Report on the Evaluation of the National Minimum Data Set for Admitted Patient Mental Health Care

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Report on the Evaluation of the National Minimum Data Set for Admitted Patient Mental Health Care

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Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AHSAC	Australian Hospital Statistics Advisory Committee
AIHW	Australian Institute of Health and Welfare
APC NMDS	Admitted Patient Care National Minimum Data Set
APMHC NMDS	Admitted Patient Mental Health Care National Minimum Data Set
AR-DRG	Australian Refined Diagnosis Related Group
ASGC	Australian Standard Geographical Classification
CALD	Cultural and linguistic diversity
DoHA	Australian Government Department of Health and Ageing
DRG	Diagnosis related group
HDSC	Health Data Standards Committee
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification
ISC	Information Strategy Committee
METeOR	Metadata Online Registry
NAGATSIHID	National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data
NCSDC	National Community Services Data Committee
NHDD	*National Health Data Dictionary*
NHIG	National Health Information Group
NHMD	National Hospital Morbidity Database
NMDS	National Minimum Data Set
NMHWG	National Mental Health Working Group
NOCC	National Outcomes and Casemix Collection
NSW	New South Wales
NT	Northern Territory
PHEC	Private Health Establishments Collection
Qld	Queensland
RMHC	Residential Mental Health Care
SA	South Australia
SACC	Standard Australian Classification of Countries
SIMC	Statistical Information Management Committee
SLA	Statistical Local Area
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Summary and recommendations

The evaluation of the National Minimum Data Set (NMDS) for Admitted Patient Mental Health Care (APMHC) was funded by the Australian Health Ministers' Advisory Council, through the National Health Information Group (NHIG) and the Statistical Information Management Committee (SIMC). It was conducted by the Australian Institute of Health and Welfare (AIHW) with the advice of the Australian Health Ministers' Advisory Council National Mental Health Working Group (NMHWG) Information Strategy Committee (ISC).

This report has been supported by the NMHWG and endorsed by the SIMC.

The aim of the evaluation was to assess the quality and utility of the NMDS to determine whether the data collection suits current requirements, and to identify changes required to improve data quality and comparability.

The method used for the evaluation included:

- a review of compliance, that is, the extent to which data for APMHC NMDS 2002–03 were collected and/or provided by states and territories in accordance with NMDS specifications as published in the *National Health Data Dictionary* (AIHW 2002)
- a review of utility, based on consultations with data collectors and users, using a survey tool based on that designed for the evaluation of the Admitted Patient Care NMDS
- formulation of recommendations for future data development and the assignment of priorities.

A summary of the recommendations compiled from the evaluation of utility and the compliance evaluation is presented below. Recommendations for modifications to existing data elements and proposals for new data elements are discussed. Priorities have been attached to each recommendation to guide the development of work programs that include implementation of the recommendations. Many recommendations are for further data development work to be undertaken. Any proposals for new or modified data elements that arise from such data development work would be submitted (with business cases) for approval to the Health Data Standards Committee (HDSC), the SIMC and the NHIG before they are incorporated into the NMDS.

Further discussion relevant to the recommendations is included in chapters 3 to 5 of this report.

General recommendations

- That the collection of the NMDS continues. As a whole, it was considered highly important and useful by most survey respondents.
- That consideration is given to changing the name of the NMDS to acknowledge specialised care in the title, and to better reflect its scope. The new name would be the Admitted Patient Specialised Mental Health Care NMDS.
- That the scope statement is revised to refer to designated psychiatric units/programs only, rather than including a reference to psychiatric hospitals.
- That consideration is given to deletion of the duplication between the APMHC NMDS and the Admitted Patient Care (APC) NMDS, with additional data elements required for the APMHC NMDS to be specified as an 'add-on' to the APC NMDS (as detailed on pages 30 and 31). This may allow a simplification of the governance arrangements for the NMDS.
- That relevant recommendations arising from this evaluation are communicated, as appropriate, to the AIHW and to the NMHWG ISC, for consideration in data development work program planning.
- That work is undertaken towards integrating the data elements and consumer outcomes measurement instruments from the National Outcomes and Casemix Collection (NOCC) into the APMHC in line with the recommendations in the *National Mental Health Information Priorities* 2nd Edition (DoHA forthcoming). It is noted that resources would be required to accomplish this task and a phased approach may be needed for one or more jurisdictions.
- That work continues to improve the completeness and accuracy of data reporting for all data elements but, in particular, those noted as of concern in the compliance evaluation.
- That it is noted that, although comments from the survey respondents have been summarised in this report, they will be available in full to inform subsequent data development work.
- That the considerable efforts of the states and territories and other survey respondents in providing information for this evaluation are recognised and applauded.

Recommendations relating to existing and proposed new data elements and concepts

Establishments-related data elements

Establishment identifier

It is recommended that preliminary work is undertaken to investigate the approaches to reporting establishments taken by the NOCC and the NMDS to ensure that the establishments in each of these collections can be identified in the same way. If the investigation shows that the establishments are not able to be identified in the same way in each collection then the differing uses of this data element and its components may need to be re-examined.

Priority: High

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning.

Establishment number

See *Establishment identifier* above.

Establishment sector

As recommended in the evaluation of the APC NMDS, it is suggested that the informal collection of information on whether a hospital is a public psychiatric, other public, private freestanding day hospital facility or private hospital using this data element is replaced with either an appropriate revision of the data domain for *Establishment sector* or the creation of a new data element on establishment type. This issue is currently being considered as part of the AIHW's work program for the development of the APC NMDS.

See also *Establishment identifier* above.

Priority: Medium

Recommendation: That work underway to review *Establishment sector* and *Establishment type* by the AIHW continues.

Region code

This data element has been deleted from the APC NMDS already, due to a recommendation arising from the evaluation of that NMDS. However, it is recommended that this data element be retained in the APMHC NMDS. It is used by jurisdictions for their specialised mental health services and is needed to maintain links with other mental health data collections such as the NOCC, Community Mental Health Care (CMHC) NMDS, Mental Health Establishments (MHE) NMDS and the Residential Community Mental Health Care (RCMHC) NMDS.

Priority: High

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning.

State identifier

See *Establishment identifier* above.

Demographic data elements

Area of usual residence

It is recommended that this data element is not changed.

Recommendation: Retain the data element unchanged.

Country of birth

Generally there was concern about the utility of this data element as a measure of the cultural and linguistic diversity of patients, and the lack of data collected on the cultural and linguistic diversity of patients in general. The Australian Bureau of Statistics (ABS) recommends that the following data elements form the minimum core set of cultural and language indicators: *Indigenous status*, *Proficiency in spoken English*, *Main language other than English spoken at home* and *Country of birth*: *Proficiency in spoken English*, *Main language other than English spoken at home* and *Parent's country of birth* could be considered as additions to the NMDS.

In 2001, a business case was prepared for the National Health Information Management Group (now SIMC) to add *Proficiency in spoken English* and *Main language other than English spoken at home* data elements to the APC NMDS. The addition of the data elements was not considered possible due to the potential cost to states and territories. Costs would similarly need to be taken into account if a proposal to add these data elements to this NMDS is considered.

Priority: Medium

Recommendation: Retain the *Country of birth* data element unchanged. Refer the issue of other data elements on cultural and linguistic diversity to the AIHW and ISC for their data development work program planning.

Date of birth

Inconsistencies in recording unknown dates of birth are of concern. It is recommended that work already begun by the AIHW to achieve consistency in handling missing or estimated dates of birth are handled at the national level continues.

Priority: High

Recommendation: That work continues by the AIHW to achieve consensus on the handling of missing or estimated dates of birth.

Employment status—acute hospital and private psychiatric hospital admissions

A range of concerns were expressed about the employment status data elements, such as a lack of clarity about the purpose for collection, difficulty in collection and the different data domains used for the two employment status data elements. It was reported for only 38% of separations in the NMDS for 2002–03.

It is recommended that consideration be given to the purpose of collecting employment status in the NMDS to inform the development of a new data element or a merged employment status data element (see below). If the purpose is to measure an aspect of functioning of patients, and it is agreed that the NMDS is the appropriate mechanism to collect this information, then an alternative data element that better measures this concept may need to be developed. If there is an alternative or additional purpose for collecting employment status, any further data development should be considered in light of this.

If it is decided that employment status should be retained in the NMDS, it is suggested that *Employment status – acute hospital and private psychiatric hospital admissions* and *Employment status – public psychiatric hospital admissions* be combined. In the new METeOR system (see page 17) these have been presented as two separate data elements (reflecting the two separate data domains) but under one data element concept (reflecting the single concept of 'employment status' in both). The standardisation of the data domains would improve the usefulness of this information.

Priority: High

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning.

Employment status—public psychiatric hospital admissions

See *Employment status – acute hospital and private psychiatric hospital admissions*

Indigenous status

The National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data has improvement of the quality of Indigenous identification in hospital morbidity data as part of its work program. This component of the work program is being undertaken by the AIHW. It is recommended that it continues. Other work at the state and territory level on improving the quality of these data also needs to continue.

Priority: High

Recommendation: That work underway by the National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data and the AIHW aimed at improving the identification of Indigenous persons in hospital morbidity data continues.

Marital status

Similar concerns were expressed about *Marital status* as for the employment status data elements, that is, unclear purpose and difficulty in collecting. In addition, it was noted that the data domain categories were not mutually exclusive.

It is recommended that consideration be given to the purpose of collecting *Marital status* in the NMDS. If a purpose is to measure carer availability, an additional data element to collect this information may be required.

If a purpose of *Marital status* is to measure socioeconomic status of patients, and it is agreed that the NMDS is the appropriate mechanism to collect this information, a data element that better measures this concept may need to be developed.

If there are other purposes for collecting *Marital status*, such as providing information on social isolation/connectedness, any further data development should be considered in light of this.

Priority: Medium

Recommendation: That this data element is retained but that it is referred to the AIHW and ISC for their data development work program planning to assess whether additional data elements are needed for related purposes.

Sex

It is recommended that this data element is not changed.

Recommendation: Retain the data element unchanged.

Length-of-stay—related data elements

Admission date

It is recommended that this data element is not changed. However, it is recommended that consideration be given to the addition of *Admission time* to the NMDS. The same recommendation was made in the evaluation of the APC NMDS.

See *Admission time* and *Separation time* below.

Separation date

It is recommended that this data element is not changed. However, it is recommended that consideration be given to the addition of *Separation time* to the NMDS (see below). The same recommendation was made in the evaluation of the APC NMDS.

See *Admission time* and *Separation time* below.

Total leave days

There was a need expressed for clarity about leave rules (see page 108), particularly in relation to involuntary patients who are not separated for legal reasons. It is proposed that consideration is given to restricting leave days to periods where the

patient is away overnight. The proposal to change this data element to a count of leave hours, as under consideration for the APC NMDS, was not considered appropriate for the APMHC NMDS because of, for example, difficulties with implementation.

If the proposal to combine the APC and APMHC NMDSs is approved then any proposed changes to *Total leave days* for either APC NMDS or APMHC NMDS would need to take these issues into account.

Priority: Medium

Recommendation: It is recommended that the proposal to restrict leave days to where the patient is away overnight is referred to the AIHW and ISC for their data development work program planning. It is also recommended that these issues are taken into account during the APC NMDS data development process that is being undertaken on this and related length of stay data elements.

Total psychiatric care days

Although there was some suggestion that this data element be changed to a count of psychiatric hours, it is recommended that this data element be retained as *Total psychiatric care days*.

Priority: Medium

Recommendation: It is recommended that this data element remain unchanged.

Admission time and Separation time

It is recommended that the addition of the data elements *Admission time* and *Separation time* to the NMDS should be considered. The same recommendation was made in the evaluation of the APC NMDS.

Priority: Medium

Recommendation: That work underway on *Admission time* and *Separation time* by the HDSC working group continues. If the proposal to combine the APC and APMHC NMDSs is approved, with the additional items in APMHC NMDS being collected only for patients receiving specialised psychiatric care, then these data elements would not need to be added to the APMHC NMDS.

Clinical and related data elements

Diagnosis

It is recommended that this data element concept is not changed.

Recommendation: Retain the data element concept unchanged.

Principal diagnosis

It is recommended that this data element is not changed.

Recommendation: Retain the data element unchanged.

Additional diagnosis

There were no detailed comments on this data element. It is recommended that this data element is not changed.

Recommendation: Retain the data element unchanged.

Diagnosis related group

There were no detailed comments on this data element. It is recommended that this data element is not changed.

Recommendation: Retain the data element unchanged.

Major diagnostic category

It is recommended that this data element is not changed.

Recommendation: Retain the data element unchanged.

Continuity of care data elements

The group of data elements that relate to continuity of care are those relating to care prior to admission: *Previous specialised treatment, Source of referral to public psychiatric hospital, Type of accommodation* and *Type of usual accommodation;* and those relating to care following separation: *Mode of separation* and *Referral to further care*.

These data elements are sensibly considered as a group.

Previous specialised treatment

The original purpose of including this data element in the NMDS was to assess pre-admission continuity of care. This data element was also planned as an indicator of new patients, who are thought to be more resource-intensive. It was reported for only 35% of separations in the NMDS for 2002–03.

Some improvements were suggested for this data element. In particular, it was suggested that further explanation is added to the guide for use section on the definition of a 'service contact', to assist with use of this data element. This should draw on the recently revised *Mental health service contact* data element concept.

At present, the guide for use of *Previous specialised treatment* refers to previous hospital admission(s) and/or service contact(s) at any time in the past. It is recommended that further definition of periodicity be added to the definition and guide for use to improve its usefulness.

Priority: High

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning.

Source of referral to public psychiatric hospital

The purpose of this data element is to provide information on pre-admission continuity of care. The compliance review of *Source of referral to public psychiatric hospital* indicates that this data element is not collected well. Comments in the survey of utility related to the need for a review of the data domains, a query as to why this data element is restricted to public psychiatric hospitals, and the possibility of deleting the data element from the NMDS.

Priority: Medium

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning. The data development work already underway on *Source of referral to public psychiatric hospital* in the APC NMDS work program should be taken into account.

Type of accommodation

Concerns were expressed about the use of two separate accommodation status data elements that contained different data domain categories. Accommodation information was only reported for 52% of separations in the NMDS for 2002–03.

There was broad support for collecting data on accommodation status in the NMDS, but using one data element only. This information was seen as important due to its links with the availability of housing before admission and after separation from hospital.

Similar to the *Employment status* and *Marital status* data elements, consideration should be given to the purpose of collecting accommodation status in the NMDS, to inform the revision of these data elements, possibly into one data domain that could be used with two data elements to capture accommodation both before admission and after separation. Possible purposes include to measure post-discharge continuity of care, assess carer availability, develop socioeconomic profiles of 'at risk' groups (for those who have listed their accommodation prior to admission in any of the 'at risk' categories, such as 'homeless persons' shelter'), or to provide information on movements between hospital and other accommodation types both before and after hospital stays.

Priority: High

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning. The work currently being done by the National Mental Health Working Group's (NMHWG) Housing and Homelessness Task Force should be taken into account.

Type of usual accommodation

See *Type of accommodation*

Mode of separation

It is recommended that the data domain be reconsidered, as it is currently a combination of non-mutually exclusive codes that describe patient destination or patient status. It is recommended that consideration be given to *Referral to further care* during development of *Mode of separation* to ensure that the data elements are able to be used together as they provide valuable information on the discharge process.

Priority: Medium

Recommendation: That issues arising in this evaluation are referred to the AIHW and ISC for their data development work program planning to inform data development work already underway on *Mode of separation*.

Referral to further care (psychiatric patients)

The purpose of this data element for the NMDS is to provide information about post-discharge continuity of care. It was reported for only 47% of separations in the NMDS for 2002–03. Patients may be referred to several different services on discharge from hospital. Acknowledgment of this in the data element could be useful, along with rules clarifying which category should take precedence if multiple apply.

Consideration should be given to *Mode of separation* during development of *Referral to further care* to ensure that concepts are consistent and data domains are able to be aligned across the data elements so the data elements can be used together.

Priority: Medium

Recommendation: That the data element is referred to the AIHW and the ISC for their data development work program planning and the issue regarding consistency between *Mode of separation* and *Referral to further care* is referred to the APC NMDS work program to inform data development work already underway on *Mode of separation*.

Admitted patients and care type data elements

Admission, Admitted patient and Episode of admitted patient care (the statistical unit for the NMDS)

Work to define admission more consistently and accurately in relation to boundaries between admitted overnight, same-day and non-admitted care is recommended. The same recommendation was made in the evaluation of the APC NMDS and is being considered by the HDSC.

Work to differentiate procedures undertaken during same-day separations that could have been undertaken in an ambulatory care setting, and could therefore be considered equivalent to ambulatory care, was previously undertaken by AIHW. It is recommended that these same-day separations considered to be ambulatory-equivalent care continue to be reported separately in the *Mental Health Services in Australia* reports.

Priority: High

Recommendation: That work underway by the HDSC on the definition of admission continues and that the comments on admission in this evaluation are conveyed to the HDSC for its consideration.

Acute care episode for admitted patients

It is recommended that this data element concept be considered for deletion, as it is covered by the *Care type* data element.

Priority: Medium

Recommendation: That this is referred to the AIHW for their data development work program planning.

Patient

It is recommended that this data element concept is not changed.

Recommendation: Retain the data element concept unchanged.

Separation

It is recommended that this data element concept is not changed.

Recommendation: Retain the data element concept unchanged.

Care type

The appropriateness of the data domain as it is currently designed for mental health, particularly for long-stay mental health rehabilitation patients and psychogeriatric patients, requires review. The separation of psychogeriatric care as a separate category from acute care is considered problematic, as psychogeriatric care may also be acute care. In addition, it is proposed that *Care type* be replaced with separate data elements that distinguish clinical intent from type of service. Any changes to *Care type* need to take into account the possible impact on the *Episode of admitted patient care* data element concept.

Care type is currently being reviewed as part of the work program for the development of the APC NMDS.

Priority: High

Recommendation: That work underway to review *Care type* in the work program for the APC NMDS continues, with advice from the ISC with regard to mental health-related issues.

Administrative data elements

Mental health legal status

In some states and territories, patients can be involuntary and not admitted to designated psychiatric units because there are insufficient designated beds. It is important that this data element is reported for involuntary patients who are not receiving specialised psychiatric care. This would mean that this data element needs to be an operational data element within the APC NMDS. Whilst this is the case for some states and territories, not all states and territories collect this data element for patients other than those in the APC NMDS, so implementation of this recommendation would have resource implications for some states and territories. In addition, there may be issues with the private sector's capacity to collect this information.

Priority: Medium

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning and also the work program for the development of the APC NMDS.

Person identifier

It is anticipated that this data element will be useful for data linkage between the National Hospital Morbidity Database (which includes the data specified by the APMHC NMDS), the National Community Mental Health Care Database, the National Residential Mental Health Care Database and the National Outcomes and Casemix Collection (NOCC) Database, to assess service utilisation and outcomes for mental health patients. This linkage should be possible because *Person identifiers* are expected to correspond to clients of public specialised mental health services that integrate admitted, ambulatory and residential care.

It is recommended that the extent to which *Person identifiers* match across these data collections is investigated and work to ensure that they do is undertaken as necessary.

It is also recommended that work being undertaken by SIMC, through the Working Group on Data Linkage, on minimum practice for data linkage, covering issues such as development of appropriate privacy and security protocols, data management, data quality and documentation standards, be taken into account. Particular attention should be paid to those principles that relate to the *Person identifier* data element.

Priority: High

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning.

New data elements

Language spoken and Need for an interpreter

It could be useful to have data elements to capture language spoken at home and the need for an interpreter. Both would be valuable in understanding the resources involved in delivering mental health services within a multicultural environment, and the effectiveness of these services. Information on need for and use of interpreters also relates to the issue of access to services.

Priority: Low

Recommendation: Refer this issue to the AIHW and ISC for their data development work program planning.

Consultation–liaison

The lack of data available on the provision of consultation–liaison services was raised in the survey of utility. There is interest in the collection of data on these services provided to patients who have comorbid psychiatric and physical disorders. It is recommended that consideration be given to the use of procedure codes available in the APC NMDS to provide this information or to the inclusion of a specific data element to collect information on consultation–liaison services in the APC NMDS. The development process will require careful discussion and negotiation among the states and territories before this can be implemented.

The Consultation–Liaison Psychiatry Mental Health Outcomes Expert Group is in the process of reporting on consultation–liaison issues relating to the NOCC. Their recommendations are likely to be of relevance to the issues above.

Priority: Medium

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning.

Carer availability

A data element on carer availability could be a useful indicator of the level of support patients receive/expect to receive when leaving hospital. The existing data element in the *National Community Services Data Dictionary* version 3 (NCSDC 2004), *Informal carer availability*, may be able to be used, with or without adaptation.

See *Marital status* above.

Priority: Medium

Recommendation: That this be considered together with data elements such as *Marital status* and *Type of accommodation* and referred to the AIHW and ISC for their data development work program planning.

Procedure and Intervention classification for mental health

The data element *Procedure* is currently collected as part of the APC NMDS. As such, it will be available for mental health care-related analysis if the APMHC NMDS becomes defined as an add-on to the APC NMDS.

Comments from the survey of utility noted that the ICD-10-AM procedure classification in its current form is of limited usefulness for admitted patient mental health care. The *National Mental Health Information Priorities 2nd edition* (DoHA forthcoming) recommended the development of national agreed mental health intervention codes. The importance of private sector involvement in this development work was noted.

