JAMA 1996; 276:1886–92. Hypertension in diabetes(Australian Prescriber Feb 2002).

American Journal of Preventive Medicine 2002;21.

Hypoglycaemia – severe

Identifying and Definitional Attributes

Knowledgebase ID: ***000827*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual has had severe hypoglycaemia, which is defined as hypoglycaemia requiring assistance from another party.

Context: Public health, health care and clinical settings:

Hypoglycaemia is defined as an abnormally low level of glucose in the blood, which occurs when the blood glucose level falls to values low enough to cause symptoms and signs.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Yes, has had severe hypoglycaemia requiring assistance from another party
2	No, has not had severe hypoglycaemia requiring assistance from another party
9	Not stated/inadequately described

Guide for use: Record whether or not the person has a history of severe hypoglycaemia requiring assistance.

Verification rules:

Collection methods: Ask the individual if he/she has had a severe hypoglycaemia requiring assistance. Alternatively obtain the relevant information from appropriate documentation.

Related metadata: relates to the data element Glycosylated haemoglobin (HbA1c) – measured vers 1

relates to the data element Glycosylated haemoglobin (HbA1c) – upper limit of normal range vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

When reporting:

- Record whether the individual has had severe hypoglycaemia requiring assistance from another party in the last 12 months. The medications used in the treatment of diabetes may cause the blood glucose value to fall below the normal range and this is called hypoglycaemia.

Most hypoglycaemic reactions, however, do not cause long term problems, but the risks of permanent injury to the brain are greater in children under the age of 5 years, the elderly with associated cerebrovascular disease and patients with other medical conditions such as cirrhosis and coeliac disease. The serious consequences of hypoglycaemia relate to its effects on the brain. Rarely hypoglycaemia may cause death.

It is important to know how to recognise and react when someone is unconscious from hypoglycaemia. These people should be placed on their side and the airway checked so that breathing is unhampered and nothing should be given by mouth as food may enter the breathing passages. Treatment needs to be given by injection – either glucagon (a hormone which raises the blood glucose by mobilising liver stores) or glucose itself. Glucagon should be given by injection (usually intramuscular) at a dose of 0.5 units (or mg) in children under the age of 5 years and 1.0 units (or mg) for all older age groups.

All diabetic patients at risk of developing hypoglycaemia should have glucagon at home. Their families need to be shown how to administer it in times of severe hypoglycaemia.

Reference:

Definition corresponds with the Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

Report of the Health Care Committee Expert Panel on Diabetes; Commonwealth of Australia 1991; ISBN 0644143207.

Indicator procedure

Identifying and Definitional Attributes

Knowledgebase ID: ***000073*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: An indicator procedure is a procedure which is of high volume, and is often associated with long waiting periods.

Context: Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision. It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful. Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
07	Inguinal herniorrhaphy
08	Myringoplasty
09	Myringotomy
10	Prostatectomy
11	Septoplasty
12	Tonsillectomy
13	Total hip replacement
14	Total knee replacement
15	Varicose veins stripping and ligation
16	Not applicable

Guide for use: These procedure terms are defined by the ICD-10-AM (2002) codes which are listed in comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance.

These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

Verification rules: Zero filled, right justified.

Collection methods:

Related metadata: supersedes previous data element Indicator procedure – ICD-9-CM code vers 2

is used in conjunction with Procedure vers 5

supplements the data element Waiting list category 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

Information model link:

NHIM Service provision event

Data Set Specifications:	***Start date***	***End date***
NMDS – Elective surgery waiting times	01/07/2002	

Comments: The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.

The following is a list of ICD-10-AM codes, for the indicator procedures:

Cataract extraction:
42698-00 [195] 42702-00 [195] 42702-01 [195] 42698-01 [196] 42702-02 [196] 42702-03 [196] 42698-02 [197] 42702-04 [197] 42702-05 [197] 42698-03 [198] 42702-06 [198] 42702-07 [198] 42698-04 [199] 42702-08 [199] 42702-09 [199] 42731-01 [200] 42698-05 [200] 42702-10 [200] 42734-00 [201] 42788-00 [201] 42719-00 [201] 42731-00 [201] 42719-02 [201] 42791-02 [201] 42716-00 [202] 42702-11 [200] 42719-00 [201] 42722-00 [201]

