Australian Government

Australian Institute of Health and Welfare

NATIONAL HEALTH DATA DICTIONARY

Version 14

2008

Australian Health Ministers' Advisory Council

Open dictionary

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NATIONAL HEALTH DATA DICTIONARY
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The Australian Institute of Health and Welfare is Australia's national health and welfare statistics and information agency. The Institute's mission is better information and statistics for better health and wellbeing.

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Quit

National Health Data Dictionary Version 14

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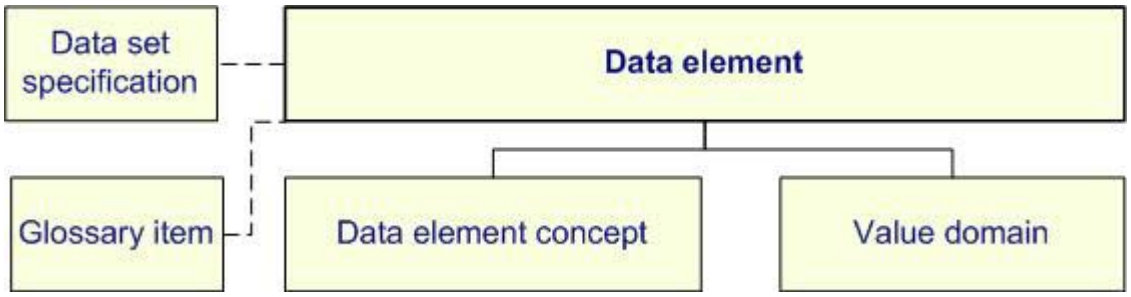
List of metadata items

Data Element Technical Names

Data Elements

A data element is the basic unit of identifiable and definable information created by combining a data element concept and a value domain. In METeOR, examples of data elements include Person—data of birth, DDMMYYY and Service provider organisation—Australian state/territory identifier, code N.

Below is a graphical representation of the relationship between data elements and related metadata item types.



Accrued mental health care days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—accrued mental health care days, total N[N(7)]
METeOR identifier:	286770
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of accrued mental health care days provided by admitted patient care services and residential mental health care services within the reference period (from 1 July to 30 June inclusive).
Data Element Concept:	Establishment—accrued mental health care days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(7)]
Maximum character length:	8
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The days to be counted are only those days occurring within the reference period, i.e. from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.

A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of accrued mental health care days:

- Admission and discharge on the same day is equal to one mental health care day.
- For a patient/resident admitted and discharged on different days all days are counted as mental health care days, except the day of discharge and any leave days.
- If the patient/resident remains in hospital or residential care facility from midnight to 2359 hours count as a mental health care day.
- The day a patient/resident goes on leave is not counted as a mental health care day, unless this was also the admission day.
- The day the patient/resident returns from leave is counted as a mental health care day, unless the patient/resident goes on leave again on the same day of return or is discharged.
- Leave days involving an overnight absence are not counted as mental health care days.
- If a patient/resident goes on leave the day they are

admitted and does not return from leave until the day they are discharged, count as one mental health care day.

- If the patient/resident remains in a hospital or residential care facility from 1 July to 30 June (the whole of the reference period) count as 365 days (or 366 days in a leap year).
- If the patient/resident remains in a hospital or residential care facility after the end of the reference period (i.e. after 30 June) do not count any days after the end of the reference period.

The following additional rules cover special circumstances and in such cases, override the basic rules:

When calculating accrued mental health care days for the reference period:

- Count the mental health care days of those patients/residents separated during the reference period. Exclude any days that may have occurred before the beginning of the reference period.
- Count the mental health care days of those patients/residents admitted during the reference period who did not separate until the following reference period. Exclude the days after the end of the reference period.
- For patients/residents admitted before the reference period and who remain in after the reference period (i.e. after 30 June), count the mental health care days within the reference period only. Exclude all days before and after the reference period.

Examples of mental health care day counting for a reference period 1 July 2004 to 30 June 2005:

Patient/resident A was admitted to hospital on 4 June 2004 and separated on 6 July 2004. If no leave or transfer occurred counting starts on 1 July. Count would be 5 days as day of discharge is not counted.

Patient/resident B was admitted to hospital on 1 August 2004 and separated on 8 August 2004. If no leave or transfer occurred counting starts on 1 August. Count would be 7 days as day of discharge is not counted.

Patient/resident C was admitted to hospital on 1 June 2005 and separated on 6 July 2005. If no leave or transfer occurred counting starts on 1 June. Count would be 30 days as patient/resident was not discharged on 30 June, so every day up to and including 30 June would be counted.

Patient/resident D was admitted to hospital on 1 August 2003 and has remained continuously in hospital to the present time. If no leave or transfer occurred counting starts on 1 July 2004 and concludes on 30 June 2005. Count would be 365 days as there is no day of discharge.

Collection methods:

To be reported for admitted patient care services, including services that are staffed for less than 24 hours, and non-government organisation services where included.

NOTE: These data need to be disaggregated by Specialised mental health service setting (excluding Ambulatory care settings). For admitted patient care settings these counts also need to be disaggregated by Specialised mental health service program type and Specialised mental health service target

population.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Activity and participation life area

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—activity and participation life area, code (ICF 2001) AN[NNN]
METeOR identifier:	320125
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The life area in which a person participates or undertakes activities, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—activity and participation life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNN]
Maximum character length:	5

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

The activities and participation codes are a neutral list that covers the full range of life areas in which a person can be involved. The domains can be used to record positive or neutral experience of functioning as well as limitations and restrictions.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Self care' (chapter level) and 'Looking after one's health' (3 digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with respective qualifiers (Activity difficulty level, Activity Need for assistance, Participation extent and Participation satisfaction level) will use the codes as indicated.

CODE d1	Learning and applying knowledge
CODE d2	General tasks and demands
CODE d3	Communication
CODE d4	Mobility
CODE d5	Self-care
CODE d6	Domestic life
CODE d7	Interpersonal interactions and relationships
CODE d8	Major life areas

CODE d9 Community, social and civic life

Data collected at this level will provide a general description of functioning for the person and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For specific more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values is listed in the **Activities** and **Participation** component of the ICF.

An example of a value domain at the 3 digit level from the Self-care chapter may include:

CODE d510 Washing oneself
CODE d520 Caring for body parts
CODE d530 Toileting
CODE d540 Dressing
CODE d550 Eating
CODE d560 Drinking
CODE d570 Looking after one's health

An example of value domains at the 4 digit level from the Mobility chapter may include:

CODE d4600 Moving around within the home
CODE d4601 Moving around within buildings other than home
CODE d4602 Moving around outside the home and other buildings
CODE d4701 Using private motorized transportation
CODE d4702 Using public motorized transportation

The prefix *d* denotes the domains within the component of *Activities and Participation*. At the user's discretion, the prefix *d* can be replaced by *a* or *p*, to denote activities or participation respectively.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item, in conjunction with Activity difficulty level code N, enables the provision of information about the presence and extent of activity limitation for any given life area; with Activity need for assistance code N, the provision of information about the need for assistance with the given life area.

The extent of, and level of satisfaction with, participation in a given area are indicated by the use of this metadata item with the qualifiers Participation extent code N and Participation satisfaction level code N.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—need for assistance with activities in a life area, code N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—level of difficulty with activities in life areas, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—extent of participation in a life area, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—level of satisfaction with participation in a life area, code N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Activities and Participation cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Activity when injured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—activity type, code (ICD-10-AM 6th edn) ANNNN
METeOR identifier:	361025
Registration status:	Health, Standard 05/02/2008
Definition:	The type of activity being undertaken by the person when injured, for admitted patients, as represented by a code.
Data Element Concept:	Injury event—activity type

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Use the appropriate External Causes of Morbidity and Mortality Activity codes from the current edition of ICD-10-AM.
Comments:	Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. This term is the basis for identifying work-related and sport-related injuries.

Source and reference attributes

Origin:	National Centre for Classification in Health National Injury Surveillance Unit

Relational attributes

Related metadata references:	Supersedes Injury event—activity type, code (ICD-10-AM 5th edn) ANNNN Health, Superseded 05/02/2008
Implementation in Data Set Specifications:	Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008 *Information specific to this data set:* To be used with ICD-10-AM external cause codes. Injury surveillance DSS Health, Standard 05/02/2008

Activity when injured (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—activity type, non-admitted patient code N[N]
METeOR identifier:	268942
Registration status:	Health, Standard 01/03/2005
Definition:	The type of activity undertaken by the non-admitted patient when injured, as represented by a code.
Data Element Concept:	Injury event—activity type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N[N]
Maximum character length:	2

Permissible values:

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

Collection and usage attributes

Guide for use:	To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of activity being undertaken by the person when injured, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin: National Centre for Classification in Health
National Injury Surveillance Unit

Relational attributes

Related metadata references: Supersedes Activity when injured, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.66 KB)

Implementation in Data Set Specifications:
Injury surveillance DSS Health, Superseded 05/02/2008
Injury surveillance DSS Health, Standard 05/02/2008
Injury surveillance NMDS Health, Superseded 03/05/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
Injury surveillance NMDS Health, Superseded 07/12/2005

Actual place of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—setting of birth (actual), code N
METeOR identifier:	269937
Registration status:	Health, Standard 01/03/2005
Definition:	The actual place where the birth occurred, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Birth event—setting of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other

Supplementary values:

9	Not stated

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

CODE 4 Home

Should be reserved for those births that occur at the home intended.

CODE 8 Other

Used when birth occurs at a home other than that intended. May also include a community health centre or be used for babies 'born before arrival'.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes Actual place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.01 KB)

Implementation in Data Set Specifications:

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

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

Acute coronary syndrome procedure type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome procedure type, code NN
METeOR identifier:	284660
Registration status:	Health, Standard 04/06/2004
Definition:	The type of procedure performed, that is pertinent to the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome procedure type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Coronary artery bypass graft (CABG)
02	Coronary stent (bare metal)
03	Coronary stent (drug eluding)
04	Angioplasty
05	Reperfusion fibrinolytic therapy
06	Reperfusion primary percutaneous coronary intervention (PCI)
07	Rescue angioplasty/stenting
08	Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities or for aortic aneurysm
09	Amputation for arterial vascular insufficiency
10	Diagnostic cardiac catheterisation/angiography
11	Blood transfusion
12	Insertion of pacemaker
13	Implantable cardiac defibrillator
14	Intra-aortic balloon pump (IABP)
15	Non-invasive ventilation (CPAP)
16	Invasive ventilation
17	Defibrillation
88	Other

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

More than one procedure can be recorded. Record all codes that apply.

Codes '88' and '99' in combination cannot be used in multiple entries.

When read in conjunction with Person—clinical procedure timing, code N, this metadata item provides information on the procedure(s) provided to a patient prior to or during admission.

When read in conjunction with Person—acute coronary syndrome risk stratum, code N, codes 01 to 10 of this metadata item provide information for risk stratification.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Steward:

The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Acute coronary syndrome procedure type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.64 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome stratum

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome risk stratum, code N
METeOR identifier:	284656
Registration status:	Health, Standard 04/06/2004
Definition:	Risk stratum of the patient presenting with clinical features consistent with an acute coronary syndrome defined by accompanying clinical, electrocardiogram (ECG) and biochemical features, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome risk stratum

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	with ST elevation (myocardial infarction)
	2	with non-ST elevation ACS with high-risk features
	3	with non-ST elevation ACS with intermediate-risk features
	4	with non-ST elevation ACS with low-risk features
Supplementary values:	9	Not reported

Collection and usage attributes

Guide for use:

CODE 1 With ST elevation (myocardial infarction)

This code is used where persistent ST elevation of >=1mm in two contiguous limb leads, or ST elevation of >=2mm in two contiguous chest leads, or with left bundle branch block (BBB) pattern on the ECG.

This classification is intended for identification of patients potentially eligible for reperfusion therapy, either pharmacologic or catheter-based. Other considerations such as the time to presentation and the clinical appropriateness of instituting reperfusion are not reflected in this metadata item.

CODE 2 With non-ST elevation ACS with high-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome (chest pain or overwhelming SOB) with high-risk features which include either:

- classical rise and fall of at least one cardiac biomarker (troponin or CK-MB),
- persistent or dynamic ECG changes of ST segment depression >= 0.5mm or new T wave inversion in three or

more contiguous leads,

- transient (= 0.5 mm) in more than 2 contiguous leads,
- haemodynamic compromise: Blood pressure 1, and/or new onset mitral regurgitation, and/or syncope, or
- presence of known diabetes without persistent ST elevation of > 1mm in two or more contiguous leads or new or presumed new bundle branch block (BBB) pattern on the initial ECG, i.e. not meeting the definition for ST elevation MI.

  This classification is intended for identification of patients potentially eligible for early invasive management and the use of intravenous glycoprotein IIb/IIIa inhibition.

CODE 3 With non-ST elevation ACS with intermediate-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome (chest pain or overwhelming SOB) with intermediate-risk features which include either:

- prolonged but resolved chest pain/discomfort at rest age greater than 65yrs,
- known coronary heart disease: prior MI, prior revascularisation, known coronary lesion > 50%,
- pathological Q waves or ECG changes of ST deviation nocturnal pain,
- two or more risk factors of known hypertension, family history, active smoking or hyperlipidaemia, or
- prior aspirin use and not meeting the definition for ST elevation MI or Non-ST elevation with high-risk features.

This classification is intended for identification of patients potentially eligible for admission and in-hospital investigation that may or may not include angiography.

CODE 4 With non-ST elevation ACS with low-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome (chest pain or overwhelming SOB) without features of ST elevation MI or Non-ST elevation ACS with intermediate or high-risk features.

This classification is intended for identification of patients potentially eligible for outpatient investigation.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Other clinical considerations influencing the decision to admit and investigate are not reflected in this metadata item. This metadata item is intended to simply provide a diagnostic classification at the time of, or within hours of clinical presentation.

Collection methods: Collected at time of presentation.

Only one code should be recorded.

Must be collected in conjunction with Person—acute coronary

syndrome procedure type, code NN and Person—clinical procedure timing, code N.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
Origin:	Management of Unstable Angina Guidelines - 2000, The National Heart Foundation of Australia, The Cardiac Society of Australia and New Zealand MJA, 173 (Supplement) S65-S88 Antman, MD; et al. The TIMI Risk Score for Unstable Angina/Non-ST Elevation MI JAMA. 2000; 284:835-842.