Priority: High

Recommendation: That the issue of intervention codes for mental health is referred to the ISC to be dealt with through the process for implementation of recommendations from the *National Mental Health Information Priorities 2nd edition*.

Other recommendations

Missing patient-derived data

Information on patient-derived data, such as demographic and socioeconomic data, may be not reported at the national level. Several respondents in the survey of utility commented that patients who are admitted to hospital with mental health problems may not be in a position to respond to requests for information at the time of admission to hospital. It is therefore important that any information required from these patients is requested at an appropriate time. An appropriate time would generally be after the patient had received treatment rather than on admission. Data may also not be available because patients were not asked to provide the relevant information.

Further consideration should be given to collecting more detailed information on 'not reported' data at the national level in order to improve the interpretability of data in the APMHC NMDS.

Priority: Low

Recommendation: That this is referred to the AIHW and ISC for their data development work program planning.

1 Introduction

This report presents the findings of an evaluation of the APMHC NMDS conducted by the AIHW. The evaluation was funded by the Australian Health Ministers' Advisory Council, through the NHIG and was conducted with the advice of the NMHWG ISC. It has been endorsed by the SIMC and supported by the NMHWG.

The aim of the evaluation was to assess the quality and utility of the NMDS to determine whether the data collection suits current requirements and to plan actions to improve data quality and comparability. The methodology used in the evaluations of the APC NMDS and the Perinatal NMDS has been used. The methodology incorporates a review of utility, based on consultations with data collectors and users; a review of compliance, that is, the extent to which data are collected and/or provided by states and territories in accordance with NMDS specifications as published in the *National Health Data Dictionary* (NHDD); and formulation of recommendations for future data development.

This report

This chapter describes the APMHC NMDS and outlines the purpose of the evaluation.

Chapter 2 describes the methodology that was developed and used as the basis for the evaluation.

Chapter 3 describes the results from the review of utility, a consultation process involving a survey of data collectors and users. Information is presented on the users and uses of the NMDS, the utility of the NMDS and individual data elements, that is, the extent to which they are perceived as important and useful, and possible areas for data development.

Chapter 4 describes the results of the compliance review, including information on the scope of the data provided by states and territories and the extent to which the data provided for each data element comply with NHDD definitions and domain values.

Chapter 5 presents comments on existing data elements obtained from both the utility and compliance evaluations. It also outlines suggestions for new data elements.

The appendixes include the survey used as the basis of the review of utility[1] and a list of survey respondents.

1 Explanatory notes accompanying the survey are available from the AIHW on request.

The National Minimum Data Set for Admitted Patient Mental Health Care

An NMDS is a core set of data elements agreed by the NHIG for mandatory collection and reporting at a national level. An NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of a national collection. The NMDS standards make data collection activities more efficient, by reducing duplication of effort through the standardisation of core data items; more effective, by ensuring that information to be collected is relevant and appropriate to its purpose; and more comparable and consistent for reporting purposes.

An NMDS includes agreement on specified data elements (discrete items of information or variables) and supporting data element concepts as well as the scope of the application of those data elements and the statistical units for collection. Definitions of all data elements that are included in NMDS collections in the health sector are included in the NHDD.

The APMHC NMDS (referred to from here on as 'the NMDS') is a specification for data that are collected on all episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units of acute care hospitals.

Episodes of admitted patient care are the statistical units of the NMDS, with data being collected from hospital patient administrative and clinical record systems and forwarded to the relevant state or territory health authority on a regular basis. Data for each financial year ending 30 June are then provided to the AIHW and the Australian Government Department of Health and Ageing (DoHA) for national collation, on an annual basis.

The data elements in the NMDS are listed in Appendix 1.

The NMDS forms the basis for nationally comparable data, such as the AIHW's annual report *Mental Health Services in Australia* (AIHW 2004b, 2005). The NMDS forms a mental health-related subset of the AIHW's National Hospital Morbidity Database (NHMD), state and territory-based hospital morbidity data collections and DoHA's National Hospital Morbidity (Casemix) Database.

Purpose of this evaluation

The APMHC NMDS was endorsed by the then National Health Information Management Group in November 1996, for collection from July 1997 (as the 'Institutional Mental Health Care NMDS'). The NMDS has been amended and augmented since then, in response to a range of different requirements. There have been no attempts until now to assess the quality and utility of the NMDS-based data in a comprehensive manner. As considerable resources are used at the state and territory and national levels to collect the data, a comprehensive evaluation of the NMDS was considered necessary to determine whether the data collection suits current requirements and to plan actions to improve data quality and consistency.

This evaluation has built on other attempts to assess the quality and utility of admitted patient data. These include the Hospital Utilisation and Costs Study Review undertaken in 1996 (which incorporated some review of the APC NMDS), the National Health Information Management Group's compliance evaluation of the 1997–98 APC NMDS undertaken in 2000 and the evaluation of the APC NMDS conducted in relation to 2000–01 data and published as *Report on the Evaluation of the National Minimum Data Set for Admitted Patient Care* (AIHW 2003).

Relationship with the evaluation of the Admitted Patient Care NMDS

The evaluation of the APC NMDS was conducted in 2003. In response to the evaluation, the DoHA provided funds to the AIHW to further develop the APC NMDS.

It is important that no duplication of effort occurs between that evaluation, this evaluation and subsequent data development work, as there is a degree of overlap in scope and the data elements collected across both collections (see Appendix 1). The data development work that has been undertaken to date on the APC NMDS by the AIHW that is of relevance to the APMHC NMDS has informed recommendations made in the current evaluation.

Recommendations arising from this evaluation relevant to the current APC NMDS data development work program of the AIHW will be communicated to the AIHW for their data development work program planning.

The NHDD and METeOR

The NHDD is published by the AIHW on a regular basis and has also been incorporated into the AIHW's on-line metadata registry, the Knowledgebase. In May 2005, the Knowledgebase was replaced by METeOR. METeOR is Australia's central repository for health, community services and housing assistance metadata, or 'data about data'. It provides definitions for data for health and community services-related topics, and specifications for related NMDSs, such as the NMDSs which form the basis of this report. METeOR can be viewed on the AIHW website at http://www.aihw.gov.au/.

The metadata standards in the NHDD were re-engineered for inclusion in METeOR, to allow greater standardisation between NMDSs, for example. The re-engineering has resulted in a range of changes in the terms used to describe the components of the APMHC NMDS. For example, data element concepts are now termed 'Object classes'. In addition, data elements have been renamed. This report uses the previous forms and names, as they were in use at the time the evaluation was conducted. However, METeOR identifiers are included in the list of data elements in Appendix 1, to allow reference to the re-engineered NMDS components as required.

2 Methodology

As part of the evaluation of the APC NMDS, the AIHW, in consultation with the Australian Hospital Statistics Advisory Committee (AHSAC), developed a methodology for NMDS reviews which comprised:

1. a review of the utility of the components of the NMDS through a consultative process, that is, assessing whether the NMDS suits current requirements, including those for informing policy development and reporting on performance (evaluation of utility)
2. assessing whether the data have been provided by states and territories and the extent to which the data were provided in accordance with the NMDS specifications as published in the NHDD, that is, use of the NHDD definitions and domain values (compliance evaluation)
3. the development of comprehensive recommendations for future development.

This methodology has become a standard with which NMDSs have been evaluated. For more information on the evaluation of other NMDSs which used this methodology, refer to *Report on the Evaluation of the National Minimum Data Set for Admitted Patient Care* (AIHW 2003) and *Report on the Evaluation of the Perinatal National Minimum Data Set* (AIHW 2004d).

This methodology has been used in the standard form described above in this evaluation of the APMHC NMDS.

Evaluation of utility

In order for an NMDS to be effective, the information collected should be relevant and appropriate to its purpose. Therefore, the aim of evaluating the utility of the NMDS is to gain an understanding of whether the data collection suits current requirements such as informing policy development and reporting on performance. If the NMDS does not suit the requirements of data collectors and/or data users then data may not be collected in a consistent manner and may not be useable. If these stakeholders do not believe particular data elements are important and/or useful then the removal of these data elements from the NMDS could be considered. If a data element is considered highly important and highly useful, it should probably remain unchanged. However, if a data element is considered to be highly important, but not useful, it may be a function of the way it is defined, in which case it probably needs to be modified through data development.

A survey to evaluate the utility of the NMDS was developed in consultation with members of the ISC (see Appendix 2 for copy of survey). The evaluation survey sought the views of users of the NMDS, either as a tool for collection of data or as a specification of data for analysis, on its usefulness and whether it suits their current requirements. Specific questions were asked about the users and uses of the NMDS

specifications and NMDS-based data, including individual data elements and data element concepts; the utility of the NMDS as a whole and of individual data elements; and areas for development including modifications to data elements, new data elements or changes to scope. Additional comments and recommendations and any other input that could assist the evaluation were encouraged.

The survey sought comments on the *National Health Data Dictionary* version 12 supplement (AIHW 2004c), the version current at the time that the evaluation was conducted (in contrast to the data assessed in the compliance evaluation, based on the *National Health Data Dictionary* version 11 (AIHW 2002)). It was thought essential that user comments be based on data elements that were current, and therefore any proposed revisions or data development would not duplicate any recently completed changes.

Attached to the survey was information on the National Health Information Agreement processes for changing NMDS items. This was included so that respondents understood that changing the NMDS would not be a trivial exercise, and that, for example, business cases would be necessary for most proposed changes.

Through this evaluation survey the AIHW aimed to gather comments from data collectors and users of the NMDS specifications and NMDS-based data, as well as other stakeholders.

A draft was sent to ISC members for comment in June 2004 and in late June 2004 the finalised survey was sent via email to:

- Information Strategy Committee (ISC) and its NMDS Sub-committee
- National Mental Health Working Group (NMHWG)
- Statistical Information Management Committee (SIMC)
- Health Data Standards Committee (HDSC)
- ISC's expert advisory groups for the National Outcomes and Casemix Collection (NOCC) (adult, child and adolescent, and older persons)
- Australian Mental Health Outcomes and Classification Network parties
- Australian Hospital Statistics Advisory Committee
- Clinical Casemix Committee of Australia
- National Centre for Classification in Health's Psychiatry Clinical Coding and Classification Group
- Measurement for Improvement Group of the Australian Council for Safety and Quality in Health Care
- state and territory admitted patient data custodians.

The evaluation survey was also advertised on the AIHW's website. People interested in participating in the survey could download the survey form online and return it to the AIHW with their comments. Survey respondents were requested to provide comments by 30 July 2004.

Compliance evaluation

The purpose of the compliance evaluation is to assess the quality and consistency of the data provided by states and territories. The NMDS is contingent upon a national agreement to collect uniform data and to supply them as part of the national collection. This means that data elements should be collected or at least reported using standard definitions and domain values, and reported for all separations within scope. However, there tends to be some variation in the way in which data are reported among the states and territories.

Through assessing the ability of states and territories to comply with the NMDS specifications (data definitions, domain values and scope), actions can be taken to improve the data quality and consistency (such as data element development) where necessary.

This evaluation uses a slightly modified version of the template developed for the evaluation of the APC NMDS in 2003.

The latest data available for this evaluation were for 2002–03 and were based on the specifications in the *National Health Data Dictionary* version 11 (AIHW 2002), whereas the data currently being collected in hospitals for 2004–05, and the data assessed in the survey of utility, are based on the most recent version, the *National Health Data Dictionary* version 12 supplement (AIHW 2004c). As the compliance evaluation is based on data provided by states and territories, assessments of compliance have been made according to the specifications in the *National Health Data Dictionary* version 11 (AIHW 2002).

The compliance evaluation was based on documentation provided with the 2002–03 data submitted by the states and territories to the AIHW, and communications between the AIHW and the jurisdictions during compilation of the 2002–03 NHMD and in association with preparation of this report and the *Mental Health Services in Australia 2002–03* report (AIHW 2005).

The compliance evaluation also involved assessing for each data element for 2002–03:

1. whether states and territories had provided it
2. the extent to which it was provided in accordance with the NMDS specifications as published in the *National Health Data Dictionary* version 11 (AIHW 2002), that is, whether the NHDD definition and domain values were used
3. whether it was reported for every separation (scope).

The overall scope of data provided by states and territories was also assessed, that is, whether data were provided for all public and private psychiatric hospitals and designated psychiatric units of acute care hospitals.

Recommendations for data development

The results of the evaluation of utility and compliance evaluation have highlighted priorities for future development of the NMDS and form the basis for the recommendations to the SIMC presented in this report. Recommendations have been

made in consultation with ISC, and with the advice of members of the Australian Hospital Statistics Advisory Committee.

Where recommendations involve the inclusion of new data elements or the revision of current data elements, the AIHW, in consultation with ISC and other stakeholders, will consider them within data development work program planning and, as appropriate, work towards developing submissions including detailed background information to be considered by the HDSC, SIMC and the NHIG.

3 Evaluation of utility

This chapter describes the results from the review of utility, a consultation process involving a survey of data collectors and users. Information is presented on the users and uses of the NMDS, the utility of the NMDS and individual data elements, that is, the extent to which they are perceived as important and useful, and possible areas for data development. Comments provided by respondents on individual data elements are included in Chapter 5 of this report.

Respondents

A total of 16 responses to the survey were received (Appendix 3). In order that the results of the survey could be interpreted effectively, respondents were asked to indicate whether they were responding for themselves, on behalf of their unit or section within an organisation or on behalf of their organisation as a whole. The majority of respondents were responding on behalf of their unit or section within an organisation (Table 3.1). Some individuals responded for themselves and their unit/section or organisation.

Table 3.1: Respondent types

Respondent	Number
On behalf of themselves	5
On behalf of their unit or section within an organisation	11
On behalf of their organisation	4
Total[(a)]	**16**

(a) Some individuals responded for themselves and their unit/section and/or organisation.

In order to gain an understanding of the types of organisations that use the NMDS specifications and NMDS-based data, respondents were asked to indicate from a list of 15 user groups (or identify additional user groups) the main user group to which they belonged. A list of the user groups is presented in Question 1.1 of the survey (Appendix 2).

The main user groups identified through the survey were the state and territory health authorities which collect and provide the NMDS data. All state and territory health authorities provided responses to the survey and were able to provide comments from a data collection/provider perspective.

Other user groups identified through the survey were the AIHW, DoHA, public and private hospitals, and medical centres.

Uses of the NMDS specifications and NMDS-based data

The survey sought information from respondents about the way the NMDS specifications and NMDS-based data are currently being used. Respondents were asked questions relating to the purposes for which they use the NMDS specifications or NMDS-based data, how they access NMDS specifications and NMDS-based data, their overall knowledge of the NMDS specifications and NMDS-based data, and their frequency of use.

Purpose

In order to gain an understanding of the way the NMDS specifications and NMDS-based data are being used, respondents were asked to indicate from a list of 11 purposes (or identify additional purposes) the three most common purposes for which they use the NMDS specifications and/or NMDS-based data. A list of common uses for the NMDS specifications and/or NMDS-based data is presented in Question 2.1 of the survey (Appendix 2).

The four most common purposes for using the NMDS specifications and/or the NMDS-based data identified by respondents were:

1. collection and reporting of NMDS-based data
2. statistical reporting
3. planning and monitoring hospital resources
4. comparisons and benchmarking.

Other purposes for which the NMDS specifications and NMDS-based data were being used were:

- epidemiological research
- management and purchasing of hospital services
- facility planning
- software development
- health services research.

The purposes identified by respondents tended to vary depending on their user group (Table 3.2).

Level

Respondents from DoHA and AIHW were the main users of national level data, with DoHA using the data for international comparisons as well as using the data at the national level. The state and territory health authorities, who were the majority of respondents, most commonly used the data at the state and territory level. Several users from individual hospitals indicated they used the data for their hospital or hospital group.

Access to NMDS specifications

The most common source used by respondents to access the NMDS specifications overall was the *National Health Data Dictionary*, followed by the *National Health Data Dictionary* online and the Knowledgebase. State and territory health authorities also identified state and territory data specifications as a common source for accessing the NMDS specifications. One respondent indicated that they used the data request document that the AIHW sends each year to data custodians for the NMDS-based data.

Source of NMDS-based data

The most common sources of NMDS-based data that respondents used were the *Mental Health Services in Australia* publication and Internet tables and state or territory hospital databases. Other common sources were the *Australian Hospital Statistics* publication and Internet tables, hospital databases and other AIHW publications.

AIHW's NHMD and DoHA's National Hospital Morbidity (Casemix) Database were also used.

Table 3.2: Purposes for which the NMDS specifications and NMDS-based data are being used, by user group

User group	Plan/ monitor hospital resources	Compare/ benchmark	Manage/ purchase hospital services	Health services research	Epidemiological research	Statistical reporting	Facility planning	Planning by private industry suppliers	Collect/ report NMDS-based data	Casemix & classification development	Software development
State or territory health authority	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Australian Government Department of Health and Ageing		✓				✓					
Australian Institute of Health and Welfare				✓	✓	✓			✓		
Public or private hospital	✓	✓	✓	✓	✓	✓				✓	
Medical centre	✓			✓	✓						

Knowledge and frequency of use

Most respondents indicated that they were either familiar or very familiar with the NMDS specifications and/or the NMDS-based data (Table 3.3).

Table 3.3: Respondents' rating of overall knowledge of the NMDS specifications and NMDS-based data

Knowledge	NMDS specifications	NMDS-based data
Very familiar	7	6
Familiar	8	7
Unfamiliar	0	3
Not answered	1	0
Total	**16**	**16**

Over one-third of respondents indicated that the NMDS specifications and NMDS-based data were used on a monthly basis, and a similar proportion used them occasionally (Table 3.4).

Table 3.4: Respondents' rating of their frequency of use of the NMDS specifications and NMDS-based data

Frequency	NMDS specifications	NMDS-based data
Daily	0	1
Weekly	2	2
Monthly	6	6
Occasionally	8	6
Never	0	1
Total	**16**	**16**

Utility of the NMDS

The main purpose of the survey was to gain an understanding of whether the NMDS is useful and whether it suits the current requirements of users. In order to assess the utility of the NMDS, respondents were asked to rate the importance and usefulness of the NMDS overall and each individual data element, and to indicate which data elements should remain unchanged, which should be modified and which deleted.

When assessing importance, respondents were asked to think of how significant they believe the NMDS and each data element are to a national collection of data on admitted patient mental health care. When assessing usefulness, respondents were asked to keep in mind whether the NMDS and each data element suit their current requirements. Importance could be rated as 'Not important', 'Important', 'Highly

important' or 'Unsure' and usefulness could be rated as 'Not useful', 'Useful', 'Highly useful' or 'Unsure'.

If all respondents think a data element is 'Highly important' and 'Highly useful', it should probably remain unchanged. However, if respondents indicate that a data element is 'Highly important', but 'Not useful', it may be a function of the way it is defined, in which case it probably needs to be modified.

Table 3.5 provides respondents' ratings of the importance and usefulness of the NMDS and individual data elements and concepts. Not all respondents provided a rating for every data element, so the frequencies will not add to the total number of respondents (16) for every data element.

Sixty–three per cent of respondents rated the NMDS as highly important and 44% rated it as highly useful. The NMDS was seen as important as it formed the basis for the collection of patient-level data on admitted patient mental health services. The NMDS was seen as useful for:

- informing policy and service planning
- planning and reviewing clinical treatment
- monitoring and planning mental health activity in hospitals
- evaluating hospital-based psychiatric service units
- identifying service gaps and monitoring performance
- enabling comparisons between jurisdictions to be undertaken at the higher level
- providing a national perspective on mental health policy issues.

Table 3.5: Respondents' rating of the importance and usefulness of the NMDS and individual data elements and data element concepts

	Importance				Usefulness			
Data element	**Not important**	**Important**	**Highly important**	**Unsure**	**Not useful**	**Useful**	**Highly useful**	**Unsure**
NMDS for Admitted Patient Mental Health Care	1	3	10	2	1	6	7	2
Establishment data elements								
Establishment identifier	0	6	9	1	0	6	9	1
Establishment number	2	5	8	1	1	6	8	1
Establishment sector	0	7	7	2	2	6	6	2
Region code	1	7	5	3	2	5	5	4
State identifier	1	4	7	4	1	4	7	4
Demographic data elements								
Area of usual residence	0	1	14	1	0	3	12	1
Country of birth	0	7	7	2	2	8	4	2
Date of birth	0	1	13	2	0	4	10	2
Employment status—acute hospital and private psychiatric hospital admissions	4	5	4	3	5	3	2	6
Employment status—public psychiatric hospital admissions	2	5	3	5	5	3	1	6
Indigenous status	0	2	12	2	0	5	9	2
Marital status	5	7	1	3	6	5	2	3
Sex	1	2	12	1	0	3	12	1
Type of accommodation	2	6	5	3	3	6	3	4
Type of usual accommodation	4	5	4	3	4	4	3	5
Length of stay data elements								
Admission date	0	2	12	2	0	3	11	2
Separation date	0	3	12	1	0	3	12	1
Total leave days	0	5	9	2	0	4	9	3
Total psychiatric care days	0	1	12	3	0	1	12	3
Clinical data elements	0	0	0	0	0	0	0	0
Additional diagnosis	0	0	15	1	0	1	14	1
Care type	1	5	9	1	2	5	7	2
Diagnosis related group	1	3	10	2	2	2	10	2
Major diagnostic category	0	6	9	1	0	6	8	2
Previous specialised treatment	3	2	5	6	2	2	6	6
Principal diagnosis	0	1	14	1	0	2	13	1

(continued)

Table 3.5 (continued): Respondent's rating of the importance and usefulness of the NMDS and individual data elements and data element concepts

	Importance				Usefulness			
Data element	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
Administrative data elements	0	0	0	0	0	0	0	1
Mental health legal status	1	3	11	1	2	3	10	1
Mode of separation	0	10	5	1	0	10	4	2
Person identifier	3	2	10	1	3	4	7	2
Referral to further care (psychiatric patients)	1	4	8	3	1	4	6	5
Source of referral to public psychiatric hospital	1	5	5	4	1	6	4	4
Data element concepts								
Acute care episode for admitted patient	2	4	8	2	3	5	5	3
Admission	1	3	9	3	1	3	8	4
Admitted patient	1	2	11	2	1	3	9	3
Diagnosis	0	2	10	4	0	3	9	4
Episode of care	0	2	10	4	0	2	10	4
Hospital	0	4	8	4	0	4	7	5
Patient	0	3	9	4	0	4	8	4
Separation	0	3	10	3	0	2	11	3

Future data development

Respondents were asked their views on possible areas for development of the NMDS, including possible changes to the scope, or any other priorities for development of definitions. The views of respondents (other than detailed comments on individual data element and data element concepts) are summarised in this section. Chapter 5 presents comments on individual data elements and data element concepts from this utility evaluation and the compliance evaluation.