Cholecystectomy:
30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965] 30446-00 [965] 30448-00 [965] 30449-00 [965]

Coronary artery bypass graft:
38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672] 38497-04 [673] 38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674] 38503-00 [674] 38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676] 38500-03 [677] 38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679] 90201-01 [679] 90201-02 [679] 90201-03 [679]

Cystoscopy:
36812-00 [1088] 36812-01 [1088] 36836-00 [1097]

Haemorrhoidectomy:
32138-00 [949] 32132-00 [949] 32135-00 [949] 32135-01 [949]

Hysterectomy:
35653-00 [1268] 35653-01 [1268] 35653-02 [1268] 35653-03 [1268] 35661-00 [1268] 35670-00 [1268] 35667-00 [1268] 35664-00 [1268] 35657-00 [1269] 35750-00 [1269] 35756-00 [1269] 35673-00 [1269] 35673-01 [1269] 35753-00 [1269] 35753-01 [1269] 35756-01 [1269] 35756-02 [1269] 35667-01 [1269] 35664-01 [1269] 90450-00 [989] 90450-01 [989] 90450-02 [989]

Inguinal herniorrhaphy:
30614-03 [990] 30615-00 [997] 30609-03 [990] 30614-02 [990 30609-02 [990]

Myringoplasty:
41527-00 [313] 41530-00 [313] 41533-01 [313] 41542-00 [315] 41635-10 [313]

Myringotomy:
41626-00 [309] 31626-01 [309] 41632-00 [309] 41632-01 [309]

Prostatectomy:
37203-00 [1165] 37203-01 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01 [1166] 37200-00 [1166] 37200-01 [1166] 37203-05 [1166] 37203-06 [1166] 37200-03 [1167] 37200-04 [1167] 37209-00 [1167] 37200-05 [1167] 90407-00 [1168] 36839-03 [1162] 36869-01 [1162]

Septoplasty:
41672-02 [379] 41679-03 [379]

Tonsillectomy:
41789-00 [412] 41789-01 [412]

Total hip replacement:
49318-00 [1489] 49319-00 [1489] 49324-00 [1492] 49327-00 [1492] 49330-00 [1492] 49333-00 [1492] 49345-00 [1492]

Total knee replacement:
49518-00 [1518] 49519-00 [1518] 49521-00 [1519] 49521-01 [1519] 49521-02 [1519] 49521-03 [1519] 49524-00 [1519] 49524-01 [1519] 49527-00

Varicose veins stripping and ligation:
32508-00 [727] 32508-01 [727] 32511-00 [727] 32504-01 [728] 32505-00 [728] 32514-00 [737]

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.

Indirect health care expenditure

Identifying and Definitional Attributes

Knowledgebase ID: ***000326*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: Expenditures on health care that cannot be directly related to programs operated by a particular establishment (that is, can only be indirectly related to particular establishments). To be provided at the State level but disaggregated into patient transport services, public health and monitoring services, central and statewide support services, central administrations and other indirect health care expenditure.

Context: Health expenditure:

To improve and substantiate financial reporting in relation to indirect health care expenditure and assist in understanding differences in costs for similar establishments in different States and regions, due to differences in the extent to which support services and other services to residents/inpatients and outpatients of establishments may be provided by the establishment itself or by other bodies.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars to the nearest whole dollar

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

Indirect health care expenditure is to be reported separately for each of the following categories:

1 Patient transport services:

Public or registered non-profit organisations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the scope of this data set.

This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of their normal services. This category includes centralised and statewide patient transport services (for example, Queensland Ambulance Transport Brigade) which operate independently of individual inpatient establishments.

2 Public health and monitoring services:

Public or registered non-profit services and organisations with centralised, statewide or national public health or monitoring services. These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical

services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council.

Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.

3 Central and statewide support services:

Public or registered services which provide central or statewide support services for residential establishments within the scope of this data set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross.

4 Central administrations:

Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (for example, the Department of Veterans' Affairs).