Relational attributes

Related metadata references:	Supersedes Acute coronary syndrome stratum, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.61 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Additional diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—additional diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	356587
Registration status:	Health, Standard 05/02/2008
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. Generally, external cause, place of occurrence and activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).
Collection methods:	An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care or the end of an episode of residential care. The additional diagnosis is derived from and must be substantiated by clinical documentation.
Comments:	Additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following: • Commencement, alteration or adjustment of therapeutic

treatment

- Diagnostic procedures
- Increased clinical care and/or monitoring

In accordance with the Australian Coding Standards, certain conditions that do not meet the above criteria may also be recorded as additional diagnoses.
Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patient to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

External cause codes, although not diagnosis of condition codes, should be sequenced together with the additional diagnosis codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Source and reference attributes

Origin: National Centre for Classification in Health

Relational attributes

Related metadata references: Supersedes Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Implementation in Data Set Specifications: Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Address line (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—address line, text [X(180)]
METeOR identifier:	286620
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A composite of one or more standard **address** components that describes a low level of geographical/physical description of a location, as represented by text. Used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode—Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a person.
Data Element Concept:	Person (address)—address line

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(180)]
Maximum character length:	180

Data element attributes

Collection and usage attributes

Guide for use:

A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:

- Suburb, town or locality
- Postcode—Australian or international
- State, Territory, local government area, electorate, statistical local area
- Postal delivery point identifier
- Countries, provinces, etc other than in Australia

These components of a complete address do not form part of the Address line.

When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:

- Building/complex sub-unit type
- Building/complex sub-unit number
- Building/property name
- Floor/level number
- Floor/level type
- House/property number

- Lot/section number
- Street name
- Street type code
- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line.

Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc.

The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format.

Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components.

Multiple Address lines may be recorded as required.

Collection methods:

The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is formed using Person (address)—street suffix, code A[A] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—street type, code A[AAA] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—street name, text [A(30)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—lot/section identifier, N[X(14)] Health, Standard 01/03/2005, Community services,

Standard 30/09/2005

Is formed using Person (address)—house/property identifier, text [X(12)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—floor/level type, code A[A] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—floor/level identifier, [NNNA] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—building/complex sub-unit type, code A[AAA] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—building/complex sub-unit identifier, [X(7)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—building/property name, text [X(30)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Supersedes Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Address line (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—address line, text [X(180)]
METeOR identifier:	290315
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A composite of one or more standard **address** components, as represented by text.
Data Element Concept:	Service provider organisation (address)—address line

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(180)]
Maximum character length:	180

Data element attributes

Collection and usage attributes

Guide for use:

A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:

- Suburb, town or locality
- Postcode
- Australian or international
- State, Territory, local government area, electorate, statistical local area
- Postal delivery point identifier
- Countries, provinces, etc. other than in Australia

These components of a complete address do not form part of the Address line.

When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:

- Building/complex sub-unit type
- Building/complex sub-unit number
- Building/property name
- Floor/level number
- Floor/level type
- House/property number
- Lot/section number
- Street name
- Street type code

- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line. Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc. The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format. Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components. Multiple Address lines may be recorded as required.

Collection methods:

The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is formed using Service provider organisation (address)—street suffix, code A[A] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—street type, code A[AAA] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—street name, text [A(30)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—lot/section identifier, N[X(14)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—house/property identifier, text [X(12)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—

	floor/level type, code A[A] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is formed using Service provider organisation (address) – floor/level identifier, [NNNA] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is formed using Service provider organisation (address) – building/complex sub-unit type, code A[AAA] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is formed using Service provider organisation (address) – building/complex sub-unit identifier, [X(7)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is formed using Service provider organisation (address) – building/property name, text [X(30)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Standard 04/07/2007

Address type (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—address type, code N
METeOR identifier:	286728
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A code set representing a type of address, as represented by a code.
Data Element Concept:	Person (address)—address type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Business
2	Mailing or postal
3	Residential
4	Temporary residential

Supplementary values:

9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Business

This code is used to indicate an address that is the physical location of a business, an office or from where a service is delivered.

CODE 2 Mailing or postal

This code is used to indicate an address that is only for correspondence purposes.

CODE 3 Residential

This code is used to indicate where a person is living. Note that this code is not valid for organisations.

CODE 4 Temporary residential

Temporary accommodation address (such as for a person from rural Australia who is visiting an oncology centre for a course of treatment, or a person who usually resides overseas). Note that this is not valid for organisations.

CODE 9 Unknown/Not stated/inadequately described

This code may also be used where the person has no fixed address or does not wish to have their residential or a correspondence address recorded.

Data element attributes

Collection and usage attributes

Guide for use:
A single address may have multiple address types associated with it. Record as many as required.

Collection methods:
At least one address must be recorded (this may be an unknown Address type).
Health care establishments should always attempt to collect the residential address of a person who is a health care client when a service is provided. When recording the address for a health care provider or organisation, the business address should always be collected. In addition, other addresses may also need to be recorded for individuals and organisations.
Overseas address:
For individuals record the overseas address as the residential address and record a temporary accommodation address as their contact address in Australia.

Comments:
'No fixed address' is coded as unknown because it (the concept) is not a type of address for a person but is an attribute of the person only i.e. it is not a location for which an address may be derived. It is not recommended that an implementation collects this attribute as an address type. A person not having a fixed address constrains the number of address types that can be collected i.e. temporary accommodation and residential address types cannot be collected. However, if it is imperative that this occurs, it is suggested that code 9 be used.

Source and reference attributes

Submitting organisation:
Standards Australia
Australian Institute of Health and Welfare

Origin:
AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Reference documents:
AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
In AS4846 and AS5017 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:
Supersedes Person (address)—address type, code A Health, Superseded 04/05/2005

Implementation in Data Set Specifications:
Health care client identification DSS Health, Standard 04/05/2005
Health care provider identification DSS Health, Superseded 04/07/2007
Health care provider identification DSS Health, Standard 04/07/2007

Address type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—address type, code N
METeOR identifier:	286792
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of geographical/physical location where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—address type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Business
	2	Mailing or postal
Supplementary values:	9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Business

This code is used to indicate an address that is the physical location of a business, an office or from where a service is delivered.

CODE 2 Mailing or postal

This code is used to indicate an address that is only for correspondence purposes.

CODE 9 Unknown/Not stated/inadequately described

This code may also be used where the person has no fixed address or does not wish to have their residential or a correspondence address recorded

Data element attributes

Collection and usage attributes

Guide for use:	A single address may have multiple address types associated with it. Record as many as required.
Collection methods:	At least one address must be recorded (this may be an unknown Address type). When recording the address for a health care provider or organisation, the business address should always be collected. In addition, other addresses may also need to be recorded for individuals and organisations.

Source and reference attributes

Origin:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia In AS4846 and AS5017 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Address—country identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—country identifier, code (SACC 1998) NNNN
METeOR identifier:	288091
Registration status:	Health, Standard 04/05/2005 Community services, Superseded 02/06/2008
Definition:	The country component of the address of a person, as represented by a code.
Data Element Concept:	Person (address)—country identifier

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 1998
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:	The Standard Australian Classification of Countries 1998 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country. A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Data element attributes

Collection and usage attributes

Collection methods:	Collect the data at the 4-digit level.
Comments:	Note that the Standard Australian Classification of Countries (SACC) is mappable to but not identical to Australian Standard Classification of Countries for Social Statistics (ASCCSS).

Source and reference attributes

Reference documents:	Standard Australian Classification of Countries, Catalogue number 1269.0, 1998, Canberra: Australian Bureau of Statistics Standard Australian Classification of Countries, Revision 2.01, Canberra 1999, Australian Bureau of Statistics. Catalogue Number 1269.0 Standard Australian Classification of Countries, Revision 2.02, Canberra 2004, Australian Bureau of Statistics. Catalogue Number 1269.0

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Administrative health region name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Administrative health region—region name, text [A(80)]
METeOR identifier:	297639
Registration status:	Health, Standard 05/12/2007
Definition:	Textual description of the full name of an administrative health region.
Data Element Concept:	Administrative health region—region name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(80)]
Maximum character length:	80

Data element attributes

Collection and usage attributes

Guide for use:	Administrative health regions are determined by the relevant state or territory.

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:	Palliative care performance indicators DSS Health, Standard 05/12/2007 *Information specific to this data set:* Within the context of this collection, administrative health region boundaries may overlap.

Administrative health region palliative care strategic plan indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Administrative health region—palliative care strategic plan indicator, yes/no code N
METeOR identifier:	288331
Registration status:	Health, Standard 05/12/2007
Definition:	Whether an administrative health region has a written strategic plan which incorporates palliative care elements, as represented by a code.
Data Element Concept:	Administrative health region—palliative care strategic plan indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A palliative care strategic plan may be an entire health region's plan, or an aggregation of the region's sub-units' plans. The plan may be specifically for palliative care or a general health service plan that includes palliative care elements.

The palliative care elements in the plan must include all of the following aspects:

- timeframe (the beginning and end-date in years), with a minimum time period of two years to demonstrate a strategic focus
- measurable objectives relating to: service access, quality, utilisation, responsiveness and evaluation
- demonstrated stakeholder involvement in plan development, such as the inclusion of a description of the consultation process in the strategic plan document
- demonstrated links with the National Palliative Care Strategy
- implementation strategies (can include resources identified for service delivery)
- evidence of ongoing development in subsequent plans.

A strategic plan typically has a mission statement, outlines a

vision, values and strategies, and includes goals and objectives. A strategic plan may: serve as a framework for decisions; provide a basis for more detailed planning; explain the business to others in order to inform, motivate and involve; assist benchmarking and performance monitoring; stimulate change and become a building block for next plan.

The plan will ideally address both palliative care at the specialist level and palliative care at the primary care (i.e. non-specialist) level.

CODE 1 Yes
The administrative health region has a written strategic plan which incorporates palliative care elements, and which includes all specified strategic plan aspects.

CODE 2 No
The administrative health region does not have a written strategic plan which incorporates palliative care elements, or has a plan with only partial coverage of the specified strategic plan aspects.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Information specific to this data set:
This information is required for the calculation of the national palliative care performance indicator number 1: 'The proportion of administrative health regions that have a written strategic plan which incorporates palliative care elements'.

Admission date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission date, DDMMYYYY
METeOR identifier:	269967
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Admission date, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.44 KB)

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care

(antenatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Right justified and zero filled.
admission date ≤ separation date
admission date ≥ date of birth

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Right justified and zero filled.
admission date ≤ separation date
admission date ≥ date of birth

Admitted patient palliative care NMDS Health, Superseded

07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Right justified and zero filled.
admission date <= separation date
admission date >= date of birth

Admission time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission time, hhmm
METeOR identifier:	269972
Registration status:	Health, Standard 01/03/2005
Definition:	Time at which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Admission time, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.48 KB) Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Admitted patient election status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—patient election status, code N
METeOR identifier:	326619
Registration status:	Health, Standard 23/10/2006
Definition:	Accommodation chargeable status elected by a patient on **admission**, as represented by a code.
Data Element Concept:	Episode of admitted patient care—patient election status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

Public patient:

A person, eligible for Medicare, who receives or elects to receive a public hospital service free of charge.

Includes: patients in public psychiatric hospitals who do not have the choice to be treated as a private patient. Also includes overseas visitors who are covered by a reciprocal health care agreement, and who elect to be treated as public patients.

Private patient:

A person who elects to be treated as a private patient and elects to be responsible for paying fees for the type referred to in clause 49 of the Australian Health Care Agreements (2003–2008).

Clause 49 states that:

Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by (the state or territory).

All patients in private hospitals (other than those receiving public hospital services and electing to be treated as a public patient) are private patients.

Includes: all patients who are charged (regardless of the level of the charge) or for whom a charge is raised for a third party payer (for example, Department of Veterans' Affairs and Compensable patients). Also includes patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital, and prisoners, who are Medicare ineligible while incarcerated.

Data element attributes

Collection and usage attributes

Guide for use:

Australian Health Care Agreements 2003–08 state that eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services.

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

- a public patient or
- a private patient

This item is independent of the patient's hospital insurance status and room type.

Notes:
Inability to sign: In cases where the patient is unable to complete the patient election form, the patient should be assumed to be a public patient.

Compensation funding decisions: A patient may be recorded as a public patient as an interim patient election status while the patient's compensable status is being decided.

Inter-hospital contracted care: If the patient receives inter-hospital contracted care the following guidelines can be used if no further information is available:

- If the patient received contracted care that was purchased by a public hospital then it will be assumed that they elected to be treated as a public patient.
- If the patient received contracted care that was purchased by a private hospital then it will be assumed that they elected to be treated as a private patient.

Source and reference attributes

Submitting organisation:

Admitted patient care NMDS Technical Reference Group

Relational attributes

Related metadata references:

Supersedes Episode of admitted patient care—elected accommodation status, code N Health, Superseded 23/10/2006

Implementation in Data Set Specifications:

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Age

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—age, total years N[NN]
METeOR identifier:	303794
Registration status:	Health, Standard 08/02/2006 Community services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006
Definition:	The age of the person in (completed) years at a specific point in time.
Context:	Age is a core data element in a wide range of social, labour and demographic statistics. It is used in the analyses of service utilisation by age group and can be used as an assistance eligibility criterion.
Data Element Concept:	Person—age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NN]	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Unknown/not stated
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	Age in single years (if aged under one year, record as zero). If age (or date of birth) is unknown or not stated, and cannot be estimated, use Code 999. National community services and housing assistance data dictionary specific: If year of birth is known (but date of birth is not) use the date, 0101YYYY of the birth year to estimate age (where YYYY is the year of birth). National housing assistance data dictionary specific: In the housing assistance data collections age is calculated at 30 June for the corresponding year.
Collection methods:	Although collection of date of birth allows more precise calculation of age, this may not be feasible in some data collections, and alternative questions are: Age last birthday? What was ..... age last birthday? What is ..... age in complete years?
Comments:	National community services data dictionary specific: Different rules for reporting data may apply when estimating

the Date of birth of children aged under 2 years since the rapid growth and development of children within this age group means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is recommended.

Those who need to conduct data collections for children where age is collected in months, weeks, or days should do so in a manner that allows for aggregation of those results to this standard.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Origin: Australian Bureau of Statistics, *Standards for Social, Labour and Demographic Variables.*

Relational attributes

Related metadata references: Supersedes Person—age, total years N[NN] Health, Superseded 08/02/2006

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

In CATI surveys, age refers to completed age of respondent on day of interview.

If collecting age in single years is not possible, age may be collected as a range. Refer to the data element Person – age range, code NN.

Age range

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—age range, code NN
METeOR identifier:	290540
Registration status:	Health, Standard 04/05/2005
Definition:	The age range that best accommodates a person's completed age in years, at the time of data collection, as represented by a code.
Data Element Concept:	Person—age range

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	0-4
02	5-14
03	15-24
04	25-34
05	35-44
06	45-54
07	55-64
08	65-74
09	75 years or older

Supplementary values:

99	Not stated

Data element attributes

Collection and usage attributes

Guide for use:	Used in computer assisted telephone interview (CATI) surveys in cases where the specific age is not available. Depending on the collection a different starting age may be used, but should map back to the standard output. Information at a finer level can be collected as long as it maps back to the proposed data domain, e.g. 75+ age group can be split into 75-84 and 85 years or older.
Collection methods:	Although collection of date of birth allows more precise calculation of age, as does the collection of a single age, this may not always be feasible. Age range should be derived from a question on date of birth or age at last birthday.
Comments:	In cases where an exact age is not known or not stated, age may be reported as an age range. The age ranges are consistent with

the standard 10 year ranges recommended by the ABS.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Origin: ABS, Statistical Concepts Library, Standards for Social, Labour and Demographic Variables. Age.