Scope

The scope of the NMDS for Admitted Patient Mental Health Care as published in the *National Health Data Dictionary* is:

> Admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals.

The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals and who are not in psychiatric units (for example, children receiving psychiatric treatment in paediatric wards).

There were some comments that a better way to scope the NMDS would be by mental health-related diagnosis, to ensure data on patients receiving psychiatric treatment in acute hospitals and not in psychiatric units are included. Due to the difficulties identifying these patients at the time of admission, it is suggested that the scope is not changed in this way. Data that allow analysis on this basis are available through the APC NMDS, as reported in the *Mental Health Services in Australia* reports. It was also suggested that the description of the scope should not reference 'public psychiatric hospitals' because some provide admitted patient services other than with specialised mental health care.

Renaming of the NMDS

As the scope of the NMDS encompasses only separations with specialised psychiatric care and not all admitted patient mental health care, it is suggested that the name of the NMDS be changed to clarify this, by including specialised care in the title. For example, the NMDS could be renamed the 'Admitted Patient Specialised Mental Health Care NMDS'.

Existence of the NMDS as separate from the Admitted Patient Care NMDS

The overlapping content of the APC NMDS and the APMHC NMDS could be a source of confusion and uncertainty in governance arrangements.

Two respondents suggested combining the APMHC NMDS with the APC NMDS, with clearly stated rules about when additional data elements are required for the APMHC NMDS.

It is suggested that consideration is given to combining the APMHC NMDS with the APC NMDS. The additional data elements required for the APMHC NMDS could be specified as an add-on to the APC NMDS. This would mean that the APMHC NMDS would consist of 11 data elements:

- Employment status—acute hospital and private psychiatric hospital admissions
- Employment status—public psychiatric hospital admissions
- Establishment identifier
- Marital status
- Previous specialised treatment
- Referral to further care (psychiatric patients)
- Region code
- Source of referral to public psychiatric hospital
- Total psychiatric care days
- Type of accommodation
- Type of usual accommodation.

Source of referral to public psychiatric hospital would be regarded as only part of the APMHC NMDS if the scope of the NMDS were clarified as noted above.

The same approach could also be considered for the Admitted Patient Palliative Care NMDS.

Data elements specific for public psychiatric hospitals

New South Wales commented that due to the nature of their data input systems they cannot apply one classification/data element to public psychiatric hospitals and another to public acute care hospitals as the same patient administration system is used in both types of hospital. However, this is more an implementation issue rather than an issue of the utility of the NMDS.

In general, the data needs relating to public psychiatric hospitals are not that different, within the context of the NMDS, from data needs relating to acute care hospitals. This is reflected in a number of recommendations made in relation to data elements in the NMDS that have been specified for either public psychiatric hospitals or acute care hospitals only.

Other issues raised by respondents

National Outcomes and Casemix Collection

Several respondents indicated the key challenge to the NMDS in the future is the incorporation of the data elements and consumer outcomes measurement instruments included in the NOCC. This will be complex and require ongoing negotiation with state and territory data custodians.

Respondents also commented on the importance of the NOCC and admitted patient mental health care databases being able to be linked for analysis purposes. This could be achieved by matching *Person identifiers* across the collections. The extent to which *Person identifiers* match across the NOCC Database, the APMHC Database, the National Community Mental Health Care Database and the Residential Mental Health Care Database requires investigation. This work, and work towards integrating the data elements and consumer outcomes measurement instruments from the NOCC into the APMHC, should be undertaken in line with the recommendations in the *National Mental Health Information Priorities 2nd Edition* (DoHA forthcoming).

Missing patient-derived data

Information on patient-derived data, such as demographic and socioeconomic data, may be not reported at the national level. Several respondents in the survey of utility commented that patients who are admitted to hospital with mental health problems may not be in a position to respond to requests for information at the time of admission to hospital. It is therefore important that any information required from

these patients is requested at an appropriate time. An appropriate time would generally be after the patient had received treatment rather than on admission. Data may also not be available because patients were not asked to provide the relevant information.

Further consideration should be given to collecting more detailed information on 'not reported' data at the national level in order to improve the interpretability of data in the APMHC NMDS.

Procedure classification for mental health

Comments from the survey of utility noted that the ICD-10-AM procedure classification in its current form is of limited usefulness for admitted patient mental health care. It was stated that little attention has been given to develop an alternative set of procedure codes that are appropriate. The *National Mental Health Information Priorities 2nd edition* recommended the development of national agreed mental health intervention codes.

It was recommended that the issue of intervention codes for mental health should be referred to the ISC to be dealt with through the process for implementation of recommendations from the *National Mental Health Information Priorities 2nd edition*.

Priorities in data development

Two respondents indicated that it is more important to develop community mental health collections at this time (for example, getting national agreement on the definition of occasions of service across states and territories).

Burden of collection of new data elements

Several respondents expressed concern regarding the burden on data collectors of implementation and collection of any new data elements arising from this evaluation. It was recommended that existing data elements in the NHDD be used for any new data elements where possible.

Training and feedback to clinicians

Respondents noted that clinicians and clinical managers need to receive continual training on the NMDSs to ensure they understand the relevance and usefulness to them of the data collected. Also, they should receive feedback they find relevant (for example, diagnostic and age information, length of stay). This would improve the accuracy of information provided and also improve the management of services.

Linkage of information systems to assist continuity of care

Clinicians identified the need for systems to link information on services provided by other hospitals and community-based health services to assist in planning and continuity of care.

Persons who should be consulted for future data development

Respondents identified a wide range of stakeholders who should be consulted in relation to data development; however, it was seen as essential to consult with those who are involved in the collection of the data.

Stakeholders identified by respondents included:

- hospitals and health care providers who collect the data. This includes, but is not limited to, clinical staff, coding staff, data entry operators, system developers and information system administrators
- state and territory health authorities, including data providers
- expert data users
- consumer and carer representatives.

More specific organisations and committees identified included:

- DoHA
- Royal Australian and New Zealand College of Psychiatrists
- Royal College of Nursing, Australia
- NMHWG ISC expert advisory groups for the NOCC (child and adolescent, adult, older persons).

It was suggested that clinical advice is critical to many of the areas mentioned for review.

4 Compliance evaluation

National summary

Scope

The National Minimum Data Set for Admitted Patient Mental Health Care (referred to as 'the NMDS' or the 'APMHC NMDS') is a specification for data collected on episodes of care for admitted patients in public psychiatric hospitals or in designated psychiatric units in acute hospitals. The scope does not include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

Episodes of admitted patient care are the statistical units of this data set, with data being collected at each hospital in scope from patient administrative and clinical record systems and forwarded to the relevant state or territory health authority on a regular basis. Data for each financial year ending 30 June are then provided on an annual basis to the AIHW for national collation, as a subset of the NHMD.

Within the NHMD, patients receiving specialised mental health care are identified through the reporting of one or more psychiatric care days, that is, care received in a specialised psychiatric hospital, unit or ward. In acute care hospitals, a 'specialised' episode of care or separation may comprise some psychiatric care and some non-psychiatric care, or psychiatric care only. An episode of care from a public psychiatric hospital is deemed to comprise psychiatric care only and to be specialised, unless some care was given in a unit other than a psychiatric unit, such as a drug or alcohol unit. There were 200,264 episodes of admitted patient mental health care reported for the NMDS for 2002–03.

Throughout this report, unless otherwise specified:

- Public psychiatric hospitals or designated psychiatric units in public acute hospitals are included in the public category.
- Private psychiatric hospitals or designated psychiatric units in private acute hospitals are included in the private category.

Essentially, all public hospitals and the majority of private hospitals in scope reported to the NHMD for 2002–03. In the public sector, data were not supplied to the NHMD for a mothercraft hospital in the Australian Capital Territory and one small rural hospital in New South Wales. The mothercraft hospital does not have a designated psychiatric unit and is therefore not in the scope of the APMHC NMDS. The small rural hospital in New South Wales did not have a designated psychiatric unit.

Within the private sector, data were not provided for 2002–03 to the APC NMDS for all private freestanding day hospital facilities in the Australian Capital Territory and

for the single day hospital facility in the Northern Territory. For Victoria, data were not provided for 3 freestanding day hospital facilities and 3 other private hospitals. Some hospitals in Victoria did not supply data for the full year of collection. For Tasmania, data were not available for one small non-freestanding day hospital facility. It is unknown whether these hospitals are in scope for the APMHC NMDS, that is, whether they provided specialised mental health admitted patient care.

For South Australia, data were not available for one country private hospital for four months. However, very low levels of admitted patient activity for this establishment mean that these missing data do not materially affect overall coverage for South Australia.

There were no private freestanding day hospital facilities reporting to the APMHC NMDS for 2002–03. Table 4.1 summarises this coverage information by state and territory and by hospital type.

Table 4.1: Coverage of hospitals contributing data to the Admitted Patient Mental Health Care NMDS, by hospital type, states and territories, 2002–03

	Public acute hospitals	Public psychiatric hospitals	Private psychiatric hospitals or designated psychiatric units in private acute hospitals
NSW	Complete	Complete	Complete
Vic	Complete	Complete	Unknown
Qld	Complete	Complete	Complete
WA	Complete	Complete	Complete
SA	Complete	Complete	Complete
Tas	Complete	Complete	Unknown
ACT	Complete	Not applicable	Complete
NT	Complete	Not applicable	Unknown

Note: Complete—all facilities in this sector reported data to the APMHC NMDS. *Unknown*—the level of under-reporting for hospitals in scope for the APMHC NMDS, a subset of the NHMD, is unknown (see text for more details). *Not applicable*—there are no facilities of this type for this state or territory.

Coverage estimates for private hospital separations in scope

As not all separations for private psychiatric hospitals or designated psychiatric units in private hospitals are reported to the NMDS, the counts are likely to be underestimates of actual counts. Over recent years, there have been slightly fewer separations for specialised mental health admitted patient care reported to the NHMD than to the ABS's Private Health Establishments Collection (PHEC) (Table 4.2). This latter collection includes all private acute and psychiatric hospitals licensed by state and territory health authorities and all private free-standing day hospital facilities approved by DoHA. Only hospitals with designated psychiatric units reporting to the PHEC have been included in this analysis, and all separations from these units have been reported.

In 2002–03, the difference between the APMHC and the PHEC was 5,695 separations (about 5.4%). This discrepancy may have been due to the use of differing definitions

or different interpretations of definitions, or differences in the quality of the data provided for different purposes. It also may reflect the omission of some private hospitals with designated psychiatric units from the NMDS, or some specific mental health separations for some private hospitals with designated psychiatric units that were otherwise included in the NHMD. It may also reflect the inclusion of separations other than for specific mental health admitted patient care in the PHEC data for hospitals which had designated a psychiatric unit but also provided other care.

Table 4.2: Private hospital separations reported to the Admitted Patient Mental Health Care NMDS and the ABS Private Health Establishments Collection, 1997–98 to 2002–03

Year	Admitted Patient Mental Health Care NMDS	Private Health Establishments Collection	Difference between collections	
	Separations with specialised psychiatric care	Separations in hospitals with designated psychiatric unit	Separations (no.)	Separations (%)
1997–98	45,870	47,747	1,877	3.9
1998–99	64,198	67,489	3,291	4.9
1999–00	65,650	76,442	10,792	14.1
2000–01	78,268	85,958	7,690	8.9
2001–02	87,770	97,798	10,028	10.3
2002–03	98,955	104,650	5,695	5.4

Source for private hospital data: ABS, unpublished PHEC data and AIHW NHMD.

Summary of selected terms relating to the use of hospital data

Episodes of admitted patient care *are the statistical units of the NHMD. An episode of care is the period of admitted patient care between admission and separation characterised by only one care type. 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).*

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. A formal admission is the administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient. In contrast, a statistical admission is 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.*

Separation *is the process by which an episode of care for an admitted patient ceases. Like admissions, a separation may be formal or statistical. A formal separation is the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient. A statistical separation is the administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.*

Use of national standard definition, domain values and NMDS scope

This is a national summary of the information to be presented in more detail later in this report. Of the 29 data elements in the NMDS, the national standard definition

was used for 23 (79%) data elements in the public sector and 19 (66%) data elements in the private sector. The national standard domain values were used for 18 (62%) data elements in the public sector and 13 (45%) data elements in the private sector. For 11 (38%) of the data elements in the public sector and 8 (28%) of the data elements in the private sector, data were provided for all reported separations. There were 3 (10%) data elements for which jurisdictions used the national standard definition and domain values and provided it for all reported separations.

Table 4.3 summarises this information. The data element was reported as provided for all separations if the data were missing or reported as Not reported/not stated for no more than 0.5% of separations, or if the requirement for reporting of the data element was ambiguous.

Table 4.3: National summary of the use of the *National Health Data Dictionary* definition and domain values and NMDS scope, by hospital sector, 2002–03

	Public sector			Private sector		
Data element	**NHDD definition used?**	**NHDD domain values used?**	**Provided for all* reported separations?**	**NHDD definition used?**	**NHDD domain values used?**	**Provided for all* reported separations?**
Establishment data elements						
Establishment number	Yes	Yes	Yes	No	No	Yes
Establishment sector[a]	Yes	Yes	Yes	No	No	Yes
Region code	No or . .	No or . .	No or . .	No or . .	No or . .	No or . .
State identifier	Yes	Yes	Yes	Yes	Yes	Yes
Demographic data elements						
Area of usual residence	Yes	No	No	Yes	No	No
Country of birth	Yes	No	No	Yes	No	No
Date of birth	Yes	Yes	No	Yes	Yes	No
Employment status—acute hospital and private psychiatric hospital admissions[b]	. .	. .	. .	. .	. .	. .
Employment status—public psychiatric hospital admissions	Yes or . .	Yes or . .	No or . .	. .	. .	. .
Indigenous status	Yes	Yes	No	Yes	Yes	No
Marital status	Yes	Yes	No	Yes	Yes	No
Sex	Yes	No	Yes	Yes	No	Yes
Type of accommodation[c]	. .	. .	. .	. .	. .	. .
Type of usual accommodation	Yes	Yes	No	Yes	Yes	No

(continued)

Table 4.3 (continued): National summary of the use of the *National Health Data Dictionary* definition and domain values and NMDS scope, by hospital sector, 2002–03

	Public sector			Private sector		
Data element	NHDD definition used?	NHDD domain values used?	Provided for all* reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all* reported separations?
Length of stay data elements						
Admission date	Yes	Yes	Yes	Yes	Yes	Yes
Separation date	Yes	Yes	Yes	Yes	Yes	Yes
Total leave days	Yes	Yes	No	Yes	Yes	Yes
Total psychiatric care days	Yes	Yes	. .	Yes or . .	Yes or . .	. .
Clinical and related data elements						
Additional diagnosis	Yes	Yes	Unknown	Yes	Yes	Unknown
Care type[(d)]	No	Yes	Yes	Yes	No	No
Diagnosis related group	Yes	No	Yes	Yes	No	No
Major diagnostic category	Yes	No	Yes	Yes	No	No
Previous specialised treatment	Yes or . .	No or . .	No or . .	Yes or . .	No or . .	No or . .
Principal diagnosis	Yes	Yes	No	Yes	Yes	No
Administrative data elements						
Mental health legal status	Yes	Yes	No	Yes	Yes	No
Mode of separation	Yes	No	Yes	No	No	No
Person identifier	No or . .	Yes or . .	Yes or . .	No or . .	Yes or . .	Yes or . .
Referral to further care (psychiatric patients)	No	No	No	No	No	No
Source of referral to public psychiatric hospital[(e)]	Yes or . .	Yes or . .	No or . .	. .	. .	. .

(a) The *National Health Data Dictionary* version 11 specifies the domain values 1 *Public* and 2 *Private*. The AIHW requests two additional categories, 4 *Public psychiatric hospital* and 5 *Private freestanding day hospital facility*. Analysis of compliance with *Establishment sector* is based on the AIHW request. Definitions and domain values were used by all states and territories, excluding Tasmania. Tasmania did not distinguish between private free-standing day hospital facilities and other private hospitals due to confidentiality concerns.

(b) The data element *Employment status—acute hospital and private psychiatric hospital admissions* was not requested by the AIHW for 2002–03.

(c) The data element *Type of accommodation* was not requested by the AIHW for 2002–03.

(d) Records for boarders and posthumous organ procurement have been excluded from the analysis as they are not part of the NMDS. Records for *Newborn care with no qualified days* have also been excluded.

(e) This data element was reported by the private sector for some states and territories.

* More than about 99.5% of reported separations.

. . Not applicable.

Table 4.4 presents information on the number and proportion of separations where data were missing or reported as Not reported for selected data elements. In both the public and private sectors, the data elements with approximately 10% or more of separations where data were missing/not reported were *Area of usual residence*, *Date of birth*, *Employment status*, *Type of usual accommodation*, *Previous specialised treatment*, *Person identifier*, *Referral to further care* and *Source of referral to public psychiatric hospital*. In addition, in the private sector, data were missing or not reported for 40% of separations for *Mental health legal status*.

Table 4.4: National summary of separations with Missing or Not reported/Not stated data for selected data elements, by hospital sector, 2002–03

	Public sector		Private sector	
Data element	**Number**	**Per cent**	**Number**	**Per cent**
Demographic data elements				
Area of usual residence[(a)]	9,816	9.7	10,941	11.1%
Country of birth	3,244	3.2	6,909	7.0%
Date of birth	27,151	26.8	46,554	43.3%
Employment status—public psychiatric hospital admissions[(b)]	10,631	68.7	. .	. .
Indigenous status	1,984	2.0	1,003	1.0
Marital status	8,053	7.9	2,844	2.9
Sex	24	0.0	0	0.0
Type of usual accommodation	44,729	44.2	52,070	52.6
Length of stay data elements				
Admission date	0	0.0	0	0.0
Separation date	0	0.0	0	0.0
Total leave days	436	0.4	0	0.0
Total psychiatric care days	0	0.0	0	0.0
Clinical and related data elements				
Care type	0	0.0	0	0.0
Diagnosis related group	281	0.3	12	0.0
Major diagnostic category	58	0.1	9	0.0
Previous specialised treatment	62,329	61.5	67,327	68.1
Principal diagnosis	73	0.1	9	0.0
Administrative data elements				
Funding source for hospital patient	10	0.0	0	0.0
Intended length of hospital stay	996	1.0	0	0.0
Mental health legal status	360	0.4	39,069	39.5
Mode of separation	0	0.0	0	0.0
Person identifier	54,098	53.4	37,679	38.1
Referral to further care (psychiatric patients)	33,256	32.8	73,354	76.4
Source of referral to public psychiatric hospital[(b)]	2,032	13.1	. .	. .

(a) Includes missing codes and '9999'.

(b) Public psychiatric hospital separations only.

. . Not applicable.

State and territory summary

State and territory differences in the scope of services provided for admitted patients

Mental health care for admitted patients in Australia is provided in a large and complex system. Differences in the data provided by states and territories to the NMDS may reflect different service delivery practices, differences in admission practices and/or differences in the types of establishments categorised as hospitals.

There is some difference in the approach that states and territories and public and private sectors take to the formal admission and separation for people attending hospital on a same-day basis, for example, for group therapy sessions or day programs. In some jurisdictions these attendances are recorded as non-admitted patient occasions of service. In other jurisdictions, the majority of patients are formally admitted for this care and therefore this care is reported as same-day separations.

States and territories also differ in the extent to which they classify some of their mental health-related residential facilities as admitted patient services within hospitals, as separate hospitals or as community-based, non-admitted services. This variation applies, for example, with psychogeriatric and long-stay rehabilitation services for people with mental health disorders, which are characterised by relatively lengthy stays.

In addition to the differing admission practices, the way jurisdictions count episodes of care may also differ. That is, there may be some variation in the way in which changes in the care type are used to trigger new episodes of care.

These variations in the scope of services provided for admitted patients, and in the changes in care type to trigger new episodes of care, are not specifically referred to in the results that follow, but should be considered in interpreting them.