5 Other:

Any other indirect health care expenditure as defined above not catered for in the above categories. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments: Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the State level and were also concerned at the lack of uniformity between States. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Individual/group session

Identifying and Definitional Attributes

Knowledgebase ID: ***000235*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: A group is defined as two or more patients receiving services at the same time from the same hospital staff. However, this excludes the situation where individuals all belong to the same family. In such cases, the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

Context: Required to distinguish between those occasions of service on an individual patient basis and those servicing groups of patients. This distinction has resource implications.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.N

Minimum size: 5

Maximum size: 5

Data domain: A12.1 Individual sessions

A12.2 Group sessions

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments:

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:

Initial visit – diabetes mellitus

Identifying and Definitional Attributes

Knowledgebase ID: ***000828*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether this is the initial visit of the patient to a health professional for diabetes or a related condition after diagnosis has been established.

Context: Public health, health care and clinical settings.

Diabetes mellitus specific data element.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Yes, this is the initial visit of the patient for diabetes or a related condition after diagnosis
2	No, this is not the initial visit of the patient for diabetes or a related condition after diagnosis
9	Not stated/inadequately described

Guide for use: Record whether or not this is the first visit of the patient to this health professional.

Verification rules:

Collection methods:

Related metadata: relates to the data element Glycosylated haemoglobin (HbA1c) – measured vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments: Used to compare findings or parameters (e.g. blood glucose control) of newly referred individuals with that of those previously seen.

Injecting drug use status

Identifying and Definitional Attributes

Knowledgebase ID: ***000432*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: The client's use of injection as a method of administering drugs. Includes intravenous, intramuscular and subcutaneous forms of injection.

Context: Alcohol and other drug treatment services:

The data element is important for identifying patterns of drug use and harms associated with injecting drug use.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Last injected three months ago or less
2	Last injected more than three months ago but less than or equal to twelve months ago.
3	Last injected more than twelve months ago.
4	Never injected
9	Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods: To be collected on commencement of treatment with a service.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this data element should not be collected.

Related metadata: is qualified by Client type – alcohol and other drug treatment services vers 3

supersedes previous data element Injecting drug use vers 1

relates to the data element Method of use for principal drug of concern vers 1

relates to the data element Other drug of concern vers 2

relates to the data element Principal drug of concern vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Alcohol and other drug treatment services	01/07/2003	

Comments:

This data element is used in conjunction with the data element Commencement of treatment for reporting the NMDS – Alcohol and other drug treatment services, and has been developed for use in clinical settings. A code that refers to a three-month period to define 'current' injecting drug use is required as a clinically relevant period of time.

The data element may also be used in population surveys that require a longer timeframe, for example to generate 12-month prevalence rates, by aggregating codes 1 and 2. However, caution must be exercised when comparing clinical samples with population samples.

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.

Intended place of birth

Identifying and Definitional Attributes

Knowledgebase ID: ***000077*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: The intended place of birth at the onset of labour.

Context: Perinatal care:

Women who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Women who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Hospital
2	Birth centre, attached to hospital
3	Birth centre, free-standing
4	Home
8	Other
9	Not stated

Guide for use:

Verification rules:

Collection methods:

Related metadata: is qualified by Actual place of birth vers 1

is qualified by Method of birth, version 1

is qualified by Onset of labour, version 2

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Planning 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.

Intensive care unit

Identifying and Definitional Attributes

Knowledgebase ID: ***000078*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/96

Definition: An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

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:

Administrative Attributes

Source document:

Source organisation: National Intensive Care Working Group

Information model link:

NHIM Service delivery setting

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

Comments: There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards. The five types of ICU are briefly described below:

- Adult intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services, and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.

- Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines).
- Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for less than a 24-hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.
- Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care; and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.
- Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature.

Definitions for high-dependency unit and coronary care unit are under development.

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:

Interest payments

Identifying and Definitional Attributes

Knowledgebase ID: ***000245*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: Payments made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (i.e. dividends on shares) in respect of profit-making private establishments.

Context: Health expenditure:

This item has been retained in the data set because of its significance for the private sector. Private profit-making establishments will seek to fund their operations either by loan borrowings (debt capital) or raising shares (equity capital). The cost of either can be significant, although the cost of the latter (that is, dividends on shares) would come out of profits.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars, rounded to nearest whole dollar.

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments: The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.

Labour force status

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/01/03

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

Context: Clinical settings:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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

Guide for use: Definitions for these categories are:

Employed:

Employed persons comprise all those aged 15 years and over who, during the reference week:

(a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers');

(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker');

(c) were 'Employees' who had a job but were not at work and were:

- on paid leave
- on leave without pay, for less than four weeks, up to the end of the reference week
- stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week

- on strike or locked out
- on workers' compensation and expected to be returning to their job
- receiving wages or salary while undertaking full-time study;

(d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

Unemployed:

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

(a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then;

(b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown.