Reference documents: Reference through: http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary and choose, Other ABS Statistical Standards, Standards for Social, Labour and Demographic Variables, Demographic Variables, Age.

Relational attributes

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For some data collection settings, using Computer Assisted Telephone Interviewing (CATI), the suggested question is :

Which age group are you in? Would it be.....

0-4
5-14
15-24
25-34
35-44
45-54
55-64
65-74
75 years or older
Refused

Alcohol consumption frequency (self reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—alcohol consumption frequency (self-reported), code NN
METeOR identifier:	270247
Registration status:	Health, Standard 01/03/2005
Definition:	A person's self-reported frequency of alcohol consumption, as represented by a code.
Data Element Concept:	Person—alcohol consumption frequency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Every day/7 days per week
02	5 to 6 days per week
03	3 to 4 days per week
04	1 to 2 days per week
05	2 to 3 days per month
06	Once per month
07	7 to 11 days in the past year
08	4 to 6 days in the past year
09	2 to 3 days in the past year
10	Once in the past year
11	Never drank any alcoholic beverage in the past year
12	Never in my life

Supplementary values:

Value	Meaning
99	Not reported

Data element attributes

Collection and usage attributes

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

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

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Australian Alcohol Guidelines: Health Risks and Benefits, National Health & Medical Research Council, October 2001

Relational attributes

Related metadata references: Supersedes Alcohol consumption frequency- self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.33 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

Alcohol can also be a contributor to acute health problems.

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

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

is recommended that, in surveys of alcohol consumption, data on age, sex, and other socio-demographic variables also be collected where it is possible and desirable to do so. It is also recommended that, when alcohol consumption is investigated in relation to health, data on other risk factors including overweight and obesity, smoking, high blood pressure and physical inactivity should be collected. The Australian Alcohol Guidelines: Health Risk and Benefits endorsed by the National Health and Medical Research Council in October 2001 have defined risk of harm in the short term and long term based on patterns of drinking.

The table below outlines those patterns.

Alcohol consumption shown in the tables is not recommended for people who: - have a condition made worse by drinking,

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

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

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

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

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

Alcohol consumption in standard drinks per day (self reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—alcohol consumption amount (self-reported), total standard drinks NN
METeOR identifier:	270249
Registration status:	Health, Standard 01/03/2005
Definition:	A person's self-reported usual number of alcohol-containing standard drinks on a day when they consume alcohol.
Data Element Concept:	Person—alcohol consumption amount

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Consumption not reported

Unit of measure: Standard drink

Collection and usage attributes

Guide for use: Alcohol consumption is usually measured in standard drinks.

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

Data element attributes

Collection and usage attributes

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

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

- Light beer (2.7%):
  - 1 can or stubbie = 0.8 a standard drink
- Medium light beer (3.5%):
  - 1 can or stubbie = 1 standard drink
- Regular Beer - (4.9% alcohol):
  - 1 can = 1.5 standard drinks
  - 1 jug = 4 standard drinks
  - 1 slab (cans or stubbies) = about 36 standard drinks
- Wine (9.5% - 13% alcohol):

- 750-ml bottle = about 7 to 8 standard drinks
- 4-litre cask = about 30 to 40 standard drinks

- Spirits:
  - 1 nip = 1 standard drink
  - Pre-mixed spirits (around 5% alcohol) = 1.5 standard drinks

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

Collection methods:

The *World Health Organisation's 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document* suggests that in assessing alcohol consumption patterns a 'Graduated Quantity Frequency' method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

The World Health Organisation's 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document -National Health and Medical Research Council's Australian Alcohol Guidelines, October 2001.

Relational attributes

Related metadata references:

Supersedes Alcohol consumption in standard drinks per day - self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.63 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

Evidence from prospective studies indicates that heavy alcohol consumption is associated with increased mortality and morbidity from coronary heart disease and stroke (Hanna et al. 1992). However, there is some evidence to suggest that alcohol appears to provide some protection against heart disease (both illness and death) for both men and women from middle age onwards. Most

if not all of this benefit is achieved with 1-2 standard drinks per day for men and less than 1 standard drink for women (the National Health and Medical Research Council's Australian Alcohol Guidelines, October 2001).

Anaesthesia administered for operative delivery of the baby

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—anaesthesia administered, code N
METeOR identifier:	292044
Registration status:	Health, Standard 07/12/2005
Definition:	Anaesthesia administered to the woman for the operative delivery of the baby, as represented by a code.
Data Element Concept:	Birth event—anaesthesia administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	None
2	Local anaesthetic to perineum
3	Pudendal
4	Epidural or caudal
5	Spinal
6	General anaesthetic
7	Combined spinal-epidural
8	Other

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Operative delivery includes caesarean section, forceps and vacuum extraction. Code 7: this code is used when this technique has been selected for the administration of anaesthesia for the operative delivery of the baby.
Collection methods:	More than one agent or technique can be recorded, except where 1=none applies. This item should only be recorded for the operative delivery of the baby and not third stage labour e.g. removal of placenta.
Comments:	Anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—anaesthesia administered, code N Health, Superseded 07/12/2005

Analgesia administered for labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—analgesia administered, code N
METeOR identifier:	292546
Registration status:	Health, Standard 07/12/2005
Definition:	Analgesia administered to the woman to relieve pain for labour, as represented by a code.
Data Element Concept:	Birth event—analgesia administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	None
2	Nitrous oxide
4	Epidural or caudal
5	Spinal
6	Systemic opioids
7	Combined spinal-epidural
8	Other
Supplementary values: 9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Comments: Note: Code 3, which had a meaning in previous versions of the data standard is no longer used. As is good practice, the code will not be reused.

Data element attributes

Collection and usage attributes

Guide for use: Systemic opioids include both intra-muscular and intravenous opioids.

Code 7: this code is used when this technique has been selected for the administration of analgesia for labour.

Collection methods: More than one agent or technique can be recorded, except where 1=none applies.

This item is to be recorded for first and second stage labour, but not third stage labour e.g. removal of placenta.

Comments: Analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of

obstetric intervention.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—analgesia administered, code N Health, Superseded 07/12/2005

Angiotensin converting enzyme (ACE) inhibitors therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—angiotensin converting enzyme inhibitors therapy status, code NN
METeOR identifier:	284751
Registration status:	Health, Standard 04/06/2004
Definition:	The person's ACE inhibitor therapy status, as represented by a code.
Data Element Concept:	Person—angiotensin converting enzyme inhibitors therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - allergy or intolerance (e.g. cough) to ACE inhibitors
23	Not given - moderate to severe aortic stenosis
24	Not given - bilateral renal artery stenosis
25	Not given - history of angio-oedema, hives, or rash in response to ACE inhibitors
26	Not given - hyperkalaemia
27	Not given - symptomatic hypotension
28	Not given - severe renal dysfunction
29	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Angiotensin converting enzyme (ACE) inhibitors therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Anticipated patient election status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—anticipated accommodation status, code N
METeOR identifier:	270074
Registration status:	Health, Standard 01/03/2005
Definition:	Accommodation chargeable status nominated by the patient when placed on an elective surgery waiting list, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—anticipated accommodation status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

CODE 1 Public patient:

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

CODE 2 Private patient:

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

Data element attributes

Collection and usage attributes

Guide for use:

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

- a public patient; or
- a private patient

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

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

Comments:

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

Relational attributes

Related metadata references:

Supersedes Anticipated patient election status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (15.17 KB)

Apgar score at 1 minute

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—Apgar score (at 1 minute), code NN
METeOR identifier:	289345
Registration status:	Health, Standard 07/12/2005
Definition:	Numerical score used to indicate the baby's condition at 1 minute after birth.
Data Element Concept:	Birth—Apgar score

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	00-10	Apgar score
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth—Apgar score (at 1 minute), code NN Health, Superseded 07/12/2005

Apgar score at 5 minutes

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—Apgar score (at 5 minutes), code NN
METeOR identifier:	289360
Registration status:	Health, Standard 07/12/2005
Definition:	Numerical score used to indicate the baby's condition at 5 minutes after birth.
Data Element Concept:	Birth—Apgar score

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	00-10	Apgar score
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth—Apgar score (at 5 minutes), code NN Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Perinatal NMDS Health, Superseded 06/09/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

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

Area of usual residence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—area of usual residence, geographical location code (ASGC 2007) NNNNN
METeOR identifier:	362291
Registration status:	Health, Standard 05/02/2008
Definition:	Geographical location of usual residence of the person, as represented by a code.
Data Element Concept:	Person—area of usual residence

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2007
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

The geographical location is reported using a five digit numerical code. The first digit is the single-digit code to indicate State or Territory. The remaining four digits are the numerical code for the Statistical Local Area (SLA) within the State or Territory.

The single digit codes for the states and territories and the four digit codes for the SLAs are as defined in the Australian Standard Geographical Classification (ASGC).

The ASGC is updated on an annual basis with a date of effect of 1 July each year. The codes for SLA are unique within each State and Territory, but not within the whole country. Thus, to define a unique location, the code of the State or Territory is required in addition to the code for the SLA.

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

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

is used with the Streets Sub-index of the NLI to assign the SLA.

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

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

Collection methods:

When collecting the geographical location of a person's usual place of residence, the Australian Bureau of Statistics (ABS) recommends that 'usual' be defined as: 'the place where the person has or intends to live for 6 months or more, or the place that the person regards as their main residence, or where the person has no other residence, the place they currently reside.' Apart from collecting a person's usual place of residence there is also a need in some collections to collect area of residence immediately prior to or after assistance is provided, or at some other point in time.

Comments:

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

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

Source and reference attributes

Origin:

Health Data Standards Committee

Relational attributes

Related metadata references:

Supersedes Person—area of usual residence, geographical location code (ASGC 2006) NNNNN Health, Superseded 05/02/2008

Implementation in Data Set Specifications:

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Aspirin therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—aspirin therapy status, code NN
METeOR identifier:	284785
Registration status:	Health, Standard 04/06/2004
Definition:	The person's aspirin therapy status, as represented by a code.
Data Element Concept:	Person—aspirin therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - true allergy to aspirin
23	Not given - active bleeding
24	Not given - bleeding risk
29	Not given - other

Supplementary values:

90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Aspirin therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.22 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Assistance with activities

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—need for assistance with activities in a life area, code N
METeOR identifier:	320213
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The level of help and/or supervision a person requires (or would require if the person currently helping/supervising was not available) to perform tasks and actions in a specified life area, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—need for assistance with activities in a life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Does not need help/supervision
1	Sometimes needs help/supervision
2	Always needs help/supervision
3	Unable to do this task or action, even with assistance

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

In the context of health, an activity is the execution of a task or action by an individual. Activity limitations are difficulties an individual may have in executing an activity.

Activity limitation varies with the environment and is assessed in relation to a particular environment; the absence or presence of assistance, including aids and equipment, is an aspect of the environment.

This value domain records the level of a person's need for help or supervision, in a specified domain, in their overall life. This means that the need for assistance may not be directly relevant to the health or community care service being provided.

Where a life area includes a range of examples, (e.g. domestic

life includes cooking, cleaning and shopping), if a person requires assistance in any of the areas then the highest level of assistance should be recorded.

Where need for assistance varies markedly over time (e.g. episodic psychiatric conditions) please record the average level of assistance needed.

The presence of an activity limitation with a given domain is indicated by a non-zero response in this value domain. Activity is limited when an individual, in the context of a health condition, either has need for assistance in performing an activity in an expected manner, or cannot perform the activity at all.

CODE 0 is used when the person has no need for supervision or help and can undertake the activity independently.

CODE 1 is used when the person sometimes needs assistance to perform an activity.

CODE 2 is used when the person always needs assistance to undertake the activity and cannot do the activity without assistance.

CODE 3 is used when the person cannot do the activity even with assistance

CODE 8 is used when a person's need for assistance to undertake the activity is unknown or there is insufficient information to use codes 0-3.

CODE 9 is used where the need for help or supervision is due to the person's age. For example, Education for persons less than 5 years and work for persons less than 15 years.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Data element attributes

Collection and usage attributes

Guide for use:

This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) AN[NNN], indicates a person's need for assistance in a given domain of activity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Activities and Participation cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Australian State/Territory identifier (establishment)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—Australian state/territory identifier, code N
METeOR identifier:	269941
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier of the Australian state or territory in which an establishment is located, as represented by a code.
Data Element Concept:	Establishment—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 30/09/2005

Data element attributes

Collection and usage attributes

Guide for use: This metadata item applies to the location of the establishment and not to the patient's area of usual residence.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes Australian State/Territory identifier, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (18.84 KB)

Is used in the formation of Establishment—geographical location, code (ASGC 2007) NNNNN Health, Standard 05/02/2008

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2007) NNNNN Health, Standard 05/02/2008

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2006) NNNNN Health, Superseded 05/02/2008

Is used in the formation of Establishment—geographical location, code (ASGC 2006) NNNNN Health, Superseded 05/02/2008

Is used in the formation of Establishment—geographical location, code (ASGC 2005) NNNNN Health, Superseded 14/09/2006

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2005) NNNNN Health, Superseded 14/09/2006

Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2004) NNNNN Health, Superseded 21/03/2006

Implementation in Data Set Specifications: Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This data element applies to the location of the establishment and not to the patient's area of usual

residence.

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Australian State/Territory identifier (jurisdiction)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Jurisdiction—Australian state/territory identifier, code N
METeOR identifier:	352480
Registration status:	Health, Standard 05/12/2007
Definition:	An identifier of the Australian state or territory of a jurisdiction, as represented by a code.
Data Element Concept:	Jurisdiction—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use:	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents:	Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 30/09/2005

Data element attributes

Source and reference attributes

Submitting organisation:	Health expenditure advisory committee

Relational attributes

Implementation in Data Set Specifications:

Government health expenditure NMDS 2008-2009 Health, Standard 05/12/2007

Implementation start date: 01/07/2008

Australian state/territory identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Australian state/territory identifier, code N
METeOR identifier:	286919
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The Australian state or territory where a person can be located, as represented by a code.
Data Element Concept:	Person—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 30/09/2005

Data element attributes

Collection and usage attributes

Collection methods: Irrespective of how the information is coded, conversion of the codes to the ABS standard must be possible.

Source and reference attributes

Origin: Australian Bureau of Statistics 2004. Australian Standard Geographical Classification (ASGC) (Cat No. 1216.0). Viewed 13 October 2005.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2004, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references: See also Person (address) — Australian postcode, code (Postcode datafile) {NNNN} Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Australian state/territory identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—Australian state/territory identifier, code N
METeOR identifier:	289083
Registration status:	Health, Standard 04/05/2005 Community services, Standard 07/12/2005
Definition:	An identifier of the Australian state or territory where an organisation or agency can be located, as represented by a code.
Data Element Concept:	Service provider organisation—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 30/09/2005

Data element attributes

Collection and usage attributes

Collection methods: Irrespective of how the information is coded, conversion of the codes to the ABS standard must be possible.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standard Committee

National Community Services Data Committee

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:

When used specifically in the collection of address information for a client, the following local implementation rules may be applied:

NULL may be used to signify an unknown address State; and Code 0 may be used to signify an overseas address.