State and territory data

The state and territory summary (tables 4.5 and 4.6) provides information on the number and proportion of data elements for which the NHDD definition and domain values were used, and the number and proportion of data elements which were reported for all separations.

The summary of private sector compliance evaluates compliance against 25 data elements, not 27 as is the case for the public sector. This is because *Employment status – public psychiatric hospital admissions* captures the self-reported employment status of a person, immediately before admission to a public psychiatric hospital and *Source of referral to public psychiatric hospital* captures the source from which the person was transferred/referred to a public psychiatric hospital. Neither of these data elements is within the scope of private hospital collection. However, some states

and territories do collect these data for private hospitals. For more information see the assessment of individual data elements.

Table 4.5: State and territory summary of the use of the *National Health Data Dictionary* definition and domain values and NMDS scope, public hospitals[(a)], 2002–03

	NHDD definition used?		NHDD domain values used?		Provided for all* reported separations?	
State or territory	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
NSW	26	100	22	85	17	68
Vic	24	96	20	80	16	64
Qld	27	100	24	89	21	78
WA	25	96	22	85	19	73
SA	26	100	22	85	20	77
Tas	24	92	20	80	16	64
ACT	25	100	23	92	20	80
NT	25	100	23	92	16	64
Total	**24**	**89**	**18**	**67**	**12**	**44**

(a) Data in this table relate only to the 101,309 public hospital records with specialised psychiatric care in the NHMD.

* More than 99.5% of reported separations.

Table 4.6: State and territory summary of the use of the *National Health Data Dictionary* definition and domain values and NMDS scope, private hospitals[(a)], 2002–03

	NHDD definition used?		NHDD domain values used?		Provided for all* reported separations?	
State or territory	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
NSW	22	96	19	79	20	83
Vic	22	92	17	71	17	71
Qld	25	100	22	88	20	80
WA	23	96	18	75	17	71
SA	24	100	20	83	22	92
Tas	20	83	15	65	14	61
ACT	24	100	22	92	16	67
NT	. .	. .	. .	. .	. .	. .
Total	**19**	**76**	**13**	**52**	**10**	**40**

(a) Data in this table relate only to the 98,955 private hospital records with specialised psychiatric care in the NHMD.

* More than 99.5% of reported separations.

. . Not applicable.

Note: The Northern Territory is reported as 'not applicable' as the one private hospital included in the NHMD did not report any separations with specialised psychiatric care.

In the public sector, the national standard definition was used for 89% or 24 of the 27 NMDS data elements by states and territories which provided these data elements. In the private sector, 76% or 19 of 25 data elements used the national standard definition. The national standard for domain values was used for 67% or 18 data elements in the public sector and 52% or 13 data elements in the private sector, by states and territories which provided these data elements.

For 44% or 12 out of 27 data elements, data were provided for all reported separations in the public sector and 40% or 10 data elements in the private sector.

Assessment of individual data elements

This section reports on the assessment of compliance for each data element in the NMDS reported by states and territories for 2002–03. It details states' and territories' use of the national standard, domain values and NMDS scope and provides details of the use of non-standard NHDD definitions and domain values and non-standard use of scope. Information is also provided on mapping required from state and territory data sets to comply with the national standard domain values, and additional information or comments provided by the states and territories to assist in the evaluation. The data elements in this section are presented in alphabetical order.

Data element name: Additional diagnosis

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care; Admitted Patient Palliative Care	**Collection year:** 2002–03
		Knowledgebase ID: 000005
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 4
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.		

Use of national standard definition, domain values and NMDS scope:

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for separations, where applicable?	NHDD definition used?	NHDD domain values used?	Provided for separations, where applicable?
NSW	Yes	Yes	Unknown	Yes	Yes	Unknown
Vic	Yes	Yes	Unknown	Yes	Yes	Unknown
Qld	Yes	Yes	Unknown	Yes	Yes	Unknown
WA	Yes	Yes	Unknown	Yes	Yes	Unknown
SA	Yes	Yes	Unknown	Yes	Yes	Unknown
Tas	Yes	Yes	Unknown	Yes	Yes	Unknown
ACT	Yes	Yes	Unknown	Yes	Yes	Unknown
NT	Yes	Yes	Unknown	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values were used by all states and territories. There were 31 separations with invalid ICD-10-AM *Additional diagnosis* codes for New South Wales in the public sector.

Details of use of non-standard NMDS scope

This data element is not compulsory for all separations. Hence it is unknown whether it was reported for all separations.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Up to 30 *Additional diagnosis* codes were requested for each separation. The NHDD recommends that a minimum of 20 codes is able to be reported. Queensland reported 31 diagnosis codes, the maximum number requested by the AIHW, and may have been restricted in the number of codes they could provide.

Table 4.7: The maximum number of diagnosis codes provided, including the *Principal diagnosis* code, by state and territory, 2002–03

	Number		Mean diagnosis codes per separation	
State or territory	Public	Private	Public	Private
NSW	20	15	2.9	1.8
Vic	24	24	3.2	1.5
Qld	31	25	3.7	2.7
WA	25	25	3.7	2.0
SA	22	12	4.5	2.3
Tas	16	3	2.5	1.4
ACT	24	2	2.8	2.6
NT	16	. .	3.1	. .
Total	**. .**	**. .**	**3.3**	**1.9**

. . Not applicable.

In 25% of public hospital separations and 56% of private hospital separations only one diagnosis code was reported, ranging from 11% in South Australia to 40% in Tasmania in the public sector and from 35% in Queensland to 63% in Tasmania in the private sector. The average number of diagnosis codes per separation was 3.3 in the public sector and 1.9 in the private sector.

Data element name: Admission date

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care Admitted Patient Palliative Care	**Collection year:** 2002–03 **Knowledgebase ID:** 000008 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 4
Definition: Date on which an admitted patient commences an episode of care.		

Use of national standard definition, domain values and NMDS scope:

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope

Not applicable. Admission date was provided for all reported separations in each state and territory.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Area of usual residence

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care; Admitted Patient Palliative Care; Community Mental Health Care	**Collection year:** 2002–03
		Knowledgebase ID: 000016
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: Geographical location of usual residence of the person—comprising state or territory and Statistical Local Area (SLA). SLAs should be based on the Australian Standard Geographical Classification (ASGC) effective for the data collection reference year.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	No	No	Yes	No	Yes
Vic	Yes	No	Yes	Yes	No	Yes
Qld	Yes	No	No	Yes	No	Yes
WA	Yes	No	No	Yes	No	No
SA	Yes	No	Yes	Yes	No	Yes
Tas	Yes	No	Yes	Yes	No	No
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Victoria, Queensland, Tasmania, the Australian Capital Territory and the Northern Territory provided the majority of SLA codes according to the 2002 edition of the ASGC. Victoria provided some SLA codes according to the 2001 edition of the ASGC and New South Wales provided SLA codes according to the 2000 and 2001 editions of the ASGC (ABS 2001).

New South Wales, Victoria, Tasmania, the Australian Capital Territory and the Northern Territory were able to provide SLA codes for both patients usually resident in the jurisdiction and patients not usually resident in the jurisdiction. Queensland and South Australia provided SLA codes for patients usually resident in the jurisdiction and postcodes for patients not usually resident in the jurisdiction.

Western Australia was unable to provide SLA codes, but provided postcodes for patients usually resident in the jurisdiction and patients usually resident elsewhere. The postcode version was unknown.

New South Wales, Victoria, Queensland, the Northern Territory and the Australian Capital Territory also provided some codes according to the ASGC 2000 which were subsequently mapped by the AIHW.

Details of use of non-standard NMDS scope

Residence state and SLA were missing for 22 separations in the public sector from New South Wales. SLA was reported as '9999' (not stated/unknown) for 115 separations in the public sector.

Residence state and SLA were missing for 195 separations from Victoria (all in the public sector). SLA was reported as '9999' (not stated/unknown) for 178 separations in the public sector.

Residence state and SLA were missing for 266 separations from Queensland in the public sector and 4 separations in the private sector.

For South Australia, SLA was reported as '9999' (not stated/unknown) for 258 separations in the public sector and 25 separations in the private sector. South Australia was unable to report area of usual residence for interstate and overseas patients.

SLA was reported as '9999' (not stated/unknown) for 1,384 separations from Tasmania. The majority of these separations were from private hospitals (1,371).

For the Australian Capital Territory, SLA was reported as '9899' (undefined) for 7 separations in the public sector.

Was mapping required from state and territory data sets?

Data provided as postcodes or using out-of-date SLA codes were mapped by the AIHW on a probabilistic basis to 2002 SLAs, using ABS concordance information. The mapping process identified missing, invalid and superseded codes, but resulted in 98% of records being assigned 2002 SLA codes.

Additional information

The AIHW requested postcodes valid for the year 2002 to be provided in addition to SLA codes. All states and territories provided postcode. Victoria, Queensland and the Australian Capital Territory provided postcodes valid for the year 2002. The postcode version used by Western Australia is unknown.

Some invalid postcodes were provided by New South Wales (1,183 separations in the public sector, 20 separations in the private sector), Victoria (373 separations in the public sector) and Western Australia (262 separations in the public sector, 2 separations in the private sector).

The NHDD specifications state that where the residence state is unknown it should be left as null, and where the SLA is unknown the code 9999 should be used.

New South Wales has advised that compliance with the specifications for this data element will improve as the new systems with geographic checking software are progressively installed in all sites.

Data element name: Care type

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care	**Knowledgebase ID:** 000168
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 4
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).		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	No
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	No	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

New South Wales, Victoria, Western Australia, South Australia, Tasmania and the Northern Territory used summary categories for the Rehabilitation (2.0) and Palliative (3.0) care types. Queensland and the Australian Capital Territory provided data for the more detailed categories for rehabilitation or palliative care delivered in a designated unit (2.1, 3.1), according to a designated program (2.2, 3.2) or as the principal clinical intent (2.3, 3.3). Note: the NHDD specifies that these more detailed categories are optional.

Victoria only used the Acute care (1.0) and Other admitted patient care (8.0) care types for the public sector, and for the private sector only the Acute care (1.0) care type was used. Victoria indicated that it is currently unable to identify Psychogeriatric care and needs to review its mapping which appears to map nursing

home type patients to Other admitted patient care (8.0) rather than to Maintenance care (6.0).

South Australia used only the Acute care (1.0) and Other admitted patient care (8.0) care types in the private sector. In South Australia, hospital at home records have been included in the Other admitted patient care (8.0) care type. Hospital at home episodes are recorded separately, rather than as part of admitted patient episodes.

Tasmania did not use the Rehabilitation care (2.0), Geriatric evaluation and management (4.0), Maintenance care (6.0) or Other admitted patient care (8.0) care types for the public sector, and for the private sector only the Acute care (1.0) care type was used.

The Australian Capital Territory did not use the Palliative care (3.0) or Psychogeriatric care (5.0) care types for the public sector, and for the private sector only the Acute care (1.0) care type was used. The Australian Capital Territory is currently reviewing the use of care types in its hospitals and is likely to have several recommendations for modification and improvement which will be provided to the AIHW when the review is complete.

The Northern Territory did not use the Psychogeriatric care (5.0).

The Northern Territory reports instances of records with psychiatric care days and missing Mental health legal status, Previous specialised treatment, Referral to further care and Type of usual accommodation. This is due in part to an incorrect care type being recorded which does not reflect mental health treatment and does not trigger the screen that requests the extra mental health data elements/fields. This implies that the Northern Territory care type data are not completely accurate.

Details of use of non-standard NMDS scope

Not applicable.

Was mapping required from state and territory data sets?

New South Wales, Victoria, Western Australia, South Australia, Tasmania and the Northern Territory all mapped the data collected at the jurisdiction level to conform to the NHDD domain values for *Care type*.

Additional information

The category Other admitted patient care (8.0) was reported for a large proportion of separations in New South Wales private hospitals (41.3%). Based on principal diagnosis and procedure codes it was considered that most of these separations were probably acute.

State-level comparisons of the median length of stay and age/sex characteristics associated with each care type have demonstrated the apparent lack of consistency between the states in the allocation of Maintenance, Geriatric evaluation and management, and Psychogeriatric care types. The relative proportions of separations across states vary markedly for these closely aligned categories. The median length of stay by care type and state for the Rehabilitation care type seems to indicate

different approaches by the states in relation to admitting people for same-day rehabilitation.

Data element name: Country of birth

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment Services Community Mental Health Care Perinatal	**Collection year:** 2002–03 **Knowledgebase ID:** 000035 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: The country in which the person was born.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	No	No	Yes	No	No
Qld	Yes	Yes	No	Yes	Yes	No
WA	Yes	Yes	No	Yes	No	No
SA	Yes	Yes	No	Yes	Yes	Yes
Tas	Yes	Yes	No	Yes	Yes	No
ACT	Yes	Yes	No	Yes	Yes	No
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

The Australian Standard Classification of Countries (SACC) was specified as the data domain in the NHDD version 11.

New South Wales, Queensland, Western Australia, South Australia and the Australian Capital Territory reported *Country of birth* using SACC, while Victoria and Tasmania reported *Country of birth* using a modified version of the Australian Standard Classification of Countries for Social Statistics.

Details of use of non-standard NMDS scope

Country of birth was reported as 9999 for 2 separations from the Australian Capital Territory in the public sector and 3 separations in the private sector. Victoria reported

a value of 9 for 9 separations in the public sector. These codes are not valid in SACC; however, it is likely that these were default values used where *Country of birth* was unknown (ABS 1999).

Country of birth was coded as 0 Inadequately described; 1 At sea; 2 Not elsewhere classified; or 3 Not stated for 10,153 separations. See table below for details by sector, state and territory.

Table 4.8: Use of codes not found in the data domain, or supplementary SACC codes for inadequate data (codes commencing with '000')

	Public sector		Private sector		Total	
State or territory	Number	Per cent	Number	Per cent	Number	Per cent
NSW	2	0.0	0	0.0	2	0.0
Vic	1,267	6.7	4,817	13.0	6,084	10.9
Qld	835	3.6	6	1.3	841	1.9
WA	188	2.1	54	0.6	242	1.3
SA	853	9.9	12	0.4	865	7.2
Tas	41	1.3	2,020	98.2	2,061	39.4
ACT	9	0.7	0	0.0	9	0.5
NT	49	5.7	. .	. .	49	5.7
Total	**3,244**	**3.2**	**6,909**	**7.0**	**10,153**	**5.1**

. . Not applicable.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Date of birth

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment Services Community Mental Health Care Health Labour Force Perinatal	**Knowledgebase ID:** 000036 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: The date of birth of the person.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	No	Yes	Yes	No
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	No	Yes	Yes	No
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope

Date of birth was not provided by Western Australia (100%) and was missing for 99% of separations from Victoria and 21 separations from New South Wales in the private sector.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Western Australia did not provide *Date of birth* in 2002–03 data, but provided age in years and age in days. Victoria provided age in years and age in days where date of birth was missing.

Data element name: Diagnosis related group

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care	**Collection year:** 2002–03
		Knowledgebase ID: 000042
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 1
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 (AR-DRGs).		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	No	Yes	Yes	No	Yes
Vic	Yes	No	Yes	Yes	No	Yes
Qld	Yes	No	Yes	Yes	No	Yes
WA	Yes	No	Yes	Yes	No	Yes
SA	Yes	No	Yes	Yes	No	Yes
Tas	Yes	No	Yes	Yes	No	Yes
ACT	Yes	No	Yes	Yes	No	No
NT	Yes	No	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

All states and territories provided DRG information based on AR-DRG version 4.2 instead of *Australian Refined Diagnosis Related Groups* version 5.0.

Details of use of non-standard NMDS scope

Data for *Diagnosis related group* were missing for 60 separations from Victoria (54 public, 6 private), 4 public sector separations from the Northern Territory and 3 private sector separations from the Australian Capital Territory.

Data were ungroupable for 226 separations, almost all in the public sector.

Table 4.9: Use of a null value, or the Ungroupable or Unacceptable Principal Diagnosis data domain for *Diagnosis related group*, by state and territory, 2002–03

State or territory	Public sector		Private sector		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
NSW	137	0.4	3	0.0	140	0.9
Vic	54	0.3	6	0.0	60	0.1
Qld	0	0.0	0	0.0	0	0.0
WA	0	0.0	0	0.0	0	0.0
SA	0	0.0	0	0.0	0	0.0
Tas	84	2.6	0	0.0	84	1.6
ACT	1	0.1	3	0.8	4	0.2
NT	5	0.6	. .	. .	5	0.6
Total	**281**	**0.3**	**12**	**0.0**	**293**	**0.1**

. . Not applicable.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

The NHDD specifies that the AR-DRG version effective from 1 July each year should be used as the valid data domain. The version effective from 1 July 2002 (based on the ICD-10-AM version that was then current) was version 5.0. The AIHW regrouped all data provided by states and territories to AR-DRG version 5.0.

Data element name: Employment status—acute hospital and private psychiatric hospital admissions

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:**	**Collection year:** 2002–03
		Knowledgebase ID: 000395
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in designated psychiatric units in acute hospitals.		**Version number:** 2
Definition: Self-reported employment status of a person, immediately prior to admission to an acute or private psychiatric hospital.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	. .	. .	. .	. .	. .	. .
Vic	. .	. .	. .	. .	. .	. .
Qld	. .	. .	. .	. .	. .	. .
WA	. .	. .	. .	. .	. .	. .
SA	. .	. .	. .	. .	. .	. .
Tas	. .	. .	. .	. .	. .	. .
ACT	. .	. .	. .	. .	. .	. .
NT	. .	. .	. .	. .	. .	. .

. . Not applicable, as not requested.

Details of use of non-standard NHDD definition and domain values

The AIHW did not request this data element for 2002–03. See *Employment status – public psychiatric hospital admissions* for more detail.

Details of use of non-standard NMDS scope

Not applicable.

Was mapping required from state and territory data sets?

Not applicable.

Additional information:

Not applicable.

Data element name: Employment status—public psychiatric hospital admissions

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:**	**Collection year:** 2002–03
		Knowledgebase ID: 000317
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in public psychiatric hospitals.		**Version number:** 2
Definition: Self-reported employment status of a person, immediately prior to admission to a public psychiatric hospital.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	. .	. .	. .	. .	. .	. .
Vic	Yes	Yes	No	. .	. .	. .
Qld	Yes	Yes	Yes	. .	. .	. .
WA	Yes	Yes	Yes	. .	. .	. .
SA	Yes	Yes	No	. .	. .	. .
Tas	Yes	Yes	No	. .	. .	. .
ACT	Yes	Yes	Yes	. .	. .	. .
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

This data element is restricted in scope to public psychiatric hospitals.

Details of use of non-standard NMDS scope

New South Wales did not report *Employment status*. Victoria provided data for public psychiatric hospitals only, but did not use category 1 Child not at school as Victoria's one public psychiatric hospital is a forensic hospital, and does not have child patients. Tasmania reported employment status for both the public and private sectors but did not use category 4 Unemployed. Queensland and Western Australia reported *Employment status* for both the public and private sectors.

Table 4.10: Separations for which a null value was used or *Employment status* was reported as 9 Not stated, by sector, state and territory

State or territory	Public hospital		Public psychiatric hospital		Private sector		Total	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
NSW	27,106	100.0	9,602	100.0	24,713	100.0	61,421	100.0
Vic	18,375	100.0	87	20.0	37,013	100.0	55,475	99.4
Qld	0	0.0	0	0.0	0	0.0	0	0.0
WA	0	0.0	0	0.0	0	0.0	0	0.0
SA	1,901	32.3	937	34.2	3,425	100.0	6,263	51.9
Tas	342	11.8	5	1.8	858	41.7	1,205	23.0
ACT	0	0.0	. .	. .	377	100.0	377	21.9
NT	180	21.1	. .	. .	. .	. .	180	21.1
Total	**47,904**	**55.8**	**10,631**	**68.7**	**66,386**	**67.1**	**124,921**	**62.4**

. . Not applicable.

Was mapping required from state and territory data sets?

Western Australia collects two additional categories: Retired and Pensioner, which they mapped to 6 Other.

Additional information

New South Wales collected this item for the first time in 2004–05. New South Wales does not consider it to be a reliable item as the categories are not mutually exclusive.

Data element name: Establishment identifier—Establishment number

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment services Community Mental Health Care Community Mental Health Establishments Perinatal Public Hospital Establishments	**Knowledgebase ID:** 000050 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3

Definition:

Identifier for the establishment in which the episode or event occurred. Each separately administered health care establishment is to have a unique identifier at the national level. *Establishment identifier* is a composite data element and is a concatenation of *State identifier*, *Establishment sector*, *Region code* and *Establishment number*.

Establishment number

An identifier for establishment, unique within the state or territory (Knowledgebase ID: 000050, version number 3).

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	No	No	Yes
Vic	Yes	Yes	Yes	No	No	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	No	No	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	No	No	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

New South Wales, Victoria, Western Australia and Tasmania did not provide a unique *Establishment number* for private hospitals; for confidentiality reasons South Australia provided a unique *Establishment identifier* for private hospitals, with establishment identifiers encrypted to ensure confidentiality.

Details of use of non-standard NMDS scope

Not applicable. *Establishment number* was provided for all reported separations in each state and territory.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Private hospitals were assigned an *Establishment number* of 300 in New South Wales, PRIV in Victoria, 999 in Western Australia and 000 in Tasmania.