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

Not in the labour force:

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

Verification rules:

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

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

Administrative Attributes

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

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Labour characteristic

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

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

Laterality of primary cancer

Identifying and Definitional Attributes

Knowledgebase ID: ***000774*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: Laterality describes which side of a paired organ is the origin of the primary cancer. Each side of a paired organ is considered separately and described as lateral when occurring unless a physician determines that it is bilateral.

A paired organ is one in which there are two separate organs of the same kind, one on either side of the body (e.g. kidney, breast, ovary, testis and lung).

Context: This information is collected for the purpose of differentiating the site of the primary cancer. For example, a woman may present with a primary cancer in the left breast. She may return at a later stage with a new primary cancer in the right breast.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Left
2	Right
3	Bilateral (Note: Bilateral cancers are very rare)
9	Not known
Null	Not applicable

Guide for use: The valid International Classification of Diseases for Oncology values for the variable are provided in the list below:

1 Left:

Origin of primary site is on the left side of a paired organ

Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)

2 Right:

Origin of primary site is on the right side of a paired organ

3 Bilateral:

Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3))

9 Unknown:

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

Verification rules:

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

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

Administrative Attributes

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

Source organisation: World Health Organization

Information model link:

NHIM Assessment event

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

Comments:

Length of non-admitted patient emergency department service episode

Identifying and Definitional Attributes

Knowledgebase ID: ***000829*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/03

Definition: The amount of time, measured in minutes, between when a patient presents at an emergency department for an emergency department service episode, and when the non-admitted component of the emergency department service episode has concluded.

Context: Emergency department care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: MMMMM

Minimum size: 5

Maximum size: 5

Data domain: Count in minutes to the nearest minute

Guide for use: A non-admitted patient Emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

Verification rules:

Collection methods:

Related metadata: is calculated using Date patient presents vers 2

relates to the data element concept Emergency department – public hospital vers 1

relates to the data element concept Non-admitted patient emergency department service episode vers 1

relates to the data element Patient presentation at emergency department vers 1

is calculated using Time patient presents vers 2

Administrative Attributes

Source document:

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

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:	***Start date***	***End date***
NMDS – Non-admitted patient emergency department care	01/07/2003	

Comments:

Length of stay

Identifying and Definitional Attributes

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

Metadata type: Derived Data Element

Admin. status: Current

01/07/01

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

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count of the number of patient days

Guide for use: Formula:

LOS (incl. leave days) = Separation date - Admission date - Total leave days

The calculation is inclusive of admission and separation dates.

Verification rules:

Collection methods:

Related metadata: is calculated using Admission date vers 4

supersedes previous data element Length of stay vers 2

is calculated using Separation date vers 5

is calculated using Total leave days vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

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

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

Length of stay (antenatal)

Identifying and Definitional Attributes

Knowledgebase ID: ***000635*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/01

Definition: The length of stay of a patient measured in days calculated from the admission date of mother to the date of birth of the baby. Total contracted days are included in the length of stay. Leave days are included.

Context: Perinatal

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Calculated number of days

Guide for use: Formula:

Antenatal LOS = baby's Date of birth - mother's Admission date

Antenatal length of stay refers only to the admission associated with the birth.

The calculation is inclusive of the day of admission of the mother and the day of birth of the baby and includes any leave days.

Verification rules:

Collection methods:

Related metadata: is calculated using Admission date vers 4

is calculated using Date of birth vers 4

relates to the data element Length of stay (including leave days) vers 1

relates to the data element Perinatal period vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

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

Comments:

Length of stay (including leave days)

Identifying and Definitional Attributes

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

Metadata type: Derived Data Element

Admin. status: Current

01/07/01

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

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

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Calculated number of days

Guide for use: Formula:

LOS (incl. leave days) = Separation date - Admission date

The calculation is inclusive of admission and separation dates.

Verification rules:

Collection methods:

Related metadata: is calculated using Admission date vers 4

relates to the data element Length of stay (antenatal) vers 1

relates to the data element Length of stay (postnatal) vers 1

relates to the data element Perinatal period vers 1

is calculated using Separation date vers 5

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

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

Comments:

Length of stay (postnatal)

Identifying and Definitional Attributes

Knowledgebase ID: ***000637*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/01

Definition: The length of stay of a patient measured in days calculated from the Date of birth of baby to Separation date of mother. Total contracted days are included in the length of stay. Leave days are included.