Behaviour-related risk factor intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—behaviour-related risk factor intervention, code NN
METeOR identifier:	270165
Registration status:	Health, Standard 01/03/2005
Definition:	The intervention taken to modify or manage the patient's behaviour-related risk factor(s), as represented by a code.
Data Element Concept:	Episode of care—behaviour-related risk factor intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

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

Supplementary values:

99	Not stated/inadequately defined

Collection and usage attributes

Guide for use:

CODE 01 No intervention

Refers to no intervention taken with regard to the behaviour-related risk factor intervention-purpose.

CODE 02 Information and education (not including written regimen)

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

CODE 03 Counselling

Refers to any method of individual or group counselling directed towards the behaviour-related risk factor intervention-purpose. This code excludes counselling activities that are part of referral options as defined in code 05 and 06.

CODE 04 Pharmacotherapy

Refers to pharmacotherapies that are prescribed or recommended for the management of the behaviour-related risk factor intervention-purpose.

CODE 05 Referral provided to a health professional

Refers to a referral to a health professional who has the expertise to assist the patient manage the behaviour-related risk factor intervention-purpose.

CODE 06 Referral to a community program, support group or service

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

CODE 07 Written regimen provided

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

CODE 08 Surgery

Refers to a surgical procedure undertaken to assist the patient with the management of the behaviour-related risk factor intervention-purpose.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Behaviour-related risk factor intervention, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.62 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Behaviour-related risk factor intervention - purpose

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—behaviour-related risk factor intervention purpose, code N
METeOR identifier:	270338
Registration status:	Health, Standard 01/03/2005
Definition:	The behaviour-related risk factor(s) associated with an intervention(s), as represented by a code.
Data Element Concept:	Episode of care—behaviour-related risk factor intervention purpose

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Smoking
	2	Nutrition
	3	Alcohol misuse
	4	Physical inactivity
	8	Other
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Smoking, Nutrition, Alcohol, Physical Activity (SNAP) Framework - Commonwealth Department of Health and Ageing - June 2001. Australian Institute of Health and Welfare 2002. Chronic Diseases and associated risk factors in Australians, 2001; Canberra.

Relational attributes

Related metadata references:	Supersedes Behaviour-related risk factor intervention - purpose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.51 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

Smoking, Nutrition, Alcohol, Physical Activity (SNAP) initiative:

SNAP Framework for General Practice is an initiative of the Joint Advisory Group (JAG) on General Practice and Population Health.

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

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

The aim of the SNAP initiative is to reduce the health and socioeconomic impact of smoking, poor nutrition, harmful and hazardous alcohol use and physical inactivity on patients and the community through a systematic approach to behavioural interventions in primary care.

This will provide an opportunity to make better use of evidence-based interventions and to ensure adoption of best practice initiatives widely through general practice.

Beta-blocker therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—beta-blocker therapy status, code NN
METeOR identifier:	284802
Registration status:	Health, Standard 04/06/2004
Definition:	The person's beta-blocker therapy status, as represented by a code.
Data Element Concept:	Person—beta-blocker therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - allergy or history of intolerance
23	Not given - bradycardia (heart rate less than 50 beats per minute)
24	Not given - symptomatic acute heart failure
25	Not given - systolic blood pressure of less than 90 mmHg
26	Not given - PR interval greater than 0.24 seconds
27	Not given - second and third degree heart block or bifascicular heart block
28	Not given - asthma/airways hyper-reactivity
29	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 15 - 29 Not given

If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Beta-blocker therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.07 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Birth order

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth order, code N
METeOR identifier:	269992
Registration status:	Health, Standard 01/03/2005
Definition:	The sequential order of each baby of a multiple birth, as represented by a code.
Data Element Concept:	Birth—birth order

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Singleton or first of a multiple birth
2	Second of a multiple birth
3	Third of a multiple birth
4	Fourth of a multiple birth
5	Fifth of a multiple birth
6	Sixth of a multiple birth
8	Other

Supplementary values:

9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:	CODE 2 Second of a multiple birth Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be recorded as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).
Collection methods:	This data should be collected routinely for persons aged 28 days or less.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee Standards Australia

Relational attributes

Related metadata references:	Supersedes Birth order, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.86 KB)
Implementation in Data Set	Health care client identification Health, Superseded 04/05/2005

Specifications:

Health care client identification DSS Health, Standard 04/05/2005

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Birth plurality

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth plurality, code N
Synonymous names:	Multiple birth
METeOR identifier:	269994
Registration status:	Health, Standard 01/03/2005
Definition:	The number of babies resulting from a single pregnancy, as represented by a code.
Data Element Concept:	Birth event—birth plurality

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other

Supplementary values:

9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:	Plurality of a pregnancy is determined by the number of live births or by the number of fetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only **live births** of any **birthweight** or gestational age, or fetuses weighing 400 g or more, are taken into account in determining plurality. Fetuses aborted before 20 completed weeks or fetuses compressed in the placenta at 20 or more weeks are excluded.
Collection methods:	This data should be collected routinely for persons aged 28 days or less.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes Birth plurality, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.59 KB)

Implementation in Data Set Specifications:

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Standard 04/05/2005

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Bleeding episode using TIMI criteria (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—bleeding episode status, code N
METeOR identifier:	284812
Registration status:	Health, Standard 04/06/2004
Definition:	A person's episode of bleeding as described by the Thrombolysis In Myocardial Infarction (TIMI) criteria, as represented by a code.
Data Element Concept:	Person—bleeding episode status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Major
2	Minor
3	Non TIMI bleeding
4	None

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Note in calculating the fall in haemoglobin or haematocrit, transfusion of whole blood or packed red blood cells is counted as 1g/dl (0.1g/l) haemoglobin or 3% absolute haematocrit.

CODE 1 Major

Overt clinical bleeding (or documented intracranial or retroperitoneal haemorrhage) associated with a drop in haemoglobin of greater than 5g/dl (0.5g/l) or a haematocrit of greater than 15% (absolute).

CODE 2 Minor

Overt clinical bleeding associated with a fall in haemoglobin of 3g/dl to less than or equal to 5g/dl (0.5g/l) or a haematocrit of 9% to less than or equal to 15% (absolute).

CODE 3 Non TIMI Bleeding

Bleeding event that does not meet the major or minor definition.

CODE 4 None

No bleeding event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Origin: Rao AK, Pratt C, Berke A, et al. Thrombolysis in Myocardial Infarction (TIMI) Trial, phase I: hemorrhagic manifestations and changes in plasma fibrinogen and the fibrinolytic system in patients with recombinant tissue plasminogen activator and streptokinase. J Am Coll Cardiol 1988; 11:1-11.

Relational attributes

Related metadata references: Supersedes Bleeding episode using TIMI criteria - status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.34 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

Can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Blindness (diabetes complication)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blindness, code N
METeOR identifier:	270065
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has become legally blind in either or both eyes, as represented by a code.
Data Element Concept:	Person—blindness

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Supplementary values:

Collection and usage attributes

Guide for use:	CODE 3 Blindness - (< 6/60) occurred in one eye within 12 months and in the other eye prior to the last 12 months Blindness can be diagnosed in one eye within 12 months even though it has been previously diagnosed on the other eye.
Collection methods:	Ask the individual if he/she has been diagnosed as legally blind (< 6/60) in both or either eye. If so record whether it has occurred within or prior to the last 12 months. Alternatively determine blindness from appropriate documentation obtained from an ophthalmologist or optometrist.

Data element attributes

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Blindness - diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (19.69 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

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

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

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

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

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

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

References:

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

The Diabetic Retinopathy Study Research Group. Photocoagulation treatment of proliferative diabetic retinopathy. Clinical application of Diabetic Retinopathy Study (DRS) finding, DRS Report Number8. Ophthalmology. 1981; 88:583/600).

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

Blood pressure—diastolic (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blood pressure (diastolic) (measured), millimetres of mercury NN[N]
METeOR identifier:	270072
Registration status:	Health, Standard 01/03/2005
Definition:	The person's diastolic **blood pressure,** measured in millimetres of mercury (mmHg).
Data Element Concept:	Person—blood pressure (diastolic)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

Guide for use:

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

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

Collection methods:

Measurement protocol for resting blood pressure:

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

- The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.
- Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).
- Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.
- Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the velcro on the cuff is not totally attached, the cuff is probably

too small.

- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.
- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2-3 mm Hg/beat (2-3 mm Hg/sec) or less.
- Recording the diastolic pressure use phase V Korotkoff (disappearance of sound). Use phase IV Korotkoff (muffling of sound) only if sound continues towards zero but does not cease. Wait 30 seconds before repeating the procedure in the same arm. Average the readings.
- If the first two readings differ by more than 4 mmHg diastolic or if initial readings are high, take several readings after five minutes of quiet rest.

Comments:

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

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

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

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

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

Reference documents:

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

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

UKPDS 38 Tight blood pressure control and risk of

macrovascular and microvascular complications in type 2 diabetes: UK Prospective Diabetes Study Group. British Medical Journal (1998); 317: 703-713.

Relational attributes

Related metadata references:

Supersedes Blood pressure - diastolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (26.27 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

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

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

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

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

High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure (Ashwell 1997; DHSH 1994b; Whelton 1994; Kannel 1991). The higher the blood pressure, the higher the risk of both stroke and coronary heart disease. The dividing line between normotension and hypertension is arbitrary. Both systolic and diastolic blood pressures are predictors of heart, stroke and vascular disease at all ages (Kannel 1991), although diastolic blood pressure is a weaker

predictor of death due to coronary heart disease (Neaton & Wentworth 1992).

The risk of disease increases as the level of blood pressure increases. When blood pressure is lowered by 4-6 mm Hg over two to three years, it is estimated that the risk reduces by14 per cent in patients with coronary heart disease and by 42 per cent in stroke patients (Collins et al 1990; Rose 1992.) When high blood pressure is controlled by medication, the risk of cardiovascular disease is reduced, but not to the levels of unaffected people.

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

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

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

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

High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure (Ashwell 1997; DHSH 1994b; Whelton 1994; Kannel 1991).

Blood pressure—systolic (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blood pressure (systolic) (measured), millimetres of mercury NN[N]
METeOR identifier:	270073
Registration status:	Health, Standard 01/03/2005
Definition:	The person's systolic **blood pressure,** measured in millimetres of mercury (mmHg).
Data Element Concept:	Person—blood pressure (systolic)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

Guide for use: For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). If Blood pressure - systolic is not collected or not able to be collected, code 999.

Collection methods: Measurement protocol for resting blood pressure:

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

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

the lower border of the cuff about 2 cm above the bend of the elbow.

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

Comments:

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

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

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

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

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

Reference documents:

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

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

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

Relational attributes

Related metadata references:

Supersedes Blood pressure - systolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (25.94 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

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

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

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

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

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

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

The risk of disease increases as the level of blood pressure increases. When blood pressure is lowered by 4-6 mm Hg over two to three years, it is estimated that the risk reduces

by14 per cent in patients with coronary heart disease and by 42 per cent in stroke patients (Collins et al 1990; Rose 1992.) When high blood pressure is controlled by medication, the risk of cardiovascular disease is reduced, but not to the levels of unaffected people.

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

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

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

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

High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure (Ashwell 1997; DHSH 1994b; Whelton 1994; Kannel 1991).

Bodily location of main injury

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—bodily location of main injury, code NN
METeOR identifier:	268943
Registration status:	Health, Standard 01/03/2005
Definition:	The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility, as represented by a code.
Data Element Concept:	Person—bodily location of main injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

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

Data element attributes

Collection and usage attributes

Guide for use:

If the full International Classification of Diseases - Tenth Revision - Australian Modification code is used to code the injury, this metadata item is not required (see metadata items Principal diagnosis and Additional diagnosis.

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

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

Comments:

The injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. The nature of main injury together with the bodily location of the main injury indicates the diagnosis.

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

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

See also Injury event—nature of main injury, non-admitted patient code NN{.N} Health, Standard 01/03/2005

Supersedes Bodily location of main injury, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.48 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Standard 05/02/2008

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Body function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body function, code (ICF 2001) AN[NNNN]
Synonymous names:	Body function code
METeOR identifier:	320141
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The physiological or psychological function of a person's body system, as represented by a code.
Data Element Concept:	Person—body function

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNNN]
Maximum character length:	6

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both Exercise tolerance functions (3 digit level) and 'fatigability' (4-digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with *Impairment extent code N* will use the codes as indicated.

CODE b1 Mental functions
CODE b2 Sensory functions and pain
CODE b3 Voice and speech functions
CODE b4 Functions of the cardiovascular, haematological, immunological and respiratory systems
CODE b5 Functions of the digestive, metabolic and the endocrine system
CODE b6 Genitourinary and reproductive functions
CODE b7 Neuromusculoskeletal and movement-related functions
CODE b8 Functions of the skin and related structures

Data collected at this level will provide a general description of the structures and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values together, with definitions is listed in the *Body Functions* component of the ICF.

An example of a value domain at the 3 digit level from the Sensory functions and pain chapter may include:

CODE b210 Seeing functions
CODE b230 Hearing functions
CODE b235 Vestibular functions
CODE b250 Taste functions
CODE b255 Smell functions
CODE b260 Proprioceptive functions
CODE b265 Touch functions
CODE b270 Sensory functions related to temperature and other stimuli
CODE b279 Additional sensory functions, other specified and unspecified

An example of a value domain at the 4 digit level from the body function component may include:

CODE b1300 Energy level
CODE b1400 Sustaining attention
CODE b1442 Retrieval of memory
CODE b1521 Regulation of emotion
CODE b1641 Organization and planning

The prefix *b* denotes the domains within the component of *Body Functions*.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element can be used to record positive or neutral body function, as well as impairment of body function when used in conjunction with the metadata item Person—extent of

impairment of body function, code (ICF 2001)N.

Where multiple body functions or impairments of body functions are recorded, the following prioritising system should be useful.

- The first recorded body function or impairment of body function is the one having the greatest impact on the individual.
- Second and subsequent body function or impairment of body function is also of relevance to the individual.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—extent of impairment of body function, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Body functions cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Body mass index—adult (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—body mass index (measured), ratio NN[N].N[N]
METeOR identifier:	270084
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where height and weight have been measured.
Data Element Concept:	Adult—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Guide for use:	Formula: BMI = weight (kg) divided by height (m) squared. Body mass index is a continuous variable. Code body mass index to one or two decimal places (i.e. 99.99 or 99.9). If any component necessary for its calculation (i.e. weight or height for adults) is unknown or has not been collected, code to 888.8, 999.9.
Collection methods:	NN.NN for BMI calculated from measured height and weight. BMI should be derived after data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Comments:	This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults. BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic

Resonance Imaging and Dual X-ray Absorptiometry.