Data element name: Establishment identifier—Establishment sector

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment services Community Mental Health Care Community Mental Health Establishments Perinatal Public Hospital Establishments	**Knowledgebase ID:** 000050 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3

Definition:

Identifier for the establishment in which the episode or event occurred. Each separately administered health care establishment is to have a unique identifier at the national level. *Establishment identifier* is a composite data element and is a concatenation of *State identifier*, *Establishment sector*, *Region code* and *Establishment number*.

Establishment sector

A section of the health care industry (Knowledgebase ID: 000050, version number 3).

Use of national standard definition, domain values and NMDS scope:

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	No*	No*	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

* See details of use of non-standard NHDD definition and domain values.

Details of use of non-standard NHDD definition and domain values

The *National Health Data Dictionary* version 11 (AIHW 2002) specifies two domain values, 1 Public and 2 Private. The AIHW requested that two additional categories be provided for Establishment sector, 4 Public psychiatric and 5 Private free-standing day hospital facility.

New South Wales, Victoria, Queensland, Western Australia, South Australia, the Northern Territory and the Australian Capital Territory provided establishment sector as requested by the AIHW.

Tasmania provided information for public acute and public psychiatric hospitals but did not distinguish between private free-standing day hospital facilities and other private hospitals due to confidentiality concerns regarding the small number of private hospitals and free-standing day facilities. A data domain of 6 Private, not further specified was assigned by the AIHW for Tasmania.

Details of use of non-standard NMDS scope

Not applicable. Establishment sector was provided for all reported separations in each state and territory.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Establishment identifier—Region code

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment Services Community Mental Health Care Community Mental Health Establishments Perinatal Public Hospital Establishments	**Knowledgebase ID:** 000050 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3

Definition:

Identifier for the establishment in which the episode or event occurred. Each separately administered health care establishment is to have a unique identifier at the national level. *Establishment identifier* is a composite data element and is a concatenation of *State identifier*, *Establishment sector*, *Region code* and *Establishment number*.

Region code

An identifier for location of health services in an area. (Knowledgebase ID: 000050 version number 3).

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	No	Yes	Yes	No
WA	Yes	Yes	Yes	Yes	Yes	No
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	No	No	No	No	No	No
ACT	. .	. .	. .	. .	. .	. .
NT	. .	. .	. .	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

As domain values are as specified by the individual states and territories and there are no standard categories that have to be reported, it is difficult to assess each individual jurisdiction's compliance with the NHDD.

Details of use of non-standard NMDS scope

Regions are not used in the Australian Capital Territory and the Northern Territory. Queensland did not provide *Region code* for separations in either the public or private sector, while Western Australia did not provide them for private hospital separations.

Western Australia has indicated that it does not provide region codes for private hospitals as this amounts to identifying the establishment in some cases. Western Australia does not wish to have private hospitals identified.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Queensland and the Australian Capital Territory used '00' for all separations, the Northern Territory used '71' for public hospitals, while Western Australia provided region codes for public hospitals and '00' for private hospitals.

The Australian Capital Territory indicated that region is not a useful disaggregation for analysis. Tasmania provided a 6-digit *Establishment number*, with no region code.

Data element name: Establishment identifier—State identifier

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment services Community Mental Health Care Community Mental Health Establishments Emergency Department Waiting Times Perinatal Public Hospital Establishments	**Knowledgebase ID:** 000050 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3

Definition:

Identifier for the establishment in which the episode or event occurred. Each separately administered health care establishment is to have a unique identifier at the national level. *Establishment identifier* is a composite data element and is a concatenation of *State identifier*, *Establishment sector*, *Region code* and *Establishment number*.

State identifier

An identifier for state or territory (Knowledgebase ID: 000050, version number 3).

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope

Not applicable. *State identifier* was provided for all reported separations in each state and territory.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Indigenous status

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment Services Community Mental Health Care Perinatal	**Knowledgebase ID:** 000001 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: 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.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	No	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	No	Yes	Yes	No
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	No	Yes	Yes	No
ACT	Yes	Yes	No	Yes	Yes	No
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD definition and domain values were used by all states and territories.

The NHDD version 11 specifies five domain values, 1 Aboriginal but not Torres Strait Islander, 2 Torres Strait Islander, 3 Both Aboriginal and Torres Strait Islander, 4 Neither Aboriginal nor Torres Strait Islander and 9 Not stated. The AIHW requested that an additional category be provided, 5 Indigenous not further specified if data were unable to be provided in categories 1–3 above. No data were provided for this additional category.

Details of use of non-standard NMDS scope

The coverage of *Indigenous status* in the APMHC NMDS is not complete for all states and territories. For example, in Queensland, *Indigenous status* was not reported for 3.5% of hospital separations, and in Tasmania some private hospitals did not collect *Indigenous status*; overall *Indigenous status* was not reported for 4.7% of Tasmanian separations.

Table 4.11: Use of the Not stated data domain for *Indigenous status*, by sector, state and territory, 2002–03

State or territory	Public sector		Private sector		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
NSW	685	1.9	39	0.2	724	1.2
Vic	0	0.0	0	0.0	0	0.0
Qld	673	2.9	900	4.1	1,573	3.5
WA	0	0.0	0	0.0	0	0.0
SA	382	4.4	0	0.0	382	1.9
Tas	204	6.4	43	2.1	247	4.7
ACT	29	2.2	21	5.6	50	2.9
NT	11	1.3	. .	. .	11	1.3
Total	**1,984**	**2.0**	**1,003**	**1.0**	**2,987**	**3.0**

. . Not applicable.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

In the evaluation of the APC NMDS it was recommended that future compliance evaluations should include a quality audit component to assess the accuracy of the responses to *Indigenous status*, including an investigation of whether Indigenous patients were likely to be recorded as non-Indigenous.

The following information relates to the quality of data reported for the APC NMDS, as no specific information on the mental health subset (the APMHC NMDS) was available.

Overall, the quality of the data provided for *Indigenous status* in 2002–03 is considered to be in need of improvement, being considered acceptable for only South Australia, Western Australia and the Northern Territory.

The AIHW requested that states and territories provide comments on the quality of their *Indigenous status* data. The following is an extract from *Australian Hospital Statistics 2002–03* (AIHW 2004a).

For 2002–03, the New South Wales Health Department reported that its data were in need of improvement. The department is working to improve the quality of Indigenous origin information in hospital separations data. Departmental publications and circulars are used to encourage both a uniform approach to the

identification of Indigenous patients and continuous improvement in this data collection. The New South Wales Health Department is also implementing its Collecting Patient Registration Information Training Program in all New South Wales Area Health Services. This training program raises awareness of data items, including *Indigenous status*, that may relate to sensitive issues and reviews strategies that may help in the collection of complete and accurate patient registration information.

The Victorian Department of Human Services reported that, despite data quality improvement in recent years, *Indigenous status* data for 2002–03 should be treated with some caution. Studies in Victoria have shown that data are more accurate if the hospital employs a Koori Hospital Liaison Officer, particularly in regional hospitals, where the officers are located in the main Koori communities. *Indigenous status* data are considered less reliable in tertiary hospitals drawing Indigenous patients from outside their local communities, and in private hospitals. Victoria has undertaken an Aboriginal and Torres Strait Islander Hospital Services Accreditation Project. When its recommendations are implemented, this is expected to lead to improved patient identification and the provision of more culturally appropriate services.

Queensland Health noted that for 2002–03, *Indigenous status* was not reported for 11% of hospital separations (1.7% for public hospital separations and 22% for private hospital separations). It suggested that it is likely that the proportion of separations that were for Indigenous patients, in those separations for which *Indigenous status* was not reported, was higher than for separations for which *Indigenous status* was reported. Overall, the available evidence suggests that the number of Indigenous separations is significantly understated in the Queensland hospital morbidity data because of non-reporting as well as misreporting of Indigenous status. Queensland Health continues to work on improving overall Aboriginal and Torres Strait Islander identification in all mainstream administrative data collections.

The Western Australian Department of Health regarded its *Indigenous status* data as being of an acceptable quality, although data from metropolitan hospitals are considered to be less accurate than data from remote areas. The department is planning to implement a quality control check on this data element on an annual basis. In documentation supplied to the AIHW with the NMDS for 2000–01, Western Australia noted survey results suggesting approximately 85% of Indigenous and 99% of non-Indigenous persons are identified correctly in broad Indigenous categories. It is suspected that code 3 Aboriginal and Torres Strait Islander is at times interpreted as Aboriginal and/or Torres Strait Islander, resulting in higher than expected counts in this category.

The South Australian Department of Human Services regarded its 2002–03 *Indigenous status* data as suitable for inclusion in national statistical reports. The department conducted training in 2002–03 on how to ask and record the *Indigenous status* question. This training was based on a training package produced by the ABS. A 30% loading for casemix payments is applied to separations for Indigenous patients in South Australian public hospitals, and this acts as an incentive for improved identification. The Tasmanian Department of Health and Human Services reported that the quality of *Indigenous status* data has continued to improve in

2002–03 in that it is now reported for most patients. However, some private hospitals do not collect information on *Indigenous status* at all. The department is hoping to improve the reporting methods for private hospitals in future years.

The Australian Capital Territory Department of Health and Community Care considered that the quality of its public hospital *Indigenous status* data is of acceptable quality, while its private hospital *Indigenous status* data require improvement.

The Northern Territory Department of Health and Community Services reported that the quality of its 2002–03 Indigenous status data is considered to be acceptable. The department retains historical reporting of Indigenous status and individual client systems receive a report of individuals who have reported their Indigenous status as Aboriginal on one occasion and as Torres Strait Islander on another. System owners follow up on these clients. All management and statistical reporting, however, is based on a person's currently reported Indigenous status.

Data element name: Major Diagnostic Category

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care	**Knowledgebase ID:** 000088
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 1

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 specialty 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.

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	No	Yes	Yes	No	Yes
Vic	Yes	No	Yes	Yes	No	Yes
Qld	Yes	No	Yes	Yes	No	Yes
WA	Yes	No	Yes	Yes	No	Yes
SA	Yes	No	Yes	Yes	No	Yes
Tas	Yes	No	Yes	Yes	No	Yes
ACT	Yes	No	Yes	Yes	No	No
NT	Yes	No	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD definitions were used by all states and territories. However, they all provided Major Diagnostic Category information based on AR-DRG version 4.2 instead of AR-DRG version 5.0. The version used by New South Wales is unknown. A value of '00' was used for Major Diagnostic Category for 131 separations in New South Wales, 84 separations in Tasmania and 2 separations in Queensland, all from the public sector. Queensland used a value of '24' for 6 public sector separations.

Details of use of non-standard NMDS scope

Data for *Major diagnostic category* were missing for Victoria for 54 separations from the public sector and 6 separations for the private sector, 4 public sector separations from the Northern Territory and 3 private sector separations from the Australian Capital Territory.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

The NHDD specifies that the AR-DRG version effective from 1 July each year should be used as the valid data domain. The version effective from 1 July 2002 (based on the ICD-10-AM version that was current then) was version 5.0. The AIHW regrouped all data provided by states and territories to AR-DRG version 5.0.

Data element name: Marital status

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:**	**Collection year:** 2002–03
		Knowledgebase ID: 000089
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: Current marital status of the person.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	No	Yes	Yes	No
Vic	Yes	Yes	No	Yes	Yes	No
Qld	Yes	Yes	No	Yes	Yes	No
WA	Yes	Yes	No	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	No	Yes	Yes	No
ACT	Yes	Yes	No	Yes	Yes	Yes
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD domain values were used by all states and territories, where known.

Details of use of non-standard NMDS scope

Data for *Marital status* were provided for all separations for all states and territories. The code 6 Not stated/inadequately described was used by all states and territories in both the public and private sectors.

Table 4.12: Use of the Not stated/inadequately described data domain for *Marital status* by sector, state and territory, 2002–03

State or territory	Public sector		Private sector		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
NSW	3,807	10.4	1,072	4.3	4,879	7.9
Vic	1,348	7.2	1,500	4.1	2,848	5.1
Qld	1,334	5.8	184	0.8	1,518	3.4
WA	163	1.9	19	0.2	182	1.0
SA	1,166	13.5	49	1.4	1,215	10.1
Tas	51	1.6	19	0.9	70	1.3
ACT	30	2.2	1	0.3	31	1.8
NT	154	18.0	. .	. .	154	18.0
Total	**8,053**	**7.9**	**2,844**	**2.9**	**10,897**	**5.4**

. . Not applicable.

Was mapping required from state and territory data sets?

New South Wales and South Australia mapped the data collected at the jurisdiction level to conform to the NHDD domain values for *Marital status*. Victoria used code 5 to represent Currently married (including de facto).

Additional information:

New South Wales, Victoria, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory provided *Marital status* for all hospital separations, not just specialised mental health care separations.

Data element name: Mental health legal status

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Community Mental Health Care	**Knowledgebase ID:** 000092
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 5

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.

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	No	Yes	Yes	No
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	No
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope

In Victoria, all private sector separations were reported as Victorian code 9 Not applicable and 114 (0.2%) separations in the public sector were reported as Unknown. Data were missing for 246 separations (28.9%) in the public sector in the Northern Territory. In Tasmania, all separations in the private sector were coded to 9 Unknown.

In Victoria, private hospitals are directed to report a code of 9 Not applicable for all patients, as private hospitals are not proclaimed to provide services for involuntary patients. Therefore, the AIHW has analysed these services as equivalent to 2 Voluntary.

Table 4.13: Use of a null value, or the Unknown data domain for *Mental health legal status*, by sector, state and territory, 2002–03

	Public sector		Private sector		Total	
State or territory	Number	Per cent	Number	Per cent	Number	Per cent
NSW	0	0.0	0	0.0	0	0.0
Vic	114	0.6	0	0.0	114	0.2
Qld	0	0.0	0	0.0	0	0.0
WA	0	0.0	0	0.0	0	0.0
SA	0	0.0	0	0.0	0	0.0
Tas	0	0.0	2,056	100.0	2,056	39.3
ACT	0	0.0	0	0.0	0	0.0
NT	246	28.8	. .	. .	246	28.9
Total	**360**	**0.4**	**2,056**	**2.1**	**2,436**	**1.2**

. . Not applicable.

Was mapping required from state and territory data sets?

South Australia and Tasmania mapped the data collected at the jurisdiction level to conform to the NHDD domain values for *Mental health legal status*.

Additional information

Mental health legal status is not required to be reported for separations without specialised psychiatric care in the APC NMDS. However, South Australia provided *Mental health legal status* for all separations, regardless of whether patients had psychiatric care days. That is, patients who were involuntary (those with and without psychiatric care days) were coded as 1 Involuntary, while all other patients (those with and without psychiatric care days) were coded as 2 Voluntary. New South Wales reported *Mental health legal status* for separations with no psychiatric care days which were in the public sector.

New South Wales, South Australia, the Australian Capital Territory and the Northern Territory coded some separations without psychiatric care days as 2 Voluntary. South Australia and the Northern Territory coded 1 separation without psychiatric care days as 1 Involuntary. These separations were in the public sector.

Data element name: Mode of separation

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care; Admitted Patient Palliative Care	**Collection year:** 2002–03
		Knowledgebase ID: 000096
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	No	Yes	Yes	No	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	No	Yes	Yes	No	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	No	Yes	No	No	No
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Victoria includes discharges/transfers to psychiatric hospitals in category 1 Discharge/transfer to an(other) acute hospital rather than category 3 Discharge/ transfer to an(other) psychiatric hospital as per NHDD specifications. Victoria has indicated that this reflects the fact that, except for the public psychiatric hospital, all public admitted patient services for mental health patients have now been mainstreamed into public acute hospitals and it may not be recorded whether a patient is transferred to a psychiatric unit or to the 'general' part of the hospital. Even when the patient notes make it clear that the transfer is to the psychiatric ward of another hospital, the codes identifying hospitals do not differentiate between the various services of that hospital: the transferring hospital can indicate only the receiving hospital. Victoria has suggested that this NHDD specification needs to be reviewed. For Victoria discharges and transfers to mental health residential facilities are mapped to category 4 Discharge/transfer to other health care accommodation.

Western Australia uses category 2 Discharge/transfer to a residential aged care service, unless this is the usual place of residence for patients who are discharged or transferred to a nursing home (not a residential aged care service). Category 3 Discharge/transfer to an(other) psychiatric hospital is used for discharges or transfers to all psychiatric facilities, not just psychiatric hospitals. Category 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals) also includes patients who are discharged or transferred to all hostels (mostly aged care). Western Australia will use Version 10 of the NHDD definitions for its 2003–04 submission. This affects categories 2 (residential aged care service rather than nursing home), 3 (psychiatric hospital rather than psychiatric facility) and 4 (aged care facilities that belong to category 2 will be excluded from this category while some psychiatric facilities and mothercraft hospitals will be included).

All separations for Tasmania in the private sector were coded to 9 Other (includes discharge to usual residence/own accommodation/ welfare institution (includes prisons, hostels and group homes providing primarily welfare services). Tasmania did not use category 3 Discharge/transfer to an (other) psychiatric hospital in the public sector.

The Australian Capital Territory did not report any separations for category 7 Statistical discharge from leave.

Details of use of non-standard NMDS scope

The AIHW requested that category 0 Unknown be reported if *Mode of separation* was not known. There were no separations coded as 0 Unknown for any state or territory. Data were missing for 3 separations in the public sector for South Australia.

Was mapping required from state and territory data sets?

New South Wales, Victoria, South Australia, Tasmania and the Northern Territory all mapped the data collected at the jurisdiction level to conform to the NHDD domain values for *Mode of separation*. Queensland derives this data element from two separate state data items.

Additional information

Not applicable.

Data element name: Person identifier

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment services Community Mental Health Care Perinatal	**Collection year:** 2002–03 **Knowledgebase ID:** 000127 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 1
Definition: Person identifier unique within establishment or agency.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	. .	. .	. .	. .
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	. .	. .	. .	. .	. .	. .
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	No	. .	. .	No	. .	. .
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

The NHDD definition appears to have generally been used by states and territories, except Western Australia, which did not provide data for *Person identifier*, and Tasmania which provided a *Person identifier* that was not unique. Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems as domain values.

The NHDD definition requires that the *Person identifier* is unique to the patient within the relevant establishment. The supplied data were examined for the repeated use of the same person identifier for patients with different demographic characteristics, such as *Sex* and *Date of birth*. There were very few cases where there were

Establishment identifier-Person identifier combinations with more than one *Sex* or *Date of birth*.

Table 4.14: Use of unique establishment identifiers-person identifiers, by state and territory, 2002–03

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Establishment id.-person id. combinations with 2 different sex values—public sector	n.a.	0	0	n.a.	77	n.a.	0	0
Establishment id.-person id. combinations with 2 different sex values—private sector	n.a.	6	1	n.a.	59	n.a.	0	. .
Establishment id.-person id. combinations with more than one date of birth—public sector	n.a.	n.a.	4	n.a.	278	n.a.	1	0
Establishment id.-person id. combinations with more than one date of birth—private sector	n.a.	n.a.	5	n.a.	107	n.a.	0	. .
Establishment id.-person id. combinations with 2 different sex values and/or more than one date of birth—public sector	n.a.	n.a.	4	n.a.	355	n.a.	1	0
Establishment id.-person id. combinations with 2 different sex values and/or more than one date of birth—private sector	n.a.	n.a.	6	n.a.	166	n.a.	0	. .

n.a. Not available. For New South Wales, person identifier not loaded due to length of data element. Victoria did not provide date of birth. Western Australia did not provide person identifier. Tasmania did not provide a unique person identifier.

. . Not applicable.

Details of use of non-standard NMDS scope

Western Australia did not report *Person identifier* for any separations in its data submission for confidentiality reasons. Western Australia indicated it does not intend to change this practice at this time. South Australia provided an encrypted *Person identifier* of a type which may have affected the analysis.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

In its documentation accompanying the 2002–03 data request for the NHMD to states and territories the AIHW asked a number of questions regarding *Person identifier* including:

1. 'Is this identifier repeated for repeat admissions of individual patients?'
2. 'If so, does this apply within individual hospitals or throughout the state and territory?'
3. 'Are the identifiers the same as those used for previous years (that is, can they be used to identify repeat admissions in previous years for the same patients)?'.

In addition, states and territories were asked to comment on whether the actual unique record number assigned at the hospital is provided or is encrypted before supply to the AIHW. If it is encrypted, states and territories were asked to indicate if the encryption is done in the same way each time so that the same encrypted number would stay with each patient each time they are re-admitted.

New South Wales indicated that, within public hospitals, *Person identifier* is the same for every new data extract and can be used to identify repeat admissions in previous years for the same patients within the same establishment. The record numbers for both public and private hospitals are encrypted, but for private hospitals they are not submitted in a form that can identify repeat admissions of the same patient.

Victoria indicated that *Person identifier* is repeated for repeat admissions of individual patients and is only unique within individual hospitals. It does not provide the unique record number assigned at the hospital, but provides an encrypted number. The encryption is done consistently so that the same encrypted number would stay with each patient each time they are re-admitted to the same hospital.

Queensland indicated that *Person identifier* is repeated for repeat admissions of individual patients and is only unique within individual hospitals.

South Australia indicated that *Person identifier* is unique to individual patients separated during 2002–03. It provided an encrypted person identifier for 2002–03 data.

Tasmania has indicated that the identifier is not repeated for repeat admissions of individual patients.

The Australian Capital Territory indicated that *Person identifier* may be used for repeat admissions within a hospital and applies across periods for the same patients.