Context: Perinatal.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Calculated number of days

Guide for use: Formula for the mother:
LOS (post-natal) = mother's Separation date - baby's Date of birth

Formula for the baby:
LOS (post-natal) = baby's Separation date - baby's Date of birth

Both calculations are inclusive of those dates and any leave days are included.
Excludes transfers, home births and other non-hospital births.

Verification rules:

Collection methods:

Related metadata: is calculated using Date of birth vers 4
relates to the data element Length of stay (including leave days) vers 1
relates to the data element concept Perinatal period vers 1
is calculated using Separation date vers 5

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

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

Comments:

Listing date for care

Identifying and Definitional Attributes

Knowledgebase ID: ***000082*** ***Version No: 4***

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.

Context: Hospital non-admitted patient care.

Community health care.

Elective surgery (admitted patient care).

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

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

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Listing date for care vers 3

is used in conjunction with Patient listing status vers 3

is used in conjunction with Scheduled admission date vers 2

is used in the calculation of Waiting time at a census date vers 2

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

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

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

Live birth

Identifying and Definitional Attributes

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

Metadata type: Data Element Concept

Admin. status: Current

01/07/94

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

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

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

Administrative Attributes

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

Source organisation: National Health Data Committee

National Perinatal Data Development Committee

National Perinatal Data Advisory Committee

Information model link:

NHIM Birth event

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

Comments:

Living arrangement

Identifying and Definitional Attributes

Knowledgebase ID: ***000629*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether a person usually resides alone or with others.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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

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

Verification rules:

Collection methods:

Related metadata: relates to the data element Carer availability vers 3

relates to the data element Formal community support access status vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Functional wellbeing

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

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

Lower limb amputation due to vascular disease

Identifying and Definitional Attributes

Knowledgebase ID: ***000830*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Amputation of toe, forefoot or leg (above or below knee), due to vascular disease.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Lower limb amputation – occurred in the last 12 months
2	Lower limb amputation – occurred prior to the last 12 months
3	Lower limb amputation – occurred both in and prior to the last 12 months
4	No history of lower limb amputation due to vascular disease
9	Not stated/inadequately described

Guide for use:

Verification rules:

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

Related metadata: relates to the data element Health professionals attended – diabetes mellitus vers 1

relates to the data element Foot deformity vers 1

relates to the data element Foot lesion – active vers 1

relates to the data element Foot ulcer – current vers 1

relates to the data element Foot ulcer – history vers 1

relates to the data element Peripheral neuropathy – status vers 1

relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

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

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

References:

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

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

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

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

Main language other than English spoken at home

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/01

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

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

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

Data domain: Valid ABS codes

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

Example 1:

The Lithuanian language has a code of 3102.

3 denotes that it is an Eastern European language

1 denotes that it is a Baltic language

02 denotes the specific language.

Example 2:

The Pintupi Aboriginal language has a code of 8217.

8 denotes that it is an Australian Indigenous language

2 denotes that the language is Central Aboriginal

17 denotes the specific language.

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

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

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

Verification rules:

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

Do you speak a language other than English at home?

No (English only)? ____

Yes, Italian? ____

Yes, Greek? ____

Yes, Cantonese? ____

Yes, Mandarin? ____

Yes, Arabic? ____

Yes, Vietnamese? ____

Yes, German? ____

Yes, Tagalog (Filipino)? ____

Yes, Other (please specify) _____

Related metadata: relates to the data element Country of birth vers 3

relates to the data element Proficiency in spoken English vers 1

Administrative Attributes

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

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

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

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

Main treatment type for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: ***000639*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern.

Context: Alcohol and other drug treatment services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Support and case management only
6	Information and education only
7	Assessment only
8	Other

Guide for use: To be completed at assessment or commencement of treatment.

The main treatment type is the principal activity, as judged by the treatment provider, that is necessary for the completion of the treatment plan for the principal drug of concern. The Main treatment type for alcohol and other drugs is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.

For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.

Code 1 refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

Code 2 refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in code 3.

Code 3 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration.

Rehabilitation activities can occur in residential or non-residential settings.