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

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

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

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

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

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

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

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

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

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

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue

in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

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

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

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

Relational attributes

Related metadata references: See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.71 KB)

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

Body mass index—adult (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—body mass index (self-reported), ratio NN[N].N[N]
METeOR identifier:	270086
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where at least one of the measures is self reported.
Data Element Concept:	Adult—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Comments:

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

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

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

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

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

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

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

Relational attributes

Related metadata references:

See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

Is formed using Person—height (self-reported), total centimetres NN[N] Health, Standard 01/03/2005

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.71 KB)

Is formed using Person—weight (self-reported), total kilograms NN[N] Health, Standard 14/07/2005

Body mass index—child (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Child—body mass index (measured), ratio NN[N].N[N]
METeOR identifier:	270085
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of a child's weight (body mass) relative to height used to assess the extent of weight excess where height and weight have been measured.
Data Element Concept:	Child—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

Comments:

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

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

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

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000),

are exceedingly common in Australia and their prevalence is increasing.

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

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

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

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

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

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

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

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

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

societies.

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

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

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

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

Relational attributes

Related metadata references: See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.71 KB)

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

Body mass index—child (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Child—body mass index (self-reported), ratio NN[N].N[N]
METeOR identifier:	270087
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of a child's weight (body mass) relative to height used to assess the extent of weight excess where at least one of the measures is self reported.
Data Element Concept:	Child—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Comments:

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

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

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

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

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

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

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

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

Relational attributes

Related metadata references:

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.71 KB)

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—height (self-reported), total centimetres NN[N] Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Is formed using Person—weight (self-reported), total kilograms NN[N] Health, Standard 14/07/2005

Body mass index—classification

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body mass index (classification), code N[.N]
METeOR identifier:	270474
Registration status:	Health, Standard 01/03/2005
Data Element Concept:	Person—body mass index (classification)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[.N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Not overweight or obese
1.1	Underweight
1.2	Normal range 18.50 - 24.99 Average
2	Overweight >= 25.00 Average
2.1	Overweight >= 25.0 Average
2.2	Pre Obese 25.00 - 29.99 Increased
3	Obese >= 30 Increased
3.1	Obese class 1 30.00 - 34.99 Moderate
3.2	Obese class 2 35.00 - 39.99 Severe
3.3	Obese class 3 >= 40.00 Very severe

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Adults:

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

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

Children/adolescents:

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

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

To determine overweight and obesity in children and

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

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

Collection methods:

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

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

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

Data element attributes

Collection and usage attributes

Guide for use:

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

Age(years)	BMI equivalent to 25 kg/m2		BMI equivalent to 30 kg/m2	
	Males	Females	Males	Females
2	18.41	18.02	20.09	19.81
2.5	18.13	17.76	19.80	19.55
3	17.89	17.56	19.57	19.36
3.5	17.69	17.40	19.39	19.23
4	17.55	17.28	19.29	19.15
4.5	17.47	17.19	19.26	19.12
5	17.42	17.15	19.30	19.17
5.5	17.45	17.20	19.47	19.34
6	17.55	17.34	19.78	19.65
6.5	17.71	17.53	20.23	20.08
7	17.92	17.75	20.63	20.51
7.5	18.16	18.03	21.09	21.01
8	18.44	18.35	21.60	21.57
8.5	18.76	18.69	22.17	22.18
9	19.10	19.07	22.77	22.81
9.5	19.46	19.45	23.39	23.46
10	19.84	19.86	24.00	24.11
10.5	20.20	20.29	24.57	24.77

11	20.55	20.74	25.10	25.42
11.5	20.89	21.20	25.58	26.05
12	21.22	21.68	26.02	26.67
12.5	21.56	22.14	26.43	27.24
13	21.91	22.58	26.84	27.76
13.5	22.27	22.98	27.25	28.20
14	22.62	23.34	27.63	28.57
14.5	22.96	23.66	27.98	28.87
15	23.29	23.94	28.30	29.11
15.5	23.60	24.17	28.60	29.29
16	23.90	24.37	28.88	29.43
16.5	24.19	24.54	29.14	29.56
17	24.46	24.70	29.41	26.69
17.5	24.73	24.85	29.70	29.84
18	25.00	25.00	30.00	30.00

Comments:

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

BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity. The robust nature of the measurements and the widespread routine inclusion of weights and heights in clinical and population health surveys mean that a more selective measure of adiposity, such as skinfold thickness measurements, provides additional rather than primary information. BMI can be used to estimate the prevalence of obesity within a population and the risks associated with it, but does not, however, account for the wide variation in the nature of obesity between different individuals and populations (WHO 2000).

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

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

For adults and children and adolescents BMI may not correspond to the same degree of fatness in different populations due, in part, to differences in body proportions. The classification table shows a simplistic relationship between BMI and the risk of comorbidity, which can be affected by a range of factors, including the nature of the diet, ethnic group and activity level. The risks associated with increasing BMI are

continuous and graded and begin at a BMI of 25 (or equivalent to 25 for children and adolescents). The interpretation of BMI grades in relation to risk may differ for different populations. Both BMI and a measure of fat distribution (waist circumference or waist: hip ratio in adults) are important in calculating the risk of obesity comorbidities.

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

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous Status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Methods used to establish cut-off points for overweight have been arbitrary and, as a result, cut-off points vary between countries. The data are derived mainly from studies of mortality and morbidity risk performed in people living in western Europe or the United States of America, and cut-off points for BMI as an indicator of adiposity and risk in populations who differ in body build and genetic disposition are likely to vary.

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

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

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

Source and reference attributes

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

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

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

Relational attributes

Related metadata references: See also Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

See also Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

See also Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

See also Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Body mass index - classification, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (79.47 KB)

Body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body structure, code (ICF 2001) AN[NNNN]
Synonymous names:	Body structure code
METeOR identifier:	320147
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	An anatomical part of a person's body such as organs, limbs or their components, as represented by a code.
Data Element Concept:	Person—body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNNN]
Maximum character length:	6

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept **disability** and gives an indication of the experience of disability for a person.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Skin and related structures' (chapter level) and 'Structure of nails' (3 digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with respective qualifiers (*Impairment extent code N*, *Impairment nature code N*, *Impairment location code N*) will use the codes as indicated.

CODE s1 Structures of the nervous system
CODE s2 The eye, ear and related structures
CODE s3 Structures involved in voice and speech
CODE s4 Structures of the cardiovascular, immunological and respiratory systems
CODE s5 Structures related to the digestive, metabolic and endocrine systems
CODE s6 Structures related to the genitourinary and reproductive systems
CODE s7 Structures related to movement
CODE s8 Skin and related structures

Data collected at this level will provide a general description of

the structures and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values together with definitions is listed in the Body Structures component of the ICF.

An example of a value domain at the 3 digit level from the Structures of the nervous system chapter may include:

CODE s110 Structure of the brain
CODE s120 Spinal cord and related structures
CODE s130 Structure of the meninges
CODE s140 Structure of sympathetic nervous system
CODE s150 Structure of parasympathetic nervous system
CODE s198 Structure of the nervous system, other specified
CODE s199 Structure of the nervous system, unspecified

An example of a value domain at the 4 digit level from the Structures related to movement chapter may include:

CODE s7300 Structure of upper arm
CODE s7301 Structure of forearm
CODE s7302 Structure of hand
CODE s7500 Structure of thigh
CODE s7501 Structure of lower leg
CODE s7502 Structure of ankle and foot
CODE s7600 Structure of vertebral column

The prefix *s* denotes the domains within the component of *Body Structures*.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element consists of a single, neutral list of body structures that can be used to record positive or neutral body function. In conjunction with *Impairment extent code N*, it

enables the provision of information about the presence and extent of impairment for any given body structures; with *Impairment nature code N*, the provision of information about the nature of the impairment for given body functions; and *Impairment location code N*, the location of the impairment for given body functions.

Where multiple body structures or **impairments of body structures** are recorded, the following prioritising system should be useful:

- The first recorded body structure or impairment of body function is the one having the greatest impact on the individual.
- Second and subsequent body structure or impairment of body function is also of relevance to the individual.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specifications: Body structures cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Building/complex sub-unit number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/complex sub-unit identifier, [X(7)]
METeOR identifier:	270018
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique number or identifier for a building/complex, marina, etc. where a person resides.
Data Element Concept:	Person (address)—building/complex sub-unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(7)]
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	The building/complex sub-unit number must be recorded with its corresponding building/complex unit type - abbreviation. Where applicable, the number may be followed by an alphanumeric suffix.
Collection methods:	To be collected in conjunction with building/complex sub-unit type - abbreviation.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Building/complex sub-unit number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.38 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Building/complex sub-unit number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/complex sub-unit identifier, [X(7)]
METeOR identifier:	290291
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique number or identifier of a building/complex, marina, etc. where an organisation is located.
Data Element Concept:	Service provider organisation (address)—building/complex sub-unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(7)]
Maximum character length:	7

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Building/complex sub-unit type—abbreviation (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/complex sub-unit type, code A[AAA]
METeOR identifier:	270023
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of building/complex where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Permissible values:

Value	Meaning
APT	Apartment
CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office
PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse
U	Unit
VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use:

Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Collection and usage attributes

Collection methods:

To be collected in conjunction with building/complex sub unit number.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

Health Data Standards Committee

Relational attributes

Related metadata references:

Supersedes Building/complex sub-unit type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.76 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Building/complex sub-unit type—abbreviation (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/complex sub-unit type, code A[AAA]
METeOR identifier:	290278
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of building/complex where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Permissible values:

Value	Meaning
APT	Apartment
CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office
PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse
U	Unit
VLLA	Villa
WARD	Ward

WE	Warehouse

Collection and usage attributes

Guide for use:	Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate. Examples: APT 6 SHOP 3A U 6 PTHS

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Building/property name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/property name, text [X(30)]
METeOR identifier:	270028
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The name of a building or property where a person resides, as represented by text.
Data Element Concept:	Person (address)—building/property name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:

Usually this information is not abbreviated.

Should include any reference to a wing or other components of a building complex, if applicable.

A comma is to be used to separate the wing reference from the rest of the building name.

Record each Building/property name relevant to the address:

- Building/property name 1 (30 alphanumeric characters)
- Building/property name 2 (30 alphanumeric characters)

For example:

Building - TREASURY BUILDING

Property - BRINDABELLA STATION

Source and reference attributes

Origin:

Health Data Standards Committee

Australia Post Address Presentation Standard

Relational attributes

Related metadata references:

Supersedes Building/property name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.77 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Building/property name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/property name, text [X(30)]
METeOR identifier:	290295
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The name of a building or property where an organisation is located, as represented by text.
Data Element Concept:	Service provider organisation (address)—building/property name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:

Usually this information is not abbreviated.

Should include any reference to a wing or other components of a building complex, if applicable.

A comma is to be used to separate the wing reference from the rest of the building name.

Record each Building/property name relevant to the address:

- Building/property name 1 (30 alphanumeric characters)
- Building/property name 2 (30 alphanumeric characters)

For example:

Building - TREASURY BUILDING

Property - BRINDABELLA STATION

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

CVD drug therapy—condition

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular disease condition targeted by drug therapy, code NN
METeOR identifier:	270193
Registration status:	Health, Standard 01/03/2005
Definition:	The condition(s) for which drug therapy is being used for the prevention or long-term treatment of cardiovascular disease, as represented by a code.
Data Element Concept:	Person—cardiovascular disease condition targeted by drug therapy

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	01	Heart failure
	02	Ischaemic heart disease
	03	Hypertension
	04	Atrial fibrillation (AF)
	05	Other dysrhythmia or conductive disorder
	06	Dyslipidaemia
	07	Peripheral vascular disease (PVD)
	08	Renal vascular disease
	09	Stroke
	10	Transient ischaemic attack (TIA)
	97	Other
	98	No CVD drugs prescribed
Supplementary values:	99	Not recorded

Collection and usage attributes

Guide for use:	The categorisations may be made using the most recent version of the Australian Modification of the appropriate International Classification of Diseases codes.

Data element attributes

Collection and usage attributes

Guide for use:	More than one code can be recorded.
Comments:	References such as the Australian Medicines Handbook can be used to identify specific drugs that are appropriate for use in

the management of the conditions identified in the value domain.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes CVD drug therapy - condition, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.03 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Caesarean section indicator, last previous birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—caesarean section indicator (last previous birth) code N
METeOR identifier:	301993
Registration status:	Health, Standard 29/11/2006
Definition:	Whether a caesarean section was performed for the woman's last previous birth, as represented by a code.
Data Element Concept:	Female—caesarean section indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	This item should be completed if there has been a previous birth. In the case of no previous births, the item should be left blank.
Comments:	Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care. This item can be used to determine vaginal births occurring after a caesarean section delivery (VBAC).

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Cancer initial treatment completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment completion date, DDMMYYYY
METeOR identifier:	288136
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the initial non-surgical treatment for cancer was completed.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Collected for radiation therapy and systemic therapy.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.65 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This field must:

- be greater than or equal to the date of initial cancer diagnosis, and
- be greater than or equal to the date of the initial course of treatment for cancer.

This item is collected for the analysis of outcome by treatment type.

Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis

to treatment, from treatment to recurrence and from treatment to death.

Cancer initial treatment starting date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment start date, DDMMYYYY
METeOR identifier:	288103
Registration status:	Health, Standard 04/06/2004
Definition:	The start date of the initial course of non-surgical treatment for cancer.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The start date of the treatment is recorded regardless of whether treatment is completed as intended or not. Treatment subsequent to a recurrence will not be recorded. Collected for radiation therapy and systemic therapy. Date of surgical treatment is collected as a separate item.

Source and reference attributes

Submitting organisation:	National Cancer Control Institute
Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - starting date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.08 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This field must:

- be greater than or equal to the date of initial cancer diagnosis, and
- be less than or equal to the date on which initial treatment for cancer was completed.

This metadata item is collected for the analysis of outcome by treatment type.

Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Cancer staging—M stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX
METeOR identifier:	293231
Registration status:	Health, Standard 13/06/2004
Definition:	Absence or presence of distant metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—distant metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid M codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: Choose the lower (less advanced) M category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence

or absence of tumour at sites distant from the primary site.
TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Origin:
International Union Against Cancer (UICC)
Commission on Cancer, American College of Surgeons

Reference documents:
UICC TNM Classification of Malignant Tumours (5th Edition) (1997)
Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:
Supersedes Cancer staging - M stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.45 KB)
Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Standard 04/06/2004

Implementation in Data Set Specifications:
Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Standard 07/12/2005

Conditional obligation:
Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:
For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—N stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX
METeOR identifier:	293254
Registration status:	Health, Standard 13/06/2004
Definition:	Extent of regional lymph node metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—regional lymph node metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid N codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: Choose the lower (less advanced) N category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence

or absence of tumour at sites distant from the primary site.
TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Cancer staging - N stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.54 KB)

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Standard 04/06/2004

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Conditional obligation:
Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:
For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—T stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X]
METeOR identifier:	293270
Registration status:	Health, Standard 13/06/2004
Definition:	Extent of primary cancer including tumour size, at the time of diagnosis, as represented by a code.
Data Element Concept:	Person with cancer—primary tumour status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX[X]
Maximum character length:	3

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid T codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: Choose the lower (less advanced) T category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence

or absence of tumour at sites distant from the primary site.
TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Reference documents: Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Cancer staging - T stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.48 KB)
Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Standard 04/06/2004

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Standard 07/12/2005

Conditional obligation:
Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:
For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—TNM stage grouping code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX}
METeOR identifier:	296925
Registration status:	Health, Standard 04/06/2004
Definition:	The anatomical extent of disease at diagnosis based on the previously coded T,N and M stage categories, as represented by a code.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XXXX{[X]XX}
Maximum character length:	6

Supplementary values:

Value	Meaning
8888	Not applicable
9999	Unknown, Stage X

Collection and usage attributes

Guide for use:	Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Data element attributes

Collection and usage attributes

Guide for use:	Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules. Choose the lower (less advanced) T category when there is any uncertainty.
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Related metadata references:	Supersedes Cancer staging - TNM stage grouping code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.35 KB) Is formed using Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX Health, Standard 13/06/2004 Is formed using Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of

Malignant Tumours 5th ed) code XX Health, Standard 13/06/2004

Is formed using Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X] Health, Standard 13/06/2004

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Conditional obligation:
Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:
For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—cancer treatment type, code N
METeOR identifier:	288185
Registration status:	Health, Standard 04/06/2004
Definition:	The type of treatment for cancer given as initial treatment for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment—cancer treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No treatment
1	Surgical treatment
2	Radiation therapy
3	Systemic agent therapy
4	Surgical and radiation treatment
5	Surgical treatment and systemic agent treatment
6	Radiation and systemic agent treatment
7	All three treatment types

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons. New South Wales Health Department.
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:	Supersedes Cancer treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.38 KB)

Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Cancer treatment—target site (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361029
Registration status:	Health, Standard 05/02/2008
Definition:	The site or region which is the target of particular surgical or radiotherapy treatment, as represented by an ICD-10-AM code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases (ICD-10-AM), Australian Modification, National Centre for Classification in Health, Sydney is used.

Relational attributes

Related metadata references:	Supersedes Cancer treatment—target site for cancer treatment, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Cancer treatment—target site (ICDO-3)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICDO-3) ANN
METeOR identifier:	293161
Registration status:	Health, Standard 13/06/2004
Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment, as represented by an ICDO-3 code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases for Oncology (ICD-O), World Health Organisation is used. Major organ only - first 3 characters.

Relational attributes

Related metadata references:	Supersedes Cancer treatment - target site, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.22 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Cardiovascular medication (current)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular medication taken (current), code N
METeOR identifier:	270237
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual is currently taking cardiovascular medication, as represented by a code.
Data Element Concept:	Person—cardiovascular medication taken

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use:

CODE 1 Angiotensin converting enzyme (ACE) inhibitors

Use this code for ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril).

CODE 2 Angiotensin II (A2) receptor blockers

Use this code for Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan).

CODE 3 Beta blockers

Use this code for Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol).

CODE 4 Calcium antagonists

Use this code for Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil).

CODE 8 None of the above

This code is used when none of the listed medications is being taken by the person.

CODE 9 Not stated/inadequately described

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

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

Are you currently taking any medication for a cardiovascular condition?

___Yes ___No

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

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

Ace Inhibitors ___Yes ___No

Angiotensin II receptor blockers ___Yes ___No

Beta blockers ___Yes ___No

Calcium antagonists ___Yes ___No

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

Data element attributes

Collection and usage attributes

Collection methods: A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be reported.

Source and reference attributes

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Australian Medicines Handbook: last modified by February 2001 Contents of Cardiovascular, Version 3, 1999 Therapeutic Guidelines Limited (05.04.2002)].

Relational attributes

Related metadata references: Supersedes Cardiovascular medication - Superseded 01/03/2005, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.07 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be reported.

Example 1:

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

Example 2:

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

Care type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital service—care type, code N[N].N
METeOR identifier:	270174
Registration status:	Health, Standard 01/03/2005
Definition:	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), as represented by a code.
Data Element Concept:	Hospital service—care type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Permissible values:

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

Collection and usage attributes

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

depends on the principal clinical intent of the care received.

Admitted care can be one of the following:

CODE 1.0 Acute care (Admitted care)

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

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

CODE 2.0 Rehabilitation care (Admitted care)

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

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

Optional:

CODE 2.1 Rehabilitation care delivered in a designated unit (optional)

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

CODE 2.2 Rehabilitation care according to a designated program (optional)

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

CODE 2.3 Rehabilitation care is the principal clinical intent (optional)

Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of

the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

Code 3.0 Palliative care

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

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

Optional:

CODE 3.1 Palliative care delivered in a designated unit (optional)

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

CODE 3.2 Palliative care according to a designated program (optional)

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

CODE 3.3 Palliative care is the principal clinical intent (optional)

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

CODE 4.0 Geriatric evaluation and management

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This

care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

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

CODE 5.0 Psychogeriatric care

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

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

CODE 6.0 Maintenance care

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

CODE 7.0 Newborn care

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

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (eg transferred from another hospital) are admitted with newborn care type
- patients aged greater than 9 days not previously admitted

(eg transferred from another hospital) are either boarders or admitted with an acute care type

- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in **Newborn qualification status**.

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

CODE 8.0 Other admitted patient care

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

Other care can be one of the following:

CODE 9.0 Organ procurement - posthumous (Other care)

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

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

CODE 10.0 Hospital boarder (Other care)

Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

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

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Care type, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (33.13 KB)

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Carer participation arrangements—carer consultants employed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N
METeOR identifier:	288833
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has carer consultants employed on a paid basis to represent the interests of carers and advocate for their needs, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—carer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N
METeOR identifier:	290367
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation periodically conducts carer satisfaction surveys, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004
Implementation in Data Set	Mental health establishments NMDS 2005-2006 Health,

Specifications:

Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N
METeOR identifier:	290370
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has a formal internal complaints mechanism in which complaints made by carers are regularly reviewed by a committee that includes carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed),

code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N
METeOR identifier:	290365
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has developed a formal and documented policy on participation by carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004
Implementation in Data Set	Mental health establishments NMDS 2005-2006 Health,

Specifications:

Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N
METeOR identifier:	290359
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service holds regular discussion groups to seek the views of carers about the service, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Cataract - history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cataract status, code N
METeOR identifier:	270252
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes, as represented by a code.
Data Element Concept:	Person—cataract status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Cataract currently present or has been previously removed from the right eye
	2	Cataract currently present or has been previously removed from the left eye
	3	Cataract currently present or has been previously removed from both eyes
	4	No cataract present or has not been previously removed from either eye
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	Examination of the lens of the eye through a dilated pupil (visible through the pupil by the use of an ophthalmoscope) by an ophthalmologist or optometrist, as a part of the ophthalmological assessment. Ask the individual if he/she has a cataract in either or both eyes or has had a cataract removed from either or both eyes previously. Alternatively obtain information from an ophthalmologist or optometrist or from appropriate documentation.
Comments:	Cataract is a clouding of the lens of the eye or its capsule sufficient to reduce vision. The formation of cataract occurs more rapidly in patients with a history of ocular trauma, uveitis, or diabetes mellitus. Cataract is an associated diabetic eye problem that could lead to blindness. Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and

to avoid or postpone vision-threatening complications. A comprehensive ophthalmological examination includes:

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

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Cataract - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.36 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Category reassignment date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—category reassignment date, DDMMYYYY
METeOR identifier:	270010
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of **clinical review** for the awaited procedure, or is assigned to a different patient listing status category.
Data Element Concept:	Elective care waiting list episode—category reassignment date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The date needs to be recorded each time a patient's urgency classification or listing status changes.
Comments:	This date is necessary for the calculation of the waiting time at admission and the waiting time at a census date.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Category reassignment date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.16 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005 Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY
METeOR identifier:	270153
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.
Data Element Concept:	Hospital census (of elective surgery waitlist patients)—census date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Census date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.42 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005 *Implementation start date:* 30/09/2006 Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005 *Implementation start date:* 30/09/2002 *Implementation end date:* 30/06/2006

Centrelink customer reference number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Centrelink customer reference number {N(9)A}
Synonymous names:	CRN; Centrelink reference number
METeOR identifier:	270098
Registration status:	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
Definition:	A personal identifier assigned by Centrelink for the purposes of identifying people (and organisations) eligible for specific services, including some public health care services, such as oral health services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	{N(9)A}
Maximum character length:	10

Data element attributes

Collection and usage attributes

Guide for use:	The CRN should only be collected from persons eligible to receive health services that are to be funded by Centrelink. The number may be reported to a Centrelink agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.
Collection methods:	The Centrelink Customer Reference Number (CRN) is provided on 'Health Care Cards' and 'Pensioner Concession Cards'.
Comments:	When a person accesses health services on the basis of being a Centrelink customer, collection of the CRN is usually necessary. This data should not be collected and recorded if it is not needed to support the provision of such health services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS5017 Health Care Client Identification

Relational attributes

Related metadata references:	Supersedes Centrelink customer reference number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.52 KB)
Implementation in Data Set	Health care client identification Health, Superseded 04/05/2005

Specifications:	Health care client identification DSS Health, Standard 04/05/2005

Cerebral stroke due to vascular disease (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cerebral stroke due to vascular disease (history), code N
METeOR identifier:	270355
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has had a cerebral stroke due to vascular disease, as represented by a code.
Data Element Concept:	Person—cerebral stroke due to vascular disease

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cerebral stroke - occurred in the last 12 months
2	Cerebral stroke - occurred prior to the last 12 months
3	Cerebral stroke - occurred both in and prior to the last 12 months
4	No history of cerebral stroke due to vascular disease

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Cerebral stroke due to vascular disease - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.35 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005
	Information specific to this data set:

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

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

References:

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

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

Change to body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—nature of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320171
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The qualitative or quantitative change of a person's impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person—nature of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No change in structure
1	Total absence
2	Partial absence
3	Additional part
4	Aberrant dimensions
5	Discontinuity
6	Deviating position
7	Qualitative changes in structure

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

CODE 0 No change in structure

Used when the structure of the body part is within the range of the population standard.

CODE 1 Total absence

Used when the body structure is not present. For example total absence of the structures of the lower leg following a thorough knee amputation.

CODE 2 Partial absence

Used when only part of a body structure is present. For example partial absence of the bones of the lower leg following below knee amputation.

CODE 3 Additional part

Used when a structure, not usually present in the population is present, for example a sixth lumbar vertebra or an sixth digit on one hand.

CODE 4 Aberrant dimensions

Used when the shape and size of a body structure is significantly different from the population standard. For example radial aplasia where the shape and size of the radial bone does not develop.

CODE 5 Discontinuity

Used when parts of a body structure are separated, for example cleft palate or fracture.

CODE 6 Deviating position

Used when the location of a structure is not according to population standard; for example, transposition of the great vessels, where the aorta arises from the right ventricle and the pulmonary vessels from the left ventricle.

CODE 7 Qualitative changes in structure

Used when the structure of a body part is altered from the population standard. This includes accumulation of fluid, changes in bone structure as a result of osteoporosis or Paget's disease.

CODE 8 Not specified

Used when there is a change to a body structure, but the nature of the change is not described.

CODE 9 Not applicable

Used when it is not appropriate to code the nature of the change to a body structure.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with specified body structures, for example 'partial absence of structures related to movement'. This data element may also be used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N and Person—location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—location of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—extent of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Body structures cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Chest pain pattern category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—chest pain pattern, code N
METeOR identifier:	284823
Registration status:	Health, Standard 04/06/2004
Definition:	The person's chest pain pattern, as represented by a code.
Data Element Concept:	Person—chest pain pattern

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Atypical chest pain
2	Stable chest pain pattern
3	Unstable chest pain pattern: rest &/or prolonged
4	Unstable chest pain pattern: new & severe
5	Unstable chest pain pattern: accelerated & severe
8	No chest pain/discomfort
9	Not stated/inadequately described

Supplementary values:

Collection and usage attributes

Guide for use:

Chest pain or discomfort of myocardial ischaemic origin is usually described as chest pain, discomfort or pressure, jaw pain, arm pain or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.

CODE 1 Atypical chest pain

Use this code for pain, pressure, or discomfort in the chest, neck, or arms not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.

CODE 2 Stable chest pain pattern

Use this code for chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.

CODE 3 Unstable chest pain pattern: rest and/or prolonged

Use this code for chest pain that occurred at rest and was prolonged, usually lasting more than 10 minutes

CODE 4 Unstable chest pain pattern: new and severe.

Use this code for new-onset chest pain that could be described

as at least Canadian Cardiovascular Society (CCS) classification III severity.

CODE 5 Unstable chest pain pattern: accelerated and severe

Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class III.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Chest pain pattern category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.14 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

The Canadian Cardiovascular Society classes of angina can be used to support categorisation of chest pain patterns. Canadian Cardiovascular Society (CCS) classes of angina (Campeau L. Grading of angina pectoris. Circulation 1976; 54:522.)

1. Ordinary physical activity (for example, walking or climbing stairs) does not cause angina; angina occurs with strenuous or rapid or prolonged exertion at work or recreation.
2. Slight limitation of ordinary activity (for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress, or only during the few hours after awakening; walking more than 2 blocks on the level or climbing more than 1 flight of ordinary stairs at a normal pace; and in normal conditions).
3. Marked limitation of ordinary activity (for example, angina occurs with walking 1 or 2 blocks on the level or climbing 1 flight of stairs in normal conditions and at a normal pace).
4. Inability to perform any physical activity without discomfort; angina syndrome may be present at rest.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cholesterol—HDL (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN
METeOR identifier:	270401
Registration status:	Health, Standard 01/03/2005
Definition:	A person's high-density lipoprotein cholesterol (HDL-C), measured in mmol/L.
Data Element Concept:	Person—high-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	[N].NN
Maximum character length:	3

Supplementary values:

Value	Meaning
9.99	Not measured/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

When reporting, record whether or not the measurement of High-density Lipoprotein Cholesterol (HDL-C) was performed in a fasting specimen.

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

Collection methods:

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

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

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

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group National Diabetes Data Working Group
Origin:	National Heart Foundation of Australia and the Cardiac Society

of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

Relational attributes

Related metadata references:

Supersedes Cholesterol-HDL - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.97 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Candidate 04/03/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

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

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

175: S57-S88.

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

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

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

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

and the target is:

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

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

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

References:

National Heart Foundation of Australia - Lipid Management Guidelines 2001.