The Northern Territory indicated that *Person identifier* is repeated for repeat admissions of the same individual across the Territory, not just within a hospital. It also provides an encrypted number, but it has a common numbering system for its five public hospitals, so each patient has the same encrypted number each time they are admitted to any of these hospitals.

Data element name: Previous specialised treatment

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:**	**Collection year:** 2002–03
		Knowledgebase ID: 000139
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: Whether a patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	No	No	. .	No	No
Vic	. .	. .	. .	. .	. .	. .
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	. .	. .	. .	. .	. .	. .
Tas	. .	. .	. .	. .	. .	. .
ACT	Yes	Yes	Yes	Yes	Yes	No
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD domain values were used by all states and territories excluding New South Wales. New South Wales did not report any separations for category 3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided or 4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided.

Details of use of non-standard NMDS scope

Data for *Previous specialised treatment* were not supplied for any separations from Victoria. No data were supplied for 55,342 (90.1%) separations from New South Wales (30,629 separations in the private sector, 24,713 in the public sector) and 165 (9.6%) separations from the Australian Capital Territory, all in the private sector. A

code of 5 Unknown/not stated was reported for all separations from South Australia and Tasmania and almost all separations in the Northern Territory (99.9%).

Table 4.15: Use of a null value, or the Unknown/not stated data domain for *Previous specialised treatment*, by sector, state and territory, 2002–03

	Public sector		Private sector		Total	
State or territory	Number	Per cent	Number	Per cent	Number	Per cent
NSW	30,629	83.4	24,713	100.0	55,342	90.1
Vic	18,811	100.0	37,013	100.0	55,824	100.0
Qld	0	0.0	0	0.0	0	0.0
WA	0	0.0	0	0.0	0	0.0
SA	8,635	100.0	3,425	100.0	12,060	100.0
Tas	3,179	100.0	2,056	100.0	5,235	100.0
ACT	222	16.5	165	43.8	387	22.5
NT	853	99.9	. .	. .	853	99.9
Total	**62,329**	**61.5**	**67,372**	**68.1**	**129,701**	**64.8**

. . Not applicable.

Was mapping required from state and territory data sets?

Western Australia mapped the data by linking the patient history at the jurisdiction level to conform to the NHDD domain values.

Additional information

New South Wales advised that systems in private hospitals were unable to collect this data element.

Data element name: Principal diagnosis

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Community Mental Health Care	**Knowledgebase ID:** 000136 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	Yes
ACT	Yes	Yes	Yes	Yes	Yes	No
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values used by all states and territories. There were 145 separations with invalid ICD-10-AM version 3 *Principal diagnosis* codes, 117 in New South Wales in the public sector and 28 in Victoria in the public sector.

Details of use of non-standard NMDS scope

New South Wales, Victoria, the Australian Capital Territory and the Northern Territory all reported separations without a *Principal diagnosis*.

Table 4.16: Separations for which *Principal diagnosis* was not reported, by sector, state and territory, 2002–03

State or territory	Public sector		Private sector		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
NSW	14	0.0	0	0.0	14	0.0
Vic	55	0.3	6	0.0	61	0.1
Qld	0	0.0	0	0.0	0	0.0
WA	0	0.0	0	0.0	0	0.0
SA	0	0.0	0	0.0	0	0.0
Tas	0	0.0	0	0.0	0	0.0
ACT	0	0.0	3	0.8	3	0.2
NT	4	0.5	. .	. .	4	0.5
Total	**73**	**0.1**	**9**	**0.0**	**82**	**0.0**

. . Not applicable.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Referral to further care (psychiatric patients)

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:**	**Collection year:** 2002–03
		Knowledgebase ID: 000143
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 1
Definition: Referral to further care by health service agencies/facilities.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	No	Yes	Yes	No
Vic	No	No	No	No	No	No
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	No	Yes	Yes	No
SA	Yes	Yes	No	Yes	Yes	Yes
Tas	Yes	Yes	No	Yes	Yes	No
ACT	Yes	Yes	No	Yes	Yes	No
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD definition and domain values were used by all states and territories except Victoria.

Details of use of non-standard NMDS scope

Data were not supplied, or coded to Not stated, for 55,660 (99.7%) separations from Victoria (data were supplied for public psychiatric hospitals only), 16,350 (89.4%) separations from Western Australia (6,809 separations in the public sector and 9,541 separations in the private sector), 5,235 (100.0%) separations from Tasmania (3,179 separations in the public sector and 2,056 separations in the private sector), 251 (29.4%) separations from the Northern Territory in the public sector and 69 (4.0%) separations from the Australian Capital Territory (38 separations in the public sector and 31 separations in the private sector).

No separations were reported for South Australia for referral to 4 Mental health/alcohol and drug non-inpatient facility or 6 Acute hospital.

The code *9* Not stated was requested by the AIHW (see table).

Table 4.17: Use of a null value, or the code 9 for *Referral to further care (psychiatric patients)*, by sector, state and territory, 2002–03

State or territory	Public sector		Private sector		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
NSW	4,073	11.1	24,713	100.0	28,786	46.9
Vic	18,647	99.1	37,013	100.0	55,660	99.7
Qld	0	0.0	0	0.0	0	0.0
WA	6,809	77.8	9,541	100.0	16,350	89.4
SA	259	3.0	0	0.0	259	2.1
Tas	3,179	100.0	2,056	100.0	5,235	100.0
ACT	38	2.8	31	8.2	69	4.0
NT	251	29.4	. .	. .	251	29.4
Total	**33,256**	**32.8**	**73,354**	**76.4**	**106,610**	**53.2**

. . Not applicable.

Was mapping required from state and territory data sets?

New South Wales mapped its data to the NHDD data domain values.

Additional information

Not applicable.

Data element name: Separation date

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care Admitted Patient Palliative Care	**Collection year:** 2002–03 **Knowledgebase ID:** 000043 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 5
Definition: Date on which an admitted patient completes an episode of care.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope:

Not applicable. *Separation date* was provided for all reported separations in each state and territory.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Sex

Evaluation NMDS:	**Other NMDSs:**	**Collection year:** 2002–03
Admitted Patient Mental Health Care	Admitted Patient Care Admitted Patient Palliative Care Alcohol and Other Drug Treatment Services Community Mental Health Care Perinatal	**Knowledgebase ID:** 000149 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 2
Definition: The sex of the person.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	Yes	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	No	Yes	Yes	No	Yes
Tas	Yes	Yes	Yes	Yes	Yes	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD definition and domain values were used by all states and territories except South Australia. South Australia does not use category 3 Indeterminate. South Australia has advised that it will fully comply with the NHDD from 1 July 2003 and a category of 3 Indeterminate will be introduced.

Details of use of non-standard NMDS scope

Not applicable. *Sex* was provided for all reported separations in each state and territory. However, the NHDD domain value of 9 Not stated/inadequately described was used for 21 separations from New South Wales (19 in the public sector, 2 in the private sector) and 3 separations from the Northern Territory in the public sector.

Was mapping required from state and territory data sets?

Each state and territory generally used the NHDD domain values for the collection of data on *Sex*, therefore mapping was not required.

Additional information

Logical checks to check for inconsistencies between diagnosis (*Principal diagnosis* and/or additional diagnoses) and sex revealed a number of separations with invalid sex and diagnosis combinations, all in the public sector.

Table 4.18: Number of separations with invalid sex and diagnosis combinations, by state and territory, 2002–03

State	Invalid sex/diagnosis
NSW	5
Vic	1
Qld	0
WA	1
SA	0
Tas	0
ACT	0
NT	0

Data element name: Source of referral to public psychiatric hospital

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** None	**Collection year:** 2002–03
		Knowledgebase ID: 000150
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in public psychiatric hospitals.		**Version number:** 3
Definition: Source from which the person was transferred/referred to the public psychiatric hospital.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	No	Yes	Yes	. .
Vic	. .	. .	. .	. .	. .	. .
Qld	Yes	Yes	Yes	. .	. .	. .
WA	Yes	Yes	No	. .	. .	. .
SA	Yes	Yes	No	. .	. .	. .
Tas	Yes	Yes	No	Yes	Yes	. .
ACT	Yes	Yes	. .	. .	. .	. .
NT	. .	. .	. .	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Queensland, Western Australia and South Australia provided data for public psychiatric hospitals only, as outlined in the NHDD definition. Tasmania provided data for all separations, not just those in public psychiatric hospitals. Similarly, the Australian Capital Territory provided data for this data element even though it does not have any public psychiatric hospitals. Data were provided for separations with psychiatric care days in public acute hospitals in the Australian Capital Territory. Northern Territory did not provide data for this data element as it does not have any public psychiatric hospitals.

Details of use of non-standard NMDS scope

Victoria was unable to provide data for this data element. According to Victoria the collection of this data element would not add value to the state's data because its

public psychiatric hospitals are forensic services and all patients would be 'referred' as part of a legal process.

Table 4.19 presents data on missing or unknown records. About 43% of separations within scope in both South Australia and Tasmania were reported as 10 Unknown.

Table 4.19: Use of a null value, or the Unknown data domain for *Source of referral to public psychiatric hospital*, by state and territory, 2002–03

	Public psychiatric hospital	
State or territory	Number	Per cent
NSW	193	2.0
Vic	436	100.0
Qld	0	0.0
WA	105	5.4
SA	1,178	43.0
Tas	120	42.6
ACT	. .	. .
NT	. .	. .
Total	**2,032**	**13.1**

. . Not applicable.

Note: The scope of this data element is restricted to public psychiatric hospitals.

Was mapping required from state and territory data sets?

New South Wales, South Australia, Western Australia and Tasmania all mapped the data collected at the jurisdiction level to conform to the NHDD domain values for *Source of referral to public psychiatric hospital*. Queensland derives this item from two separate data items.

Additional information

Western Australia has indicated difficulty reporting this data element.

Data element name: Total leave days

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care	**Collection year:** 2002–03
		Knowledgebase ID: 000163
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 3
Definition: Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for separations, where applicable?	NHDD definition used?	NHDD domain values used?	Provided for separations, where applicable?
NSW	Yes	Yes	Yes	Yes	Yes	Yes
Vic	Yes	Yes	No	Yes	Yes	Yes
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	Yes	Yes	Yes	Yes
SA	Yes	Yes	Yes	Yes	Yes	Yes
Tas	Yes	Yes	Yes	Yes	Yes	Yes
ACT	Yes	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope

This data element is not compulsory for all separations. *Total leave days* was provided where applicable by all states and territories except for Victoria, where it was not reported for any separations from public psychiatric hospitals. Victoria has advised that it will be reporting *Total leave days* for all hospitals in scope in future data submissions.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Total psychiatric care days

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:** Admitted Patient Care Community Mental Health Care	**Collection year:** 2002–03 **Knowledgebase ID:** 000164 **NHDD version:** 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 2
Definition: The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	. .	Yes	Yes	. .
Vic	Yes	Yes	. .	Yes	Yes	. .
Qld	Yes	Yes	. .	Yes	Yes	. .
WA	Yes	Yes	. .	Yes	Yes	. .
SA	Yes	Yes	. .	Yes	Yes	. .
Tas	Yes	Yes	. .	Yes	Yes	. .
ACT	Yes	Yes	. .	Yes	Yes	. .
NT	Yes	Yes	. .	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not applicable. NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope

The data element *Total psychiatric care days* is recorded for persons receiving care as an admitted patient or resident within a designated psychiatric unit. Separations are defined as being in the APMHC NMDS if they have at least one psychiatric care day. All states and territories reported that all psychiatric care days were reported in 2002–03, for the public sector. However, private sector reporting may have been incomplete in some jurisdictions.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Victoria reports psychiatric care days for all separations with a Victorian *Care type* of 5 Approved mental health/Psychogeriatric.

Data element name: Type of accommodation

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:**	**Collection year:** 2002–03
		Knowledgebase ID: 000173
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 2
Definition: The type of accommodation setting in which the person usually lives/lived.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	. .	. .	. .	. .	. .	. .
Vic	. .	. .	. .	. .	. .	. .
Qld	. .	. .	. .	. .	. .	. .
WA	. .	. .	. .	. .	. .	. .
SA	. .	. .	. .	. .	. .	. .
Tas	. .	. .	. .	. .	. .	. .
ACT	. .	. .	. .	. .	. .	. .
NT	. .	. .	. .	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

Not requested by the AIHW for 2002–03.

Details of use of non-standard NMDS scope:

Not applicable.

Was mapping required from state and territory data sets?

Not applicable.

Additional information

Not applicable.

Data element name: Type of usual accommodation

Evaluation NMDS: Admitted Patient Mental Health Care	**Other NMDSs:**	**Collection year:** 2002–03
		Knowledgebase ID: 000173
		NHDD version: 11.0
Scope: Episodes of care for admitted patients in psychiatric hospitals or in designated psychiatric units in acute hospitals.		**Version number:** 1
Definition: The type of physical accommodation the person lived in prior to admission.		

Use of national standard definition, domain values and NMDS scope

State or territory	Public sector			Private sector		
	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?	NHDD definition used?	NHDD domain values used?	Provided for all reported separations?
NSW	Yes	Yes	No	Yes	Yes	Yes
Vic	Yes	Yes	No	Yes	Yes	No
Qld	Yes	Yes	Yes	Yes	Yes	Yes
WA	Yes	Yes	No	Yes	Yes	No
SA	Yes	Yes	No	Yes	Yes	No
Tas	Yes	Yes	No	Yes	Yes	No
ACT	Yes	Yes	No	Yes	Yes	No
NT	Yes	Yes	No	. .	. .	. .

. . Not applicable.

Details of use of non-standard NHDD definition and domain values

NHDD definition and domain values were used by all states and territories.

Details of use of non-standard NMDS scope

In Victoria, data were reported for public psychiatric hospitals only. Data were missing for 745 (55.4%) separations from the Australian Capital Territory in the public sector and 246 (28.8%) separations from the Northern Territory, also in the public sector.

The code *9* Not stated, which was requested by the AIHW, was used by New South Wales, Victoria, Western Australia, South Australia, Tasmania and the Australian Capital Territory. See Table 4.20 below for more detail.

Table 4.20: Use of a null value, or the code 9 for *Type of usual accommodation*, by sector, state and territory, 2002–03

State or territory	Public sector		Private sector		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
NSW	11,915	32.5	5	0.0	11,920	19.4
Vic	18,521	98.5	37,013	100.0	55,534	99.5
Qld	0	0.0	0	0.0	0	0.0
WA	8,646	98.8	9,541	100.0	18,187	99.4
SA	1,477	17.1	3,425	100.0	4,902	40.6
Tas	3,179	100.0	2,056	100.0	5,235	100.0
ACT	745	55.4	30	8.0	775	45.0
NT	246	28.8	. .	. .	246	28.8
Total	**44,729**	**44.2**	**52,070**	**52.6**	**96,799**	**48.3**

. . Not applicable.

Was mapping required from state and territory data sets?

Western Australia collects an additional code for Correctional institutions, which they mapped to 6 Other accommodation.

Additional information

Type of usual accommodation was developed in 1989 to capture the accommodation a patient lived in prior to admission to hospital. *Type of accommodation* was developed in 1999 to capture information on the usual accommodation a patient lived in regardless of whether that was the type of accommodation they had come from directly prior to admission. *Type of accommodation* was initially proposed as a new version of *Type of usual accommodation* but the original data element was also retained as it captured different information. Both data elements have the same Knowledgebase identifier but will have different identifiers in the new METeOR system.

5 Comments on data elements

This chapter brings together summary information on the utility and importance of the NMDS data elements, comments and suggestions from both the utility and compliance evaluations, and other comments obtained during the NMDS evaluation.

The order of data elements in this section largely follows the order in which the data elements are presented in tables 3.5 and 4.3. Data elements relating to continuity of care have been grouped together from page 110.

Existing data elements and data element concepts

Establishment data elements

Establishment identifier

Ninety-four per cent of respondents rated this data element as either important (38%) or highly important (56%), and 94% rated it as either useful (38%) or highly useful (56%). Six per cent were unsure of its importance and usefulness.

Respondents indicated the importance and usefulness of this data element in allowing comparisons to be made across states and territories for other data elements. Inconsistency between jurisdictions in the level at which establishments are identified was seen to limit its usefulness.

Another issue raised was that the approach used to report establishments in the NMDS varies from that used in the National Survey of Mental Health Services and the NOCC, limiting the ability to integrate the NMDS data with data from these sources. The DoHA commented that this issue is of high priority.

Establishment number

Eighty-one per cent of respondents rated this data element as either important (31%) or highly important (50%), and 88% rated it as either useful (38%) or highly useful (50%). Thirteen per cent did not think the data element was important and 6% not useful. Six per cent were unsure of both its usefulness and importance.

There were no comments about this data element.

Establishment sector

Eighty-eight per cent of respondents rated this data element as either important (44%) or highly important (44%), and 75% rated it as either useful (38%) or highly useful (38%). Thirteen per cent did not think the data element was useful and a further 13% were unsure of its usefulness.

A recommendation from the evaluation of the APC NMDS, relevant to the current evaluation, was that the informal collection of information on whether the hospital is a public psychiatric, other public, private free-standing day hospital facility or other private hospital using this data element should be replaced with either an appropriate revision of the data domain for *Establishment sector* or the creation of a new data element on hospital type. This is currently being considered as part of the AIHW's work program for the development of the APC NMDS.

Region code

Seventy-five per cent of respondents rated this data element as either important (44%) or highly important (31%), and 63% rated it as either useful (31%) or highly useful (31%). Six per cent did not think the data element was important and 12% not useful. Another 19% were unsure of its importance and 25% of its usefulness.

Comments included that it would be preferable to define the location of health services in terms of their SLA; and that because a region means completely different things in different jurisdictions, inter-jurisdictional comparisons of other data elements on the basis on this data element are not possible. However, it was noted that this data element is used at the local level within jurisdictions.

Another comment was that while *Region code* may have little value for the general health sector, it is still useful to collect as mental health services are organised on a catchment population basis; for all states and territories, *Region code* points to the geographic populations served. It was also noted that there is a need to align any replacement concept with the concept in the NOCC and the National Survey of Mental Health Services.

This data element has been deleted from the APC NMDS, subsequent to a recommendation of the evaluation of that NMDS. However, given its usefulness in identifying catchment populations, it was thought useful to retain it in the APMHC NMDS. However, it should be revised to clarify how it would be used for this NMDS to indicate catchment areas and/or align with the region concept in the NOCC.

State identifier

Sixty-nine per cent of respondents rated this data element as either important (25%) or highly important (44%), and 69% rated it as either useful (25%) or highly useful (44%). Only 6% rated it as not important or not useful. Twenty-five per cent were unsure of its importance and usefulness.

There were no comments on this data element.

Demographic data elements

Area of usual residence

Ninety-four per cent of respondents rated this data element as either important (6%) or highly important (88%), and 94% rated it as either useful (19%) or highly useful (75%). Only 6% were unsure about its importance and usefulness.

It was commented that this data element is important for service delivery planning.

Country of birth

Eighty-eight per cent of respondents rated this data element as either important (44%) or highly important (44%), and 75% rated it as either useful (50%) or highly useful (25%). Twelve per cent rated it as not useful and 12% were unsure.

Generally, there was concern about the lack of data collected on the cultural and linguistic diversity of patients, with *Country of birth* generally regarded as a necessary but insufficient element to measure cultural and linguistic diversity.

The ABS has identified a minimum recommended core set of cultural and language indicators comprising *Indigenous status*, *Main language other than English spoken at home*, *Country of birth* and *Proficiency in spoken English*.

Date of birth

Eighty-eight per cent of respondents rated this data element as either important (6%) or highly important (81%), and 88% rated it as either useful (25%) or highly useful (63%). Twelve per cent were unsure about its importance and usefulness.

Generally comments related to the need for clarification on how to report an unknown date of birth if only day is known, month is known, or year is known. There is no estimated date of birth flag in the NMDS at present to indicate which part(s) of the date was estimated.

Comments included that work underway by the AIHW to achieve consensus on how missing data are handled needs to be pursued.

Employment status—acute hospital and private psychiatric hospital admissions

Only 57% of respondents rated this data element as either important (31%) or highly important (25%), and only 31% rated it as either useful (19%) or highly useful (13%). Twenty-five per cent rated it as not important and 31% as not useful. Another 19% were unsure of its importance, and 38% of its usefulness.

There were a number of comments relating to this data element and to *Employment status – public psychiatric hospital admissions*. Many respondents expressed concern regarding the existence of two separate data elements to collect information on employment status. There was also general concern expressed that the data domains are not clearly defined or mutually exclusive and that the data are difficult to collect.

Another problem raised as an issue to be resolved is that there is no definition of 'employed' in the data element. The ABS classifies a person as employed if they work 1 hour or more a week for the calculation of the unemployment rate.

In addition, information under the collection method refers to the current or last occupation of the patient, which is not descriptive of the data domain.

It was indicated that local users rarely request information on employment status, and that it is already possible to examine relationships between socioeconomic status

and the use of mental health based services at the SLA level, using Census and local administrative data.

It was noted that the different data domains in *Employment status – acute hospital and private psychiatric hospital admissions* and *Employment status – public psychiatric hospital admissions* result in incomparable data collected using the two data elements and are causing confusion for data collectors.

Possible solutions to the problems discussed above involve forming a new 'merged' data element or deleting the two employment status data elements from the NMDS altogether. It was suggested that a merged data element could use the data domain from *Employment status – public psychiatric hospital admissions,* but incorporate a separate pension category. Further work would need to be done on clarifying the definition of employed for the purposes of this NMDS.