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

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

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

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

Verification rules:

Collection methods: Only one code to be selected.

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

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Service provision event

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

Comments:

Major diagnostic category

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/93

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

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

Context: All admitted patient care contexts:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Australian refined diagnosis related groups

Guide for use: Version effective 1 July each year

Verification rules:

Collection methods:

Related metadata: is derived from Additional diagnosis vers 4

is derived from Admission date vers 4

is derived from Date of birth vers 4

is used in the derivation of Diagnosis related group vers 1

is derived from Infant weight, neonate, stillborn vers 3

is derived from Principal diagnosis vers 3

Administrative Attributes

Source document:

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

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***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.

Marital status

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: Current marital status of the person.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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

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

Verification rules:

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

Related metadata: supersedes previous data element Marital status vers 2

Administrative Attributes

Source document:

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

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

Comments:

ABS standards identify two concepts of marital status:

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

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

Maternal medical conditions

Identifying and Definitional Attributes

Knowledgebase ID: ***000090*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal statistics:

Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the foetus and perinatal morbidity.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.NN

Minimum size: 3

Maximum size: 6

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

Guide for use: Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.

Verification rules: Conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM

Collection methods:

Related metadata: is used in conjunction with Complications of pregnancy vers 2

supersedes previous data element Maternal medical conditions – ICD-9-CM code vers 1

Administrative Attributes

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

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

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

Comments:

Medical and surgical supplies

Identifying and Definitional Attributes

Knowledgebase ID: ***000239*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: The cost of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: $999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars. Rounded to nearest whole dollar.

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

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

Comments:

Medicare card number

Identifying and Definitional Attributes

Knowledgebase ID: ***000091*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.

Context: Medicare utilisation statistics.

Persons eligible for Medicare services

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: N(11)

Minimum size: 11

Maximum size: 11

Data domain: Full Medicare card number for an individual (i.e. family number plus person (individual reference) number).

Guide for use: As a person can be identified on more than one Medicare card this is not a unique identifier for a person.

The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.

Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Medicare number vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Recipient role

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

Comments:

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

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

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

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

Medicare eligibility status

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/00

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

Context: Admitted patient care:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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:

Method of birth

Identifying and Definitional Attributes

Knowledgebase ID: ***000093*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: The method of complete expulsion or extraction from its mother of a product of conception.

Context: Perinatal statistics:

The method of delivery may affect the health status of the mother and the baby at birth and during the postpartum period.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Spontaneous vaginal
2	Forceps (assisted vaginal birth)
3	Vaginal breech
4	Caesarean section
5	Vacuum extraction
8	Other
9	Not stated

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

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

Comments:

Method of use for principal drug of concern

Identifying and Definitional Attributes

Knowledgebase ID: ***000433*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The client's usual method of administering the Principal drug of concern as stated by the client.

Context: Alcohol and other drug treatment services:

Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Ingests
2	Smokes
3	Injects
4	Sniffs (powder)
5	Inhales (vapour)
6	Other
9	Not stated/inadequately described

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

Verification rules:

Collection methods: Collect only for Principal drug of concern.

To be collected on commencement of treatment with a service.

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

relates to the data element Principal drug of concern vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Lifestyle characteristic

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

Comments:

Microalbumin – units

Identifying and Definitional Attributes

Knowledgebase ID: ***000832*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The units used for measuring microalbumin dependent upon laboratory methodology.

Context: Public health, health care and clinical settings:

A small amount of protein (albumin) in the urine (Microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	mg/L (milligrams per litre)
2	µg/min (micrograms per minute)
3	mg/24hr (milligrams per 24-hour period)
4	albumin/creatinine ratio
9	Not stated/inadequately described

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

Verification rules:

Collection methods: Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Report the methodology used by the laboratory.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Related metadata: relates to the data element Microalbumin – upper limit of normal range vers 1

relates to the data element Microalbumin/protein – measured vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Surveillance/monitoring event

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

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

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

Microalbumin – upper limit of normal range

Identifying and Definitional Attributes

Knowledgebase ID: ***000833*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Laboratory standard for the value of Microalbumin that is the upper boundary of the normal reference range.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN.N

Minimum size: 3

Maximum size: 5

Data domain: Measured value or

999.9 Not stated/inadequately described

Guide for use: Record the upper limit of the microalbumin normal reference range for the Laboratory

Verification rules:

Collection methods: Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Related metadata: is qualified by Microalbumin – units vers 1

relates to the data element concept Microalbumin/protein – measured vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Surveillance/monitoring event

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

Comments:

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

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

If microalbuminuria is present:

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

If macroalbuminuria is present:

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

Microalbumin/protein – measured

Identifying and Definitional Attributes

Knowledgebase ID: ***000831*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A person's measured total microalbumin in a spot test, 24 hour or timed collection.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNN.N

Minimum size: 3

Maximum size: 6

Data domain: Measured in different units dependant upon laboratory methodology

9999.9 Not stated/inadequately described

Guide for use: Record the result expressed as the absolute amount of albumin (mg/L) or as albumin excretion rate (AER: µg/min or mg/24hr) or albumin/creatinine ratio.

Verification rules:

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

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are:

- spot urine 30 to 300mg/L
- timed urine (24 hr collection) 20 to 200 µg /min.

Related metadata: relates to the data element Microalbumin – units vers 1

relates to the data element Microalbumin – upper limit of normal range vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Assessment event

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

Comments:

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

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

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

Minutes of operating theatre time

Identifying and Definitional Attributes

Knowledgebase ID: ***000094*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/89

Definition: Total time spent by a patient in operating theatres during current episode of hospitalisation.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: MMMM

Minimum size: 4

Maximum size: 4

Data domain: Calculated number of minutes

Guide for use:

Verification rules: Right justified, zero filled

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments: This item was recommended for inclusion in the *National Health Data Dictionary* by Hindle (1988a, 1988b) to assist with diagnosis related group costing studies in Australia.

This data element has not been accepted for inclusion in the NMDS – Admitted patient care.

Mode of admission

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/99

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

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Admitted patient transferred from another hospital

2 Statistical admission – episode type change

3 Other

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

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

Verification rules:

Collection methods:

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

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

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

Comments:

Mode of separation

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/00

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

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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.

Morphology of cancer

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/02

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

Context: This information is collected for the purpose of:

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNN

Minimum size: 5

Maximum size: 5

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

Guide for use: ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.

In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.

Record morphology codes in accordance with ICDO coding standards. Use the 5th digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant
- borderline malignancy
- low malignant potential

2 Carcinoma in situ
- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site
- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Verification rules:

Collection methods: Cancer registry use:

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

Hospital morbidity use:

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

Related metadata:

Administrative Attributes

Source document: International Classification of Diseases for Oncology, Second Edition (ICDO-2)

New South Wales Inpatient Statistics Collection Manual, 2000/2001

Source organisation: World Health Organization.

New South Wales Health Department.

State and Territory Cancer Registries.

Information model link:

NHIM Assessment event

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

Comments:

Mother's original family name

Identifying and Definitional Attributes

Knowledgebase ID: ***000793*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The original family name of the person's mother as reported by the person.

Context:

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Text

Representational layout: A(40)

Minimum size: 0

Maximum size: 40

Data domain: Text

Guide for use: May be used to confirm the identity of a person.

Mixed case should be used (rather than upper case only).

Verification rules:

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

Related metadata:

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

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

Comments:

Multi-disciplinary team status

Identifying and Definitional Attributes

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

Metadata type: Data Element

Admin. status: Current

01/07/00

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

Context: Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

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

Guide for use:

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Individual/group session vers 1

is used in conjunction with New/repeat status vers 1

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

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

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

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Assessment event

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

Comments:

Myocardial infarction – history

Identifying and Definitional Attributes

Knowledgebase ID: ***000834*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether the individual has had a myocardial infarction.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Myocardial infarction – occurred in the last 12 months
2	Myocardial infarction – occurred prior to the last 12 months
3	Myocardial infarction – occurred both in and prior to the last 12 months
4	No history of myocardial infarction
9	Not stated/inadequately described

Guide for use:

Verification rules:

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

Alternatively obtain this information from appropriate documentation.

Related metadata: relates to the data element Blood pressure – diastolic measured vers 1

relates to the data element Blood pressure – systolic measured vers 1

relates to the data element Cholesterol-HDL – measured vers 1

relates to the data element Cholesterol-total – measured vers 1

relates to the data element Tobacco smoking status – diabetes mellitus vers 1

relates to the data element Triglycerides – measured vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

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

Comments:

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

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

Reference:

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

INDEX

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y