Cholesterol—LDL (calculated)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N
METeOR identifier:	270402
Registration status:	Health, Standard 01/03/2005
Definition:	A person's calculated low-density lipoprotein cholesterol (LDL-C).
Data Element Concept:	Person—low-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N].N	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	99.9	Not stated/inadequately described
Unit of measure:	Millimole per litre (mmol/L)	

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

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

Collection methods:

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

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

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

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

Comments:

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

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is

the prime determinant of its level of blood cholesterol.

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

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

Relational attributes

Related metadata references:

Is formed using Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Standard 01/03/2005

Is formed using Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN Health, Standard 01/03/2005

Is formed using Person—triglyceride level (measured), total millimoles per litre N[N].N Health, Standard 01/03/2005

Supersedes Cholesterol-LDL calculated, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (19.67 KB)

Is formed using Health service event—fasting indicator, code N Health, Standard 21/09/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

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

- the majority of people with CHD do not have markedly elevated levels of plasma total cholesterol or LDL-C,
- there is a continuous positive but curvilinear relationship between the concentration of plasma total

(and LDL) cholesterol and the risk of having a coronary event and of dying from CHD,

- there is no evidence that a low level of plasma (or LDL) cholesterol predisposes to an increase in non-coronary mortality.

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

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

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

Cholesterol—total (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cholesterol level (measured), total millimoles per litre N[N].N
METeOR identifier:	270403
Registration status:	Health, Standard 01/03/2005
Definition:	A person's total cholesterol (TC), measured in mmol/L.
Data Element Concept:	Person—cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Measurement in mmol/L to 1 decimal place.

Record the absolute result of the total cholesterol measurement. When reporting, record whether or not the measurement of Cholesterol-total - measured was performed in a fasting specimen.

Collection methods:

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

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

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

Comments:

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

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

Poor nutrition can be a contributing factor to heart, stroke and

vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

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

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

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

Relational attributes

Related metadata references: Supersedes Cholesterol-total - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.35 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Candidate 04/03/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

Several generalisations can be made from these cholesterol

lowering trials:

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

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

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

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

- To reduce total Cholesterols to less than 5.5 mmol/L
- To reduce triglyceride levels to less than 2.0 mmol/L
- To increase high density lipoprotein Cholesterols to more than or equal to 1.0 mmol/L.

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

Classification of health labour force job

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—occupation, code ANN
METeOR identifier:	270140
Registration status:	Health, Standard 01/03/2005
Definition:	The position or job classification of a health professional, as represented by a code.
Data Element Concept:	Health professional—occupation

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Medicine - General practitioner working mainly in general practice
A02	Medicine - General practitioner working mainly in a special interest area
A03	Medicine - Salaried non-specialist hospital practitioner: Resident medical officer or intern
A04	Medicine - Salaried non-specialist hospital practitioner: other hospital career medical officer
A05	Medicine - Specialist
A06	Medicine - Specialist in training (e.g. registrar)
B01	Dentistry (private practice only) - Solo practitioner
B02	Dentistry (private practice only) - Solo principal with assistant(s)
B03	Dentistry (private practice only) - Partnership
B04	Dentistry (private practice only) - Associateship
B05	Dentistry (private practice only) - Assistant
B06	Dentistry (private practice only) - Locum
C01	Nursing - Enrolled nurse
C02	Nursing - Registered nurse
C03	Nursing - Clinical nurse
C04	Nursing - Clinical nurse consultant/supervisor
C05	Nursing - Nurse manager
C06	Nursing - Nurse educator
C07	Nursing - Nurse researcher
C08	Nursing - Assistant director of nursing

C09	Nursing - Deputy director of nursing
C10	Nursing - Director of nursing
C11	Nursing - Tutor/lecturer/senior lecturer in nursing (tertiary institution)
C12	Nursing - Associate professor/professor in nursing (tertiary institution)
C98	Nursing - Other (specify)
D01	Pharmacy (community pharmacist) - Sole proprietor
D02	Pharmacy (community pharmacist) - Partner-proprietor
D03	Pharmacy (community pharmacist) - Pharmacist-in-charge
D04	Pharmacy (community pharmacist) - Permanent assistant
D05	Pharmacy (community pharmacist) - Reliever, regular location
D06	Pharmacy (community pharmacist) - Reliever, various locations
E01	Pharmacy (Hospital/clinic pharmacist) - Director/deputy director
E02	Pharmacy (Hospital/clinic pharmacist) - Grade III pharmacist
E03	Pharmacy (Hospital/clinic pharmacist) - Grade II pharmacist
E04	Pharmacy (Hospital/clinic pharmacist) - Grade I pharmacist
E05	Pharmacy (Hospital/clinic pharmacist) - Sole pharmacist
F01	Podiatry - Own practice (or partnership)
F02	Podiatry - Own practice and sessional appointments elsewhere
F03	Podiatry - Own practice and fee-for-service elsewhere
F04	Podiatry - Own practice, sessional and fee-for-service appointments elsewhere
F05	Podiatry - Salaried podiatrist
F06	Podiatry - Locum, regular location
F07	Podiatry - Locum, various locations
F08	Podiatry - Other (specify)
G01	Physiotherapy - Own practice (or partnership)
G02	Physiotherapy - Own practice and sessional appointments elsewhere
G03	Physiotherapy - Own practice and fee-for-service elsewhere
G04	Physiotherapy - Own practice, sessional and fee-for-service appointments elsewhere
G05	Physiotherapy - Salaried physiotherapist

	G06	Physiotherapy - Locum, regular location
	G07	Physiotherapy - Locum, various locations
Supplementary values:	C99	Nursing - Unknown/inadequately described/not stated

Data element attributes

Collection and usage attributes

Comments:

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

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

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Classification of health labour force job, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.72 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

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

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

Client type (alcohol and other drug treatment services)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—client type, code N
METeOR identifier:	270083
Registration status:	Health, Standard 01/03/2005
Definition:	The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—client type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Own alcohol or other drug use
2	Other's alcohol or other drug use

Collection and usage attributes

Guide for use:

CODE 1 Own alcohol or other drug use

Use this code for a client who receives treatment or assistance concerning their own alcohol and/or other drug use.

Use this code where a client is receiving treatment or assistance for both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person.

CODE 2 Other's alcohol or other drug use

Use this code for a client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person.

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

Data element attributes

Collection and usage attributes

Guide for use:

Where Code 2 Other's alcohol or other drug use is reported, do not collect the following data elements:

Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN;

Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN;

Client—injecting drug use status, code N; and

Client—method of drug use (principal drug of concern), code

N.

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

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Client type - alcohol and other drug treatment services, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Clinical evidence of chronic lung disease (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (chronic lung disease), code N
METeOR identifier:	285285
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of chronic lung disease, as represented by a code.
Data Element Concept:	Person—clinical evidence status (chronic lung disease)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Objective evidence is coded where the diagnosis is supported by current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline, aminophylline, or steroids), or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/forced vital capacity (FVC) less than 0.7 (post bronchodilator). Respiratory failure partial pressure of oxygen (PaO2) less than 60 mmHg (8kPa), or partial pressure of carbon dioxide (PaCO2) greater than 50 mmHg (6.7 kPa).
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status(chronic lung disease), code N; Person—clinical evidence status(heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status(sleep apnoea syndrome), code N must also be recorded.
Comments:	The diagnosis rests on the airflow limitation, which is not fully reversible. Consider treating as asthma if airflow limitation is substantially reversible. (The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook.

Version 1, November 2002.)

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Clinical evidence of heart failure (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (heart failure), code N
METeOR identifier:	285287
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of heart failure, as represented by a code.
Data Element Concept:	Person—clinical evidence status (heart failure)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Objective evidence is coded where a patient has current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion and objective evidence of cardiac dysfunction at rest. The diagnosis is derived from and substantiated by clinical documentation from testing according to current practices.
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status(chronic lung disease), code N; Person—clinical evidence status(heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status(sleep apnoea syndrome), code N must also be recorded.
Comments:	The most widely available investigation for documenting left ventricular dysfunction is the transthoracic echocardiogram (TTE). Other modalities include: • transoesophageal echocardiography (TOE), • radionuclide ventriculography (RVG),

- left ventriculogram (LVgram),
- magnetic resonance imaging (MRI).

In the absence of any adjunctive laboratory tests, evidence of supportive clinical signs of ventricular dysfunction. These include:

- third heart sound (S3),
- cardiomegaly,
- elevated jugular venous pressure (JVP),
- chest X-ray evidence of pulmonary congestion.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Clinical evidence of peripheral arterial disease (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (peripheral arterial disease), code N
METeOR identifier:	285289
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of peripheral arterial disease, as represented by a code.
Data Element Concept:	Person—clinical evidence status (peripheral arterial disease)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

For peripheral artery disease, objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation for a patient with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

For aortic aneurysm, objective evidence is coded when the diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) is supported and substantiated by appropriate documentation of objective testing.

For renal artery stenosis, objective evidence is coded when the diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

Collection methods:

For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status (chronic lung disease), code N; Person—clinical evidence status (heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status (peripheral arterial disease), code N; Person—clinical evidence status (sleep apnoea syndrome), code N must also be recorded.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Clinical evidence of sleep apnoea syndrome (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (sleep apnoea syndrome), code N
METeOR identifier:	285291
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of sleep apnoea syndrome, as represented by a code.
Data Element Concept:	Person—clinical evidence status (sleep apnoea syndrome)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status(chronic lung disease), code N; Person—clinical evidence status(heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status(sleep apnoea syndrome), code N must also be recorded.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Clinical evidence of stroke (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (stroke), code N
METeOR identifier:	285293
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of stroke, as represented by a code.
Data Element Concept:	Person—clinical evidence status (stroke)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	For ischaemic: non-haemorrhagic cerebral infarction, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI), or For haemorrhagic: intracerebral haemorrhage, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI).
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status (chronic lung disease), code N; Person—clinical evidence status (heart failure), code N; Person—clinical evidence status (stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status (sleep apnoea syndrome), code N must also be recorded.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Clinical procedure timing (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical procedure timing, code N
METeOR identifier:	284863
Registration status:	Health, Standard 04/06/2004
Definition:	The timing of the provision of a clinical procedure, as represented by a code.
Data Element Concept:	Person—clinical procedure timing

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Procedure performed prior to an episode of admitted patient care
2	Procedure performed during an episode of admitted patient care

Data element attributes

Collection and usage attributes

Guide for use:	Record only for those procedure codes that apply.
Collection methods:	This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Clinical procedure timing status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.93 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Clinical urgency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—clinical urgency, code N
METeOR identifier:	270008
Registration status:	Health, Standard 01/03/2005
Definition:	A clinical assessment of the urgency with which a patient requires elective hospital care, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—clinical urgency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Data element attributes

Collection and usage attributes

Guide for use:	The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.
Comments:	A patient's classification may change if he or she undergoes **clinical review** during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (metadata item Elective care waiting list episode—category reassignment date, DDMMYYYY).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Clinical urgency, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.39 KB)

See also Elective surgery waiting list episode—overdue patient status, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Clopidogrel therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clopidogrel therapy status, code NN
METeOR identifier:	284873
Registration status:	Health, Standard 04/06/2004
Definition:	The person's clopidogrel therapy status, as represented by a code.
Data Element Concept:	Person—clopidogrel therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - true allergy to clopidogrel
24	Not given - active bleeding
25	Not given - bleeding risk
26	Not given - thrombocytopenia
27	Not given - severe hepatic dysfunction
29	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODES 21 - 29 Not given If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Clopidogrel therapy status, version 1, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Co-location status of mental health service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—co-location with acute care hospital, code N
METeOR identifier:	286995
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a mental health service is co-located with an acute care hospital, as represented by a code.
Data Element Concept:	Specialised mental health service—co-location with acute care hospital

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Co-located
2	Not co-located

Collection and usage attributes

Guide for use:

CODE 1 Co-located

Co-located health services are those that are established physically and organisationally as part of an acute care hospital service. There are two forms of co-location:

- a health service that is built and managed as a ward or unit within an acute care hospital; or
- the health service operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus.

In the second option, units and wards within a psychiatric hospital may be classified as co-located when all the following criteria apply:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital;
- a single employer covers the staff of the acute care hospital and the psychiatric hospital;
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus; and
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods: To be reported for mental health services that primarily provide overnight admitted patient care. Excludes residential mental health services and ambulatory mental health services.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Compensable status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—compensable status, code N
METeOR identifier:	270100
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a patient is a **compensable patient**, as represented by a code.
Data Element Concept:	Patient—compensable status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Compensable
	2	Non-compensable
Supplementary values:	9	Not stated/not known

Data element attributes

Collection and usage attributes

Guide for use:	This definition of **compensable patient** excludes eligible beneficiaries (Department of Veterans' Affairs), Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.
Comments:	To assist in the analyses of utilisation and health care funding.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Compensable status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.25 KB)
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Complication of labour and delivery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361071
Registration status:	Health, Standard 05/02/2008
Definition:	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta, as represented by a code.
Data Element Concept:	Birth event—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Comments:	Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—complication, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Complications of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (current)—complication, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333938
Registration status:	Health, Standard 07/12/2005
Definition:	Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome, as represented by a code
Data Element Concept:	Pregnancy (current)—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.
Comments:	Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Pregnancy (current)—complication, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Concurrent clinical condition (on presentation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome concurrent clinical condition, code NN
METeOR identifier:	284891
Registration status:	Health, Standard 04/06/2004
Definition:	The concurrent medical conditions, which are pertinent to the risk stratification and treatment of acute coronary syndrome that a person has or has undergone prior to presentation, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome concurrent clinical condition

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
11	Angina for more than last two weeks
12	Angina only in the last two weeks
21	Chronic lung disease
31	Heart failure
41	Hypertension
51	Ischaemic: non-haemorrhagic cerebral infarction
52	Haemorrhagic: intracerebral haemorrhage
61	Peripheral artery disease
62	Aortic aneurysm
63	Renal artery stenosis
71	Sleep apnoea

Supplementary values:

99	not stated/inadequately described

Collection and usage attributes

Guide for use:

Angina:

CODE 11 Angina for more than last two weeks

This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, for more than the last two weeks.

CODE 12 Angina only in the last two weeks

This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, only in the last two weeks.

Chronic lung disease:

CODE 21 Chronic lung disease

This code is used where there is a history or symptoms suggestive of chronic lung disease.

Heart failure:

CODE 31 Heart failure

This code is used where a patient has past or current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion suggestive of cardiac dysfunction.

Hypertension:

CODE 41 Hypertension

This code is used where there is current use of pharmacotherapy for hypertension and/or clinical evidence of high blood pressure.

Stroke:

CODE 51 Ischaemic: non-haemorrhagic cerebral infarction

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from an ischaemic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

CODE 52 Haemorrhagic: intracerebral haemorrhage

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from a haemorrhagic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Peripheral arterial disease:

CODE 61 Peripheral artery disease

This code is used where there is history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

CODE 62 Aortic aneurysm

This code is used where there is a history of aneurysmal dilatation of the aorta (thoracic and or abdominal).

CODE 63 Renal artery stenosis

This code is used where there is history of functional stenosis of one or both renal arteries.

Sleep Apnoea syndrome:

CODE 71 Sleep apnoea

This code is used where there is evidence of sleep apnoea syndrome (SAS) on history.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: More than one medical condition may be recorded.

Record only those codes that apply.

Record all codes that apply.

Codes 21, 31, 51, 52, 61, 62, 63 and 71 must be accompanied by a

Clinical evidence status code.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Concurrent clinical condition - on presentation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.84 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Condition onset flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—condition onset flag, code N
METeOR identifier:	354816
Registration status:	Health, Standard 05/02/2008
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—condition onset flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Condition with onset during the episode of admitted patient care
2	Condition not noted as arising during the episode of admitted patient care

Supplementary values:

9	Not reported

Collection and usage attributes

Guide for use:

1 Condition with onset during the episode of admitted patient care

- a condition which arises during the episode of admitted patient care and would not have been present on admission

Includes:

Conditions resulting from misadventure during medical or surgical care during the episode of admitted patient care.

Abnormal reactions to, or later complication of, surgical or medical care arising during the episode of admitted patient care.

Conditions arising during the episode of admitted patient care not related to surgical or medical care (for example, pneumonia).

2 Condition not noted as arising during the episode of admitted patient care

- a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status.
- a previously existing condition not diagnosed until the episode of admitted patient care.

Includes:

In the case of neonates, the conditions present at birth.

A previously existing condition that is exacerbated during the

episode of admitted patient care.

Conditions that are suspected at the time of admission and subsequently confirmed during the episode of admitted patient care.

Conditions that were not diagnosed at the time of admission but clearly did not develop after admission (for example malignant neoplasm).

Conditions where the onset relative to the beginning of the episode of admitted patient care is unclear or unknown.

9 Not reported

The condition onset flag could no be reported due to limitations of the data management system.

Data element attributes

Collection and usage attributes

Guide for use:

Assign the relevant condition onset flag to ICD-10-AM diagnosis codes assigned in the principal diagnosis and additional diagnosis fields for the National Hospital Morbidity Database collection.

The sequencing of diagnosis codes must comply with the Australian Coding Standards and therefore diagnosis codes should not be re-sequenced in an attempt to list diagnosis codes with the same condition onset flag together.

When it is difficult to decide if a condition was present at the beginning of the episode of care or if it arose during the episode, assign a value of 1 - Condition not noted as arising during this episode of care.

The principal diagnosis should always have a condition onset flag value of 1.

Explanatory notes:

The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

The flag on morphology codes should match that on the corresponding neoplasm code

When a single diagnosis code describes a condition and that code contains more than one concept (e.g. diabetes with renal complications) and each concept within that code has a different condition onset flag, then assign a value of 1.

When a condition requires more than one diagnosis code to describe it, it is possible for each diagnosis code to have a different condition onset flag.

The flag on Z codes related to the outcome of delivery on the mother's record (Z37), should always be assigned a value of 1

The flag on Z codes related to the outcome of delivery on the baby's record (Z38), should always be assigned a value of 1

Collection methods:

A condition onset flag should be recorded and coded upon completion of an episode of admitted patient care.

Comments:

The condition onset flag is a means of differentiating those conditions which arise during, or arose before, an admitted patient episode of care. Having this information will provide an insight into the kinds of conditions patients already have when entering hospital and what arises during the episode of

care. A better understanding of those conditions arising during the episode of care may inform prevention strategies particularly in relation to complications of medical care.

The flag only indicates when the condition had onset, and cannot be used to indicate whether a condition was considered to be preventable.

Source and reference attributes

Origin: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—diagnosis onset type, code N Health, Superseded 05/02/2008

Implementation in Data Set Specifications: Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Congenital malformations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333934
Registration status:	Health, Standard 07/12/2005
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by an ICD-10-AM code.
Context:	Admitted patient care
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Source and reference attributes

Origin:	International Classification of Diseases - 10th Revision, Australian Modification (5th Edition 2004) National Centre for Classification in Health, Sydney.

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see the metadata item Person—congenital malformations, code (BPA 1979) ANN.N[N]).
Comments:	Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Person—congenital malformation, code (ICD-10-

AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Congenital malformations—BPA code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (BPA 1979) ANN.N[N]
METeOR identifier:	270408
Registration status:	Health, Standard 01/03/2005
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by a BPA code.
Context:	Perinatal statistics
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	British Paediatric Association Classification of Diseases 1979
Representation class:	Code
Data type:	String
Format:	ANN.N[N]
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. For perinatal data collections, the use of British Paediatric Association (BPA) Classification of Diseases is preferred as this is more detailed.
Comments:	There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the states and territories have used the 5-digit BPA Classification of Diseases to code congenital malformations since the early 1980s.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	British Paediatric Association Classification of Diseases (1979)

Relational attributes

Related metadata references:	Supersedes Congenital malformations - BPA code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.15 KB)

Consumer committee representation arrangements

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer committee representation arrangements, code N
METeOR identifier:	288855
Registration status:	Health, Standard 08/12/2004
Definition:	Extent to which a specialised mental health service organisation has formal committee mechanisms in place to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer committee representation arrangements

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers
2	Specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation
3	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation
4	Consumers participate on a broadly based advisory committee which include a mixture of organisations and groups representing a wide range of interests
5	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required
6	No specific arrangements exist for consumer participation in planning and evaluation of services

Collection and usage attributes

Guide for use:	Select the option above that best describes the type of formal committee mechanisms within your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Data element attributes

Collection and usage attributes

Guide for use:

Select the option above that best describes the type of formal committee mechanisms with in your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—consumer consultants employed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N
METeOR identifier:	288866
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service employs consumer consultants on a paid basis to represent the interests of consumers and advocate for their needs, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health,

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—consumer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N
METeOR identifier:	290418
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service conducts consumer satisfaction surveys, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health,

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N
METeOR identifier:	290415
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service has developed a formal internal complaints mechanism in which complaints can be made by consumers and are regularly reviewed by a committee that includes consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N
METeOR identifier:	290410
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service has developed a formal and documented policy on participation by consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (formal participation policy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health,

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N
METeOR identifier:	290408
Registration status:	Health, Standard 08/12/2004
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Contract establishment identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—organisation identifier, NNX[X]NNNNN
METeOR identifier:	270013
Registration status:	Health, Standard 01/03/2005
Definition:	The unique establishment identifier of the other hospital involved in the contracted care.
Data Element Concept:	Contracted hospital care—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNX[X]NNNNN
Maximum character length:	9

Data element attributes

Collection and usage attributes

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

Relational attributes

Related metadata references:	Supersedes Contract establishment identifier, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.93 KB)

Contract procedure flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care (procedure)—contracted procedure flag, code N
METeOR identifier:	270473
Registration status:	Health, Standard 01/03/2005
Definition:	Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service, as represented by a code.
Data Element Concept:	Episode of care (procedure)—contracted procedure flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	[N]
Maximum character length:	1

Permissible values:

Value	Meaning
1	Contracted admitted procedure
2	Contracted non-admitted procedure

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Relational attributes

Related metadata references:

Supersedes Contract procedure flag, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.29 KB)

Contract role

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract role, code A
METeOR identifier:	270114
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the hospital is the purchaser of hospital care or the provider of an admitted or non-admitted service, as represented by a code.
Data Element Concept:	Hospital—contract role

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
A	Hospital A
B	Hospital B

Collection and usage attributes

Guide for use:

CODE A Hospital A
Hospital A is the contracting hospital (purchaser).
CODE B Hospital B
Hospital B is the contracted hospital (provider).

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract role, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
Is used in the formation of Episode of admitted patient care—inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Contract type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract type, code N
METeOR identifier:	270475
Registration status:	Health, Standard 01/03/2005
Definition:	The type of contract arrangement between contractor and the contracted hospital, as represented by a code.
Data Element Concept:	Hospital—contract type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use:

The contracting hospital (purchaser) is termed Hospital A. The contracted hospital (provider) is termed Hospital B.

CODE 1 Contract Type B

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

CODE 2 Contract Type ABA

Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient returns to Hospital A on completion of service by Hospital B.

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

CODE 3 Contract Type AB

Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient does not return to Hospital A on completion of service by Hospital B.
For example, a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.

CODE 4 Contract Type (A)B

This contract type occurs where a Hospital A contracts Hospital

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

CODE 5 Contract Type BA

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care. For example, a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after care.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.37 KB)

Is used in the formation of Episode of admitted patient care — inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Contracted care commencement date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—contracted care commencement date, DDMMYYYY
METeOR identifier:	270105
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care commenced.
Data Element Concept:	Contracted hospital care—contracted care commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

Relational attributes

Related metadata references:	Supersedes Contracted care commencement date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.67 KB)

Contracted care completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—contracted care completed date, DDMMYYYY
METeOR identifier:	270106
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care is completed.
Data Element Concept:	Contracted hospital care—contracted care completed date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is to be used by the contracting hospital to record the date of completion of the contracted hospital care and will be the separation date for the contracted hospital.

Relational attributes

Related metadata references:	Supersedes Contracted care completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.67 KB)

Coordinator of volunteers indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—coordinator of volunteers indicator, yes/no code N
METeOR identifier:	352862
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether a service provider organisation has at least one designated person to coordinate their volunteer labour force, as represented by a code.
Data Element Concept:	Service provider organisation—coordinator of volunteers indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A coordinator of volunteers may be employed part-time or full-time and may be engaged on a paid or unpaid basis.
The duties of a volunteer coordinator may include:

- managing the workloads of volunteer staff;
- liaising with clinical staff regarding clients' needs;
- assessing human resource needs of the organisation;
- recruiting volunteers;
- developing orientation kits and programs;
- developing volunteer policies;
- arranging training and development opportunities; and
- maintaining volunteer records.

CODE 1 Yes
The organisation has a designated coordinator of volunteers.
CODE 2 No
The organisation does not have a designated coordinator of volunteers.

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:	Palliative care performance indicators DSS Health, Standard 05/12/2007

Coronary artery disease—history of intervention or procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery disease intervention (history), code N
METeOR identifier:	270227
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent, as represented by a code.
Data Element Concept:	Person—coronary artery disease intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	CABG, angioplasty or stent - undertaken in last 12 months
2	CABG, angioplasty or stent - undertaken prior to the last 12 months
3	CABG, angioplasty or stent - both within and prior to the last 12 months
4	No CABG, angioplasty or stent undertaken

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Comments:

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

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

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

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

The sooner procedures are done, the greater the chances of

saving heart muscle.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Coronary artery disease - history of intervention or procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.32 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Country of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—country of birth, code (SACC 1998) NNNN
METeOR identifier:	270277
Registration status:	Health, Standard 01/03/2005 Community services, Superseded 02/06/2008 Housing assistance, Standard 20/06/2005
Definition:	The country in which the person was born, as represented by a code.
Data Element Concept:	Person—country of birth

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 1998
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:	The Standard Australian Classification of Countries 1998 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country. A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Data element attributes

Collection and usage attributes

Collection methods:	Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category. Recommended questions are: In which country were you/was the person/was (name) born? Australia Other (please specify) Alternatively, a list of countries may be used based on, for example common Census responses. In which country were you/was the person/was (name) born? Australia England

New Zealand
Italy
Viet Nam
Scotland
Greece
Germany
Philippines
India
Netherlands
Other (please specify)
In either case coding of data should conform to the SACC.
Sometimes respondents are simply asked to specify whether they were born in either 'English speaking' or 'non-English speaking' countries but this question is of limited use and this method of collection is not recommended.

Comments: This metadata item is consistent with that used in ABS collections and is recommended for use whenever there is a requirement for comparison with ABS data.

Source and reference attributes

Origin: National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references: See also Person—proficiency in spoken English, code N Health, Standard 01/03/2005, Community services, Standard 01/03/2005, Housing assistance, Standard 10/02/2006
Supersedes Country of birth, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (19.86 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:
Country of birth for newborn babies should be 'Australia'.

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Creatine kinase MB isoenzyme level (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284903
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme level, as represented by an index.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	X[XXX]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 88888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (international units)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total international units N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284905
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in international units.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284915
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure:	kCat/L

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf

(13.97 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNNN]
METeOR identifier:	284921
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in micrograms per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described
8888	Not measured

Unit of measure:	Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB) Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf

(13.97 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total nanograms per decilitre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284923
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in nanograms per decilitre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

Implementation in Data Set Acute coronary syndrome (clinical) DSS Health, Standard

Specifications: 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284913
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme as a percentage.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB) Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

See also Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - units
METeOR identifier:	284931
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as an index that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	X[XXX]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Person—creatine kinase myocardial band isoenzyme level (measured), index code X[XXX] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (international units)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN]
METeOR identifier:	284959
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in international units (IU) that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Person—creatine kinase-myocardial band isoenzyme level (measured), total international units N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN]
METeOR identifier:	284963
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure:	kCat/L

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Person—creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper

	limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]
METeOR identifier:	284965
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in microgram per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described
8888	Not measured

Unit of measure:	Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper

	limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total nanograms per decilitre N[NNN]
METeOR identifier:	285957
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in nanograms per decilitre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB) Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)
Implementation in Data Set	Acute coronary syndrome (clinical) DSS Health, Standard

Specifications:	07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN]
METeOR identifier:	284961
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as a percentage that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Person—creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatinine serum level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatinine serum level, micromoles per litre NN[NN]
METeOR identifier:	270392
Registration status:	Health, Standard 01/03/2005
Definition:	A person's serum creatinine level measured in micromoles per litre (µmol/L).
Data Element Concept:	Person—creatinine serum level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NN[NN]
Maximum character length:	4
Unit of measure:	Micromole per litre (µmol/L)

Data element attributes

Collection and usage attributes

Guide for use:	There is no agreed standard as to which units serum creatinine should be recorded in. Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.
Collection methods:	Measurement of creatinine should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. • Single venous blood test taken at the time of other screening blood tests. • Fasting not required.
Comments:	Serum creatinine can be used to help determine renal function. Serum creatinine by itself is an insensitive measure of renal function because it does not increase until more than 50% of renal function has been lost. Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/ function. The calculation uses the Cockcroft-Gault formula. Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function. GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal

function in the elderly tends to be overestimated, and GFR should be used to assess renal function, according to the Cockcroft-Gault formula:

GFR (ml/min) = (140 - age [yrs]) x body wt (kg) [x 0.85 (for women)]
814 x serum creatinine (mmol/l)

To determine chronic renal impairment

GFR > 90ml/min - normal

GFR >60 - 90ml/min - mild renal impairment

GFR >30 - 60ml/min - moderate renal impairment

GFR 0 - 30 ml/min - severe renal impairment

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

In general, patients with GFR < 30 ml/min are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure.

Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required.

Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (ie. hypertensive, proteinuric (>1g/24hours), significant comorbid illness) should be considered for referral to a nephrologist well before function declines to less than 30ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation). Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group
National Diabetes Data Working Group

Origin: Caring for Australians with Renal Impairment (CARI) Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references: Supersedes