As a first step, it needs to be decided why employment status information is collected. Although employment status is often included with a range of other data elements to provide information on socioeconomic status, it was suggested that employment status on its own is not a good indicator of socioeconomic status. It was also noted that information on employment status is important to collect for use as a correlate for a range of other data elements and development of socioeconomic profiles of 'at risk' groups. However, if the purpose is to measure an aspect of functioning of the patient, then an alternative data element that better measures this concept may need to be developed.

It was also stated that the measurement of socioeconomic status of psychiatric patients is a highly complex and resource-intensive task. For this reason, measurement of concepts contributing to measurement of socioeconomic status may be better collected in a sample survey or limited-time in-depth study. For example, it could be collected on a sample basis at selected hospitals using the assistance of social workers.

The AIHW in the past has only requested data for one data element *Employment status.* The data domain from *Employment status – public psychiatric hospital admissions* has been used, but the scope has not been limited to public psychiatric hospitals.

Employment status—public psychiatric hospital admissions

Only 53% of respondents rated this data element as either important (33%) or highly important (20%), and 27% rated it as either useful (20%) or highly useful (7%). Thirteen per cent rated it as not important and 33% as not useful. Another 33% were unsure of its importance and 40% of its usefulness.

See previous data element for detailed comments.

Indigenous status

Eighty-eight per cent of respondents rated this data element as either important (13%) or highly important (75%), and 88% rated it as either useful (31%) or highly useful (56%). Thirteen per cent were unsure of its importance and usefulness.

One respondent indicated the need for a Declined/unable to respond category, to separately measure Declined/unable to respond from other reasons for which data are not available.

The AIHW has no information on whether *Indigenous status* is collected independently for each episode of care for mental health patients, or if it is recorded only once and then replicated for repeat admissions. Ideally, information should be collected at each admission.

In addition, the AIHW has no specific information on the quality of the Indigenous data collected in the APMHC NMDS. For quality information on data collected for the APC NMDS for 2002–03, see page 70.

The National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data has improvement of the quality of Indigenous identification in hospital morbidity data as part of its work program.

The AIHW, in collaboration with the National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data, is currently undertaking work aimed at improving the identification of Indigenous patients in admitted patient care data. The specific outcomes for this work are:

- description of the completeness of Indigenous identification in work undertaken to date
- outline of methods used by jurisdictions to improve identification, including examples of best practice and examples of those methods that have not worked
- development of analysis guidelines to support the consistent and appropriate analysis of *Indigenous status* in hospital morbidity data.

Marital status

Only 50% of respondents rated this data element as either important (44%) or highly important (6%), and only 44% rated it as either useful (31%) or highly useful (13%). Thirty-one per cent rated it as not important and 38% not useful. A further 19% were unsure about its importance and usefulness.

Many respondents questioned the importance and usefulness of the collection of marital status. It was noted that information on marital status is rarely requested at the local level. It was also stated that categories are not mutually exclusive, for example, a person can be divorced and currently married at the same time.

Some respondents questioned the use of marital status as a measure of the level of social support patients receive at home, as stated in the context of the data element. It was suggested as not being useful in this role, as a person's marital status does not necessarily reflect the level of support they receive. For example, a person who is married could have an invalid dependent spouse for whom they provide care but do not receive any in return. Marital status is also a mix of legal and social concepts, so the categories, even if defined better, will always mean different things to different users. The respondents who commented generally suggested that a new data element should be developed to collect the type of information that is actually required.

Another problem raised was the lack of apparent relevance of collection of these data to the provision of health care services, which makes this data element a candidate for review under privacy legislation.

However, it was also commented that information on marital status is important to collect for use as a correlate for a range of other data elements and for the development of socioeconomic profiles of 'at risk' groups. Comments included that marital status combined with other sociodemographic data is known to be a predictor of psychiatric service utilisation and has been used by numerous Australian and international studies, and that marital status is a proxy for social isolation/connectedness.

It was also suggested that the collection of the data element to measure the association of marital status with the need for and use of services, and for epidemiological analysis may be better met by in-depth short-term studies at selected sites.

Sex

Eighty-eight per cent of respondents rated this data element as either important (13%) or highly important (75%), and 94% rated it as either useful (19%) or highly useful (75%). Only 6% rated it as not important. A further 6% were unsure about its importance and usefulness.

No comments were received on this data element.

Length of stay data elements

Admission date

Eighty-eight per cent of respondents rated this data element as either important (13%) or highly important (75%), and 88% rated it as either useful (19%) or highly useful (69%). Thirteen per cent were unsure about its importance and usefulness.

Comments on this data element referred to the addition of admission time to the NMDS. This has been proposed as an effective method of monitoring the use of the data element concepts *Overnight stay patient* and *Same-day patient* and would allow more accurate measures of length of stay.

It was also recommended in the evaluation of the APC NMDS that consideration be given to the addition of admission time to the APC NMDS.

Separation date

Ninety-four per cent of respondents rated this data element as either important (19%) or highly important (75%), and 94% rated it as either useful (19%) or highly useful (75%). Six per cent were unsure about its importance and usefulness.

Similar to *Admission date*, comments on this data element referred to the addition of separation time to the NMDS. This has been proposed as an effective method of

monitoring the use of the data element concepts *Overnight stay patient* and *Same-day patient* and would allow more accurate measures of length of stay.

It was also recommended in the evaluation of the APC NMDS that consideration be given to the addition of separation time to the APC NMDS.

Total leave days

Eighty-eight per cent of respondents rated this data element as either important (31%) or highly important (56%), and 81% rated it as either useful (25%) or highly useful (56%). Another 13% were unsure of its importance and 19% of its usefulness.

Comments were made on the need for clarity and consistency in leave day rules, particularly in relation to involuntary patients who cannot be separated or discharged for legal reasons. There was also a proposal to redefine the concept to total leave nights and to not record absences during the day.

In the evaluation of the APC NMDS, it was recommended that this data element be changed to total leave hours. This change could be accompanied by the introduction of data elements for time of admission and time of separation, to allow yet more accurate measurement of length of stay in hours. In general, there were concerns about the difficulties in implementing this approach for mental health patients and the usefulness of doing so.

Total psychiatric care days

Eighty-one per cent of respondents rated this data element as either important (6%) or highly important (75%), and 81% rated it as either useful (6%) or highly useful (75%). Another 19% were unsure of its importance and usefulness.

Some respondents indicated difficulty in collecting this data element and concern regarding the accuracy of data currently collected.

The recording psychiatric care in hours was suggested. However, given the high proportions of respondents reporting high levels of usefulness and importance of this data element it was considered that it should be retained in its current form.

Clinical and related data elements and data element concepts

Diagnosis

Seventy-five per cent of respondents rated this data element concept as either important (13%) or highly important (63%), and 75% rated it as either useful (19%) or highly useful (56%). Another 25% were unsure of its importance and 19% of its usefulness.

There were no comments from respondents in relation to this data element concept.

Additional diagnosis

Ninety-four per cent of respondents rated this data element as highly important, and 94% rated it as either useful (6%) or highly useful (88%). Another 6% were unsure of its importance and usefulness.

It was noted that *Additional diagnosis* is useful to signify additional complexity in the episode of care.

There were also comments that the quality of additional diagnosis data should be assessed to ensure that its usefulness was not compromised.

Care type

Eighty-eight per cent of respondents rated this data element as either important (31%) or highly important (56%), and 75% rated it as either useful (31%) or highly useful (44%). Six per cent did not think the data element was important and 13% not useful. Another 6% were unsure of its importance and 13% were unsure of its usefulness.

Many respondents were concerned about the appropriateness of the data domain as it is currently designed for mental health. They commented that the current code set is acute-hospital care orientated and does not take into account the type of care provided to many psychiatric patients, particularly long-stay rehabilitation patients and psychogeriatric patients.

The separation of psychogeriatric care as a separate category from acute care was considered problematic, as psychogeriatric care may also be acute care. The data domain does not allow this to be recognised and has possibly contributed to (or reinforced) existing conceptualisations that mental health care to the elderly ('psychogeriatric') is subacute. It was commented that, although usually having a longer length of stay, the older patient requiring mental health hospitalisation often has multiple active comorbidities and requires an acute level of care. Similarly, older patients with mental health problems may require other types of care, for example, rehabilitation.

It was suggested that mental health should perhaps have its own specific set of care types that do not overlap the non-mental health care types.

The recommendation of the DoHA is to replace *Care type* with separate data elements that distinguish clinical intent from type of service. Clinical intent would be the basis for separating acute from subacute episodes. Such an approach has the following advantages from the mental health services perspective:

1. It would provide a basis for consistency with the service type classification that has been implemented within the National Survey of Mental Health Services since 1994, and which is in the Mental Health Establishments National Minimum Data Set. This classification distinguishes services on the basis of main program type (acute, other) and target population (child and adolescent, older persons, forensic, general).

2. It would allow scope for a fuller elaboration of the concept of clinical intent. For example, there is value in distinguishing intensive psychiatric care as a subcategory of 'acute'.

In the evaluation of the APC NMDS it was recommended that *Care type* be comprehensively reviewed with input by clinicians. The limitations of this data element for psychiatric care were particularly noted. A number of new data domains including Psychiatric care and Acute psychiatric care were suggested, as was splitting the data element into two—one for clinical intent and the other for 'service type'.

Care type is currently being reviewed as part of the APC NMDS data development work program of the AIHW.

Diagnosis Related Group

Eighty-one per cent of respondents rated this data element as either important (19%) or highly important (63%), and 75% rated it as either useful (13%) or highly useful (63%). Only 6% did not think the data element was important and 13% not useful. Another 13% were unsure of its importance and usefulness.

No comments were received on this data element.

Principal diagnosis

Ninety-four per cent of respondents rated this data element as either important (6%) or highly important (88%), and 94% rated it as either useful (13%) or highly useful (81%). Another 6% were unsure of its importance and usefulness.

There were no detailed comments received on this data element.

Major Diagnostic Category

Ninety-four per cent of respondents rated this data element as either important (38%) or highly important (56%), and 88% rated it as either useful (38%) or highly useful (50%). Another 6% were unsure of its importance and 13% of its usefulness.

No comments were received on this data element.

Continuity of care data elements

The group of data elements that relate to continuity of care are those relating to care prior to admission: *Previous specialised treatment, Source of referral to public psychiatric hospital, Type of accommodation* and *Type of usual accommodation;* and those relating to care following separation: *Mode of separation* and *Referral to further care*.

Previous specialised treatment

Only 44% of respondents rated this data element as either important (13%) or highly important (31%), and only 50% rated it as either useful (13%) or highly useful (38%).

Nineteen per cent did not think the data element was important and 13% not useful. Another 38% were unsure of its importance and usefulness.

The original purpose of this data element for the NMDS was to assess continuity of care, that is, whether a patient has received similar treatment in the past or is known to the health service, or has been admitted for specialised mental health care for the first time.

Several respondents were unsure as to how well the data element is being collected or how often it is being used.

It was commented that since its introduction, this item has had little attention in terms of analysis and reporting. However, its importance has increased as it is fundamental to the 'New Client Index' indicator included in the recently agreed the recently agreed *Key Performance Indicators for Australian Public Mental Health Services* (DoHA 2005). A new patient is thought to be more resource-intensive than patients who have previously received admitted care, community care or both.

It was suggested that the definition and data domain for this data element require review to make clear that specialised mental health service contacts are included in scope. It was stated that staff don't understand 'service contact' as a concept and it is difficult for them to explain this concept to a mental health patient. More explanation may be required in the guide for use.

The *Mental health service contact* data element concept was endorsed by the National Health Information Group in December 2004 for inclusion in the NMDS for Community Mental Health Care from 1 July. This new data element concept replaced the previous *Service contact* data element concept and provided clarification of the definition, context and guide for use to improve consistency in data collected across states and territories and more accurately reflect clinical practice. Hence, the *Previous specialised treatment* data element should be revised to reflect that new data element.

The question of 'how recent is relevant' was raised. At present, the guide for use refers to previous hospital admission(s) and/or service contact(s) at any time in the past. It was suggested that this data element should have further definition of periodicity to improve its usefulness. Its appropriateness should also be reviewed, given that it is currently described generically rather than being specific to mental health care, and this review should consider whether it or a new data element is required to capture the intent of the 'New Client Index' indicator.

Source of referral to public psychiatric hospital

Seventy-five per cent of respondents rated this data element as either important (33%) or highly important (33%), and 75% rated it as either useful (40%) or highly useful (27%). Seven per cent did not think the data element was important or useful. Another 27% were unsure of its importance and usefulness.

Comments included that the value of this data element is limited due to its restriction to public psychiatric hospitals, and also that it is unlikely that redefinition of the data element to meet the generic needs of the overall admitted patient collection will provide reliable and useful data. It should therefore be removed from the NMDS. However, it was recommended in the evaluation of the APC NMDS that the

feasibility of expanding this data element for collection in all public hospitals is investigated.

It was also suggested to combine *Source of referral to public psychiatric hospital* with *Mode of admission*. Some respondents commented that work on the data domain is needed. One suggestion was that the data domain should include 'Other public hospital', and perhaps 'Residential aged care facility'. 'Other health care establishment' is quite vague and it is probably better to be specific rather than general.

New South Wales commented that they cannot apply one classification to public psychiatric hospitals and another to other public hospitals as they share the same patient administration system.

Type of accommodation

Sixty-nine per cent of respondents rated this data element as either important (38%) or highly important (31%), and 56% rated it as either useful (38%) or highly useful (19%). Thirteen per cent rated it as not important and 19% as not useful. Another 19% were unsure of its importance and 25% of its usefulness.

Similar to the employment status data elements, several respondents indicated concern over the existence of two separate data elements collecting information on accommodation status. A number of respondents suggested merging *Type of accommodation* with *Type of usual accommodation*. There was also support for using the data domain from *Type of accommodation* for the new merged data element, as it is the most useable.

It was commented that the continuing prominence of accommodation issues in mental health highlight the importance of retaining such an item in the NMDS. There are links with the issue of 'extended stay' patients (see below) and the availability of housing after separation from hospital. However, limited analysis of these data elements has been reported, making it difficult to comment on data quality.

Comments included that it was difficult to see the relevance of collecting information on accommodation status in a patient administration system. It may more logically sit with information held by a social worker, who works with the patient for transition back to the community and assesses the appropriateness of their accommodation. For this reason, the item may be better collected in a small sample survey or in an in-depth study over a short period of time, rather than for every separation.

Some noted that information on *Type of accommodation* and *Type of usual accommodation* was considered important to collect for use as a correlate for a range of other data elements and development of socioeconomic profiles of 'at risk' groups.

As with the employment status data elements and *Marital status*, a first step is to decide why accommodation data are collected in the NMDS. Once the purpose is clarified, the definition and data domains will require further work. Possible purposes include to measure post-discharge continuity of care, and access carer availability, develop socioeconomic profiles of at-risk groups, or to assess quality of care across the health care system.

The AIHW is currently undertaking data development work to capture information about 'extended stay' patients (that is, patients who had an extended stay in hospital after being ready for discharge), and the results may inform this work.

Type of usual accommodation

Only 56% of respondents who provided a rating for the importance of this data element rated it as either important (31%) or highly important (25%), and only 44% rated it as either useful (25%) or highly useful (19%). Twenty-five per cent rated it as not important and not useful. A further 19% were unsure about its importance and 31% about its usefulness.

See previous data element for detailed comments.

Mode of separation

Ninety-four per cent of respondents rated this data element as either important (63%) or highly important (31%), and 88% rated it as either useful (63%) or highly useful (25%). Another 6% were unsure of its importance and 13% of its usefulness.

It was noted that this data element is currently a combination of non-mutually exclusive codes that describe patient destination or patient status. Consideration should be given to *Referral to further care* during any development of *Mode of separation* to ensure the data elements can be used together (that is, compatibility between codes, definitions and guides for use).

Work is continuing by the AIHW to refine this data element. The proposed approach involves separating the mode and destination.

Referral to further care (psychiatric patients)

Seventy-five per cent of respondents rated this data element as either important (25%) or highly important (50%), and 63% rated it as either useful (25%) or highly useful (38%). Six per cent did not think the data element was important or useful. Another 19% were unsure of its importance and 31% of its usefulness.

It was commented that this data element, developed in 1989, has the important objective of gathering information about post-discharge continuity of care and referral pathways, but has not been subject to a detailed analysis. Comments also included that the data domain is outdated and requires review.

Respondents also commented that a patient may be referred to several different services after separation. Acknowledgment of this is required in the data element, along with rules clarifying what should take precedence if multiple referrals occur.

It was also suggested that the data domains covering both mental health and drug and alcohol facilities should be split. These can be quite different services, and the category label is far too long to display in a drop-down menu in a patient administration system. It was noted that there is sometimes confusion at the point of collection between *Referral to further care (psychiatric patients)* and *Source of referral to public psychiatric hospital*.

Respondents also commented on the overlap between *Referral to further care (psychiatric patients)* and *Mode of separation.* For example, discharge/transfers to acute hospitals are collected in both data elements. This needs to be considered in any redevelopment so as to not duplicate what is being collected between two data items.

Administrative data elements

Mental health legal status

Eighty-eight per cent of respondents rated this data element as either important (19%) or highly important (69%), and 81% rated it as either useful (19%) or highly useful (63%). Six per cent did not think the data element was important and 13% not useful. Another 6% were unsure of its importance and usefulness.

New South Wales commented that patients can be involuntary and not admitted to designated psychiatric units because there are more patients than designated beds. They suggested that consideration should be given to whether this data element should be included in the APMHC NMDS or the APC NMDS, where it would be used to identify involuntary patients who are not receiving specialised psychiatric care.

For the APC NMDS data for 2002-03, South Australia reported 2,123 separations in the public sector with a *Mental health legal status* of involuntary and no psychiatric care days.

The recommendation arising from the evaluation of the APC NMDS was that *Mental health legal status* be deleted from the APC NMDS and retained in the APMHC NMDS. A reversal of this recommendation may need to be considered.

Person identifier

Seventy-five per cent of respondents rated this data element as either important (13%) or highly important (63%), and 69% rated it as either useful (25%) or highly useful (44%). Nineteen per cent did not think the data element was important or useful. Another 6% were unsure of its importance and 13% of its usefulness.

It was noted that *Person identifier* is only useful in longitudinal studies, and then only within the context of the treatment provided at a single hospital (except if a single jurisdiction-wide patient identifier is introduced).

It was commented that lack of compliance by several jurisdictions limits the utility of this key item and that this should be given prominence in this evaluation. It has been expected that, for public specialised mental health services, *Person identifiers* would correspond with clients of area-based specialised mental health services that integrate admitted, ambulatory and residential care.

It is anticipated that this data element will be useful for data linkage across the NHMD, the National Community Mental Health Care Database, the National Residential Mental Health Care Database and the National Outcomes and Casemix Collection Database, to assess service utilisation and outcomes for mental health

patients. The extent to which *Person identifiers* match across these data collections requires investigation.

For more information on this data element as provided for 2002–03, see page 81.

Data element concepts

Acute care episode for admitted patient

Seventy-five per cent of respondents rated this data element concept as either important (25%) or highly important (50%), and 63% rated it as either useful (31%) or highly useful (31%). Thirteen per cent did not think the data element concept was important and 19% not useful. Another 13% were unsure of its importance and 19% of its usefulness.

Several respondents suggested that this data element concept is covered by *Care type* and should be deleted. The recommendation arising from the evaluation of the APC NMDS was that this data element concept be reconsidered with *Care type*. Data development work on *Care type* is currently being undertaken as part of the APC NMDS data development work program.

Admission

Seventy-five per cent of respondents rated this data element concept as either important (19%) or highly important (56%), and 69% rated it as either useful (19%) or highly useful (50%). Only 6% did not think the data element concept was important or useful. Another 19% were unsure of its importance and 25% of its usefulness.

Respondents indicated general concern about this data element concept. They acknowledged its importance but agreed that work needs to be done on the distinction between 'admitted' and 'non-admitted', and that rules need to be standardised and applied consistently across Australia for data comparisons to have real meaning.

The DoHA noted that the admission concept is critical but, as currently defined, only recognises admitted patient care. They commented that, within the mental health sector, 'admission' to non-admitted patient care (that is, commencement of an episode of non-admitted patient care) is substantially more frequent and needs to be incorporated in future revisions of the NHDD. The DoHA suggested that this data element concept be retitled 'Admission to Admitted Patient Care', to be consistent with the recent revision of the *Episode of care* data element concept.

The DoHA discussed the inclusion of same-day admissions within the admitted patient data and the particular problem this creates for the mental health field. They commented that same-day separations usually have a different meaning in mental health than in general health. In the latter case, there are procedural events associated with such admissions which are detailed in the data element *Same-day patient*. Based on those criteria, the DoHA noted that most same-day admissions in mental health do not meet the definition of a same-day patient.

The DoHA noted that many same-day separations are better considered as a series of treatment events occurring during a period of ambulatory care. Typically, they involve daily attendance by patients at a variety of day and group-based programs that could otherwise be provided in community settings. The continued inclusion of same-day patients within the admitted patient mental health data may misrepresent the nature of the care actually involved.

This issue has been acknowledged in the AIHW report *Mental Health Services in Australia 2001–02* (AIHW 2004b) where same-day separations considered to be ambulatory-equivalent care were reported separately for the first time. The DoHA commented that this new approach to reporting is a major advance over previous reports but it needs to be recognised that such approaches do not deal with the fundamental problem.

The solution offered by the DoHA to the problem of same-day patients in the mental health data is twofold:

1. Better definition and agreement within the mental health service industry regarding the events that should be classed as genuine same-day separations
2. A clear distinction between intended same-day patients from those who were discharged on the same day when the original intent was an overnight admission. The introduction in 2001 of the data element *Intended length of hospital stay* within the APC NMDS provided the potential for this, but full compliance has not been reached. Work needs to be done to promote the full implementation of this data element by the mental health sector.

The DoHA commented that *Intended length of hospital stay* was recommended for removal from the APC NMDS following the 2004 evaluation, pending consultation with the mental health sector. The DoHA recommended that, although the data element has had poor compliance to date, it is retained as it provides the means to address problems that arise for the sector as a result of the inclusion of same-day patients within the admitted patient collection.

The AIHW suggested that same-day separations considered to be ambulatory-equivalent care continue to be reported separately in the *Mental Health Services in Australia* reports.

The AIHW notes that variations in admission practices affect other types of health care and not just mental health. For example, chemotherapy is undertaken on an admitted basis in some state and territories and on a non-admitted basis in others. It is currently undertaking work for the HDSC to document admission practices and policies comprehensively and to propose greater standardisation.

It was noted that in the context of a co-located specialist mental health acute care admitted patient unit/ward, admission may frequently be via other, general wards. The definition may need to include a concept of an 'administrative' admission due to action to transfer patients between wards/units within multi-unit facilities. However, this could also be addressed through consideration of the types of triggers used for statistical separation, and in the related consideration of the *Care type* data element.

The recommendation arising from the evaluation of the APC NMDS in relation to mental health-related care was that some types of mental health admitted patient care be regarded as non-admitted, particularly non-procedural same-day admissions that had not been intended to be overnight admissions. It was suggested that the issue be resolved through revision of the data element concept, or the use of a data analysis solution.

Admitted patient

Eighty-one per cent of respondents rated this data element concept as either important (13%) or highly important (69%), and 75% rated it as either useful (19%) or highly useful (56%). Only 6% did not think the data element concept was important or useful. Another 13% were unsure of its importance and 19% of its usefulness.

Similar to the comments for *Admission*, it was suggested that one of the major areas of work required for the NMDS is to define more consistently and accurately the boundaries between admitted overnight, same-day and non-admitted care, including in relation to hospital-in-the-home care.

It was suggested that within the mental health sector, patients treated in the home environment are best not described as 'admitted patients' as currently defined, as they may fall within the category of ambulatory care.

The DoHA suggested that this element be retitled 'Admitted Hospital Patient', reflecting the use of the term 'admission' for non-admitted care in the mental health sector.

Episode of admitted patient care

Seventy-five per cent of respondents rated this data element concept as either important (13%) or highly important (63%), and 75% rated it as either useful (13%) or highly useful (63%). Another 25% were unsure of its importance and usefulness.

The DoHA noted that the concept *Episode of care* was recently redefined as *Episode of admitted patient care* to accommodate other episode types, for example, episodes of residential care. They acknowledged this to be a positive development and consistent with recommendations submitted by the National Mental Health Working Group's Information Strategy Committee to the evaluation of the APC NMDS.

The DoHA commented that improvement in the utility of *Episode of admitted patient care* will rest upon redefining the *Care type* definition, given that, under current arrangements, a change of care type precipitates a new episode.

The recommendation arising from the evaluation of the APC NMDS was that the concept of an episode of care be reviewed along with the data element *Care type*.

It was also recommended that consideration be given to amending the APC NMDS data collection arrangements to change the statistical unit for longer term care, for selected analysis applications. This 'long stay' issue derives from the separation-based definition of the NMDS. A significant proportion of patient care in designated mental health units (and for extended stay or nursing home type patients) is longer term care which remains invisible to the current NMDS approach. Acknowledging

that the scope would be difficult to define in many cases, it was suggested that the concept of a 'statistical separation' should be extended to accommodate these groups of patients whereby a NMDS record of the ordinary kind is generated, but is separately identified. This approach has recently been adopted for the Residential Health Care National Minimum Data Set.

Hospital

Seventy-five per cent of respondents rated this data element concept as either important (25%) or highly important (50%), and 69% rated it as either useful (25%) or highly useful (44%). Another 25% were unsure of its importance and 31% of its usefulness.

It was noted that the concept of a 'hospital' is continually changing in reality, as new methods of service delivery emerge.

The DoHA commented that the current definition, by its acceptance of multi-campus reporting under a single hospital, allows considerable imprecision in identifying specific hospitals. It is inconsistent with the approach taken to hospital reporting under the National Survey of Mental Health Services, where separate campuses are reported as discrete hospital entities. Additionally, the current approach allows public psychiatric hospitals managed by 'parent' public acute hospital to be reported as part of the public acute hospital.

See comments under *Establishment identifier* above.

Work to develop *Establishment type* is continuing by the HDSC and with the APC NMDS data development work program of the AIHW.

Patient

Seventy–five per cent of respondents rated this data element concept as either important (19%) or highly important (56%), and 75% rated it as either useful (25%) or highly useful (50%). Another 25% were unsure of its importance and usefulness.

It was commented that boarders should be separately classified from patients in the NMDS. The issue of clarifying the scope of the APC NMDS in relation to boarders was also raised in the evaluation of the APC NMDS.

Separation

Eighty-one per cent of respondents rated this data element concept as either important (19%) or highly important (63%), and 81% rated it as either useful (13%) or highly useful (69%). Another 19% were unsure of its importance and usefulness.

No comments were received on this data element concept.

See comments under *Episode of admitted patient care* above.

Proposed new data elements

There were some concerns raised by respondents about the idea of introducing new data elements (or modifying existing data elements) into the NMDS. A business case is required for changes to NMDSs.

Despite the concerns raised by a number of respondents, a number of new data elements (or suites of data elements) were suggested.

Consultation–liaison

Some respondents suggested the need for information on consultation–liaison services provided, for example, to people with psychiatric comorbidity and physical disorders.

Language spoken and Need for an interpreter

It was suggested that it would be useful to have data elements to capture language spoken at home/preferred language and the need for an interpreter. The need for an interpreter could be organised with the categories 'no', 'occasionally', 'usually', 'always'; or 'no', 'for complex information', 'for most communication' and 'for all communication' (rather than yes/no).

It was indicated that such items would be valuable in analysing the resources required to deliver mental health services within a multicultural environment, and to assess the effectiveness of mental health services in delivering care within this environment. Information on need for interpreters was noted as also relating to access to services. It was also considered useful to have information on whether an interpreter was used. The broader issue of cultural and linguistic diversity is discussed on page 104 under *Country of birth*.

Carer availability

It was suggested that a data element for carer availability could allow the analysis of carer availability in relation to discharge destination and length of stay. It would provide information on the level of support available to the patient when leaving hospital. This item could be considered together with other relevant data elements such as *Marital status* and *Type of accommodation*.

Procedure

This data element is currently being collected for the APC NMDS and recommended for inclusion in the APMHC NMDS, if the latter continues to be defined to overlap with the APC NMDS.

See also 'Intervention classification for mental health', page 13.

Appendix 1: Data elements that constitute the NMDS for Admitted Patient Mental Health Care and the NMDS for Admitted Patient Care

Table A1: Data elements that constitute the Admitted Patient Care NMDS and Admitted Patient Mental Health Care NMDS, 2004–05

Admitted Patient Mental Health Care NMDS	Admitted Patient Care NMDS	METeOR Identifier
Establishment data elements	**Establishment data elements**	
Establishment identifier	NOT INCLUDED	269973
Australian state and territory identifier	Australian state and territory identifier	269941
Establishment sector	Establishment sector	269977
Region code	NOT INCLUDED	269940
Establishment number	Establishment number	269975
Demographic data elements	**Demographic data elements**	
Area of usual residence	Area of usual residence	270070
Country of birth	Country of birth	270277
Date of birth	Date of birth	287007
Employment status—acute hospital and private psychiatric hospital admissions	NOT INCLUDED	269948
Employment status—public psychiatric hospital admissions	NOT INCLUDED	269955
Indigenous status	Indigenous status	291036
Marital status	NOT INCLUDED	291045
Sex	Sex	287316
Type of accommodation	NOT INCLUDED	270079
Type of usual accommodation	NOT INCLUDED	270088
Length of stay data elements	**Length of stay data elements**	
Admission date	Admission date	269967
NOT INCLUDED	Number of days of hospital in the home care	270305
NOT INCLUDED	Number of leave periods	269097
NOT INCLUDED	Number of qualified days for newborns	270033
Separation date	Separation date	270025
Total leave days	Total leave days	270251
Total psychiatric care days	Total psychiatric care days	270300
Clinical data elements	**Clinical data elements**	
NOT INCLUDED	Activity when injured	268950
Additional diagnosis	Additional diagnosis	270189
Care type	Care type	270174
Diagnosis related group	Diagnosis related group	270195

Admitted Patient Mental Health Care NMDS	Admitted Patient Care NMDS	METeOR Identifier
NOT INCLUDED	External cause–admitted patient	268945
NOT INCLUDED	Infant weight, neonate, stillborn	269938
NOT INCLUDED	Intended length of stay	270399
Major diagnostic category	Major diagnostic category	270400
NOT INCLUDED	Place of occurrence of external cause of injury	268948
Previous specialised treatment	NOT INCLUDED	270374
Principal diagnosis	Principal diagnosis	270187
NOT INCLUDED	Procedure	269932
Administrative data elements	**Administrative data elements**	
NOT INCLUDED	Admitted patient election status	270044
NOT INCLUDED	Funding source for hospital patient	270103
NOT INCLUDED	Hospital insurance status	270253
NOT INCLUDED	Intended length of hospital stay	270399
NOT INCLUDED	Inter-hospital contracted patient	270409
NOT INCLUDED	Medicare eligibility status	270093
NOT INCLUDED	Mode of admission	269976
Mode of separation	Mode of separation	270094
Mental health legal status	Mental health legal status	270351
Person identifier	Person identifier	290046
Referral to further care (psychiatric patients)	NOT INCLUDED	269990
Source of referral to public psychiatric hospital	Source of referral to public psychiatric hospital	269947
NOT INCLUDED	Urgency of admission	269986
Data element concepts	**Data element concepts**	
Acute care episode for admitted patients	Acute care episode for admitted patients	Glossary item
Admission	Admission	Glossary item
Admitted patient	Admitted patient	268957
Australian state and territory identifier	Australian state and territory identifier	269461
Diagnosis	Diagnosis	Glossary item
Episode of admitted patient care	Episode of admitted patient care	268956
Hospital	Hospital	268971
NOT INCLUDED	Hospital boarder	Glossary item
NOT INCLUDED	Hospital in the home care	Glossary item
NOT INCLUDED	Live birth	Glossary item
NOT INCLUDED	Neonate	Glossary item
NOT INCLUDED	Newborn qualification status	Glossary item
Patient	Patient	268959
NOT INCLUDED	Same-day patient	Glossary item
Separation	Separation	Glossary item

Appendix 2: Survey of users and data collectors for the evaluation of the National Minimum Data Set for Admitted Patient Mental Health Care

Survey of users and data collectors of the National Minimum Data Set for Admitted Patient Mental Health Care

Australian Government
Australian Institute of Health and Welfare

Contact details

The Australian Institute of Health and Welfare is interested in obtaining contact details for any follow-up queries and to gain an understanding of the types of organisations using the NMDS specifications and NMDS-based data. This information will also help us interpret responses to the more specific questions that follow.

Please note that the identifying details provided will NOT be used for any purpose other than that specified in the explanatory notes, nor will any individual be identified in the analysis and reporting of results.

Name:_____

Position/job title: _____

Unit/section:_____

Organisation:_____

Address:_____

City/town: _____**State:** _____ **Postcode:**_____

Telephone: _____ **Fax:** _____

E-mail address: _____

Date this survey was completed: _____

For whom are you responding? Please indicate (X) all that apply.

Respondent	[X]
On behalf of yourself	[ ]
On behalf of your unit or section within an organisation	[ ]
On behalf of your organisation	[ ]

1. Users of the NMDS specifications and NMDS-based data

The Australian Institute of Health and Welfare is interested in gaining an understanding of the types of organisations who use the NMDS specifications and NMDS-based data. For the purposes of this survey, a user is defined as any person who uses the NMDS specifications to either collect or to access and analyse NMDS-based data. In order for us to develop an understanding of who the main user groups are, please indicate the main user group to which you belong. This information will also help us interpret responses to the more specific questions that follow.

1.1. Please indicate (X) the main user group to which you belong.

User group	[X]
State or territory health authority	[ ]
Other state or territory government department	[ ]
Australian Government Department of Health and Ageing	[ ]
Other Australian government department	[ ]
Australian Institute of Health and Welfare	[ ]
Public hospital	[ ]
Private hospital	[ ]
Other health service provider	[ ]
University or other research organisation	[ ]
Private planning consultant	[ ]
Clinical equipment/therapeutic device company	[ ]
Pharmaceutical company	[ ]
Software developer	[ ]
Interest group	[ ]
Student	[ ]
Other	[ ]
Please specify _____	

2. Use of the NMDS specifications and NMDS-based data

The Australian Institute of Health and Welfare is interested in obtaining information about the way the NMDS specifications and NMDS-based data is currently being used. This section includes questions on the purpose for which you use the NMDS specifications or NMDS-based data, how you access NMDS specifications and NMDS-based data, your overall knowledge of the NMDS specifications and NMDS-based data, and your frequency of use. This information will also help us interpret responses to the more specific questions that follow.

2.1. For what purpose do you use the NMDS specifications and the NMDS-based data? Rate the three most common purposes, where 1 is the most common and 3 is the least common.

Purpose	[1, 2, 3]
Planning and monitoring hospital resources	[ ]
Comparisons and benchmarking	[ ]
Management and purchasing of hospital services	[ ]
Health services research	[ ]
Epidemiological research (e.g. population health research)	[ ]
Statistical reporting	[ ]
Facility planning	[ ]
Planning by private industry suppliers of therapeutic devices and other hospital equipment or pharmaceuticals	[ ]
Collection and reporting of NMDS-based data	[ ]
Casemix and classification development	[ ]
Software development	[ ]
Other	[ ]
Please specify _____	

2.2. Please indicate (X) at which level you use the data.

Level	[X]
Data for one hospital only	[ ]
Data for hospital group (within state and territory or national)	[ ]
Data for state or territory	[ ]
National	[ ]
International	[ ]

2.3. Please provide more detail about the purpose(s) for which you use the NMDS specifications or NMDS-based data (optional).

Example: Investigation of the pattern of separations with specialised psychiatric care and a principal diagnosis of Schizophrenia, for planning purposes.

2.4. Please rate the three most common sources you use to access the NMDS specifications, where 1 is the most common and 3 is the least common.

Source	[1, 2, 3]
National Health Data Dictionary publication	[ ]
National Health Data Dictionary publication online	[ ]
The Knowledgebase	[ ]
State and territory data specifications	[ ]
Hospital-based data specifications	[ ]
Other (please specify) _____	[ ]
Not applicable, do not access	[ ]

2.5. Please rate the three most common sources of NMDS-based data you use, where 1 is the most common and 3 is the least common.

Source	[1, 2, 3]
AIHW Mental Health Services in Australia publications/internet tables	[ ]
AIHW Australian Hospital Statistics publications/internet tables	[ ]
Other AIHW publications	[ ]
AIHW National Hospital Morbidity Database unit record extract	[ ]
AIHW National Hospital Morbidity Database tabulated data (unpublished)	[ ]
AIHW National Hospital Morbidity Database online (COGNOS cubes)	[ ]
Hospital database	[ ]
State or territory hospital database	[ ]
State or territory publications	[ ]
Department of Health and Ageing National Hospital Morbidity (Casemix) Database	[ ]
Department of Health and Ageing National Hospital Cost Data Collection	[ ]
Department of Health and Ageing Hospital Casemix Protocol Data Collection	[ ]
Other (please specify) _____	[ ]
Not applicable, do not use	[ ]

2.6. Please rate (X) your overall knowledge of the NMDS specifications or the NMDS-based data.

Knowledge	NMDS specifications	NMDS-based data
Very familiar	[ ]	[ ]
Familiar	[ ]	[ ]
Unfamiliar	[ ]	[ ]

2.7. Please indicate (X) how often you use the NMDS specifications or the NMDS-based data.

Frequency	NMDS specifications	NMDS-based data
Daily	[ ]	[ ]
Weekly	[ ]	[ ]
Monthly	[ ]	[ ]
Occasionally	[ ]	[ ]
Never	[ ]	[ ]

3. Utility

As outlined in the explanatory notes, the main purpose of this survey is to gain an understanding of whether the NMDS is useful and whether it suits your current requirements. In this section, respondents are asked to rate the importance and usefulness of the NMDS overall and each individual data element, and to indicate which data elements should remain unchanged, which should be modified and which deleted. Please note, the data elements are as specified in the *National Health Data Dictionary* version 12 Supplement (AIHW 2004c).

3.1. Please indicate (X) the importance and usefulness of the NMDS overall and each individual data element and provide comments on whether you believe each data element should remain unchanged, be modified or deleted.

When assessing importance, think of how significant you believe the NMDS and each data element are to a national collection of data on admitted patient care. When assessing usefulness, keep in mind whether the NMDS and each data element suit your current requirements. If a data element is highly important and highly useful, it should probably remain unchanged. However, if a data element is highly important, but not useful, it may be a function of the way it is defined, in which case it probably needs to be modified.

Within your comments please indicate why a data element should be modified or deleted and describe the proposed modifications, for example, changes to the name, definition, data domains or other aspects.

Please provide any other comments that will assist in the interpretation of your response.

Data element	Importance				Usefulness			
	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
NMDS for Admitted Patient Mental Health Care	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								

Data element	Importance				Usefulness			
	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
Establishment data elements								
Establishment identifier	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Establishment number	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Establishment sector	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Region code	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Australian State and territory identifier	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Demographic data elements								
Area of usual residence	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Country of birth	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Date of birth	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								

Data element	Importance				Usefulness			
	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
Employment status — acute hospital and private psychiatric hospital admissions	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Employment status — public psychiatric hospital admissions	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Indigenous status	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Marital status	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Sex	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Type of accommodation	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Type of usual accommodation	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Length of stay data elements								
Admission date	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								

Data element	Importance				Usefulness			
	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
Separation date	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Total leave days	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Total psychiatric care days	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Clinical and related data elements								
Additional diagnosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Care type	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Diagnosis Related Group	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Major Diagnostic Category	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Previous specialised treatment	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								

Data element	Importance				Usefulness			
	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
Principal diagnosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Administrative data elements								
Mental health legal status	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Mode of separation	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Person identifier	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Referral to further care (psychiatric patients)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Source of referral to public psychiatric hospital	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Data element concepts								
Acute care episode for admitted patients	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								

Data element	Importance				Usefulness			
	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
Data element concepts								
Admission	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Admitted patient	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Diagnosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Episode of care	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Hospital	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Patient	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								
Separation	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Comments:								

4. Areas for development

The Australian Institute of Health and Welfare is interested in obtaining your views on possible areas for development of the NMDS, including new data elements which you feel would make the NMDS more useful, possible changes to the scope, or any other priorities for definitional development.

4.1. Are there any new data elements that should be included in the NMDS?

4.2. Do you have any comments on the scope of the NMDS?

4.3. What do you see as the priorities for definitional development (data elements, data element concepts, scope)?

4.4. Who should be consulted about any proposed data development?

5. Other comments

Please provide any additional views or comments you have which may assist the evaluation.

If you would like to provide more detail on any of the questions, please e-mail danielle.sellick@aihw.gov.au

Thank you for your time in completing this survey.

Appendix 3: Survey respondents

Australian, state or territory government

Child and Adolescent Health Service, Mental Health, Australian Capital Territory Department of Health and Community Care

Data Management Unit, South Australian Department of Health

Data Services Unit, Queensland Health

Health Data Collections, Western Australian Department of Health

Hospitals and Mental Health Services Unit, Australian Institute of Health and Welfare

Information Management and Support Unit, New South Wales Health Department

Information Services Branch, Australian Capital Territory Department of Health and Community Care

Mental Health Branch, Aged, Community and Mental Health Division, Department of Human Services, Victoria

Mental Health Program, Northern Territory Department of Health and Community Services

Mental Health Services Tasmania, Department of Health and Human Services, Tasmania

Performance Evaluation Branch, Office of Mental Health, Western Australian Department of Health

Quality and Effectiveness Section, Health Priorities and Suicide Prevention Branch, Australian Government Department of Health and Ageing

Strategic Planning and Integration Branch, South Australian Department of Health

Public or private hospitals or medical centres

Aged Care Mental Health, Division of Mental Health, Princess Alexandra Hospital, Woolloongabba, Queensland

Department of Psychiatry and Pain Management Unit, Flinders Medical Centre, Bedford Park, South Australia

Medical Records Department, St John of God Health Services, Burwood, New South Wales

Individuals responding for themselves only

Brendan Ludvigsen, Manager, Patient Data, Information Management and Support Unit, New South Wales Health Department

Paul Basso, Manager, Strategic Information, Health Information and Evaluation, South Australian Department of Health

Roderick McKay, Senior Staff Specialist/Director of Service, Aged Care Psychiatry, Braeside Hospital, Wetherill Park, New South Wales

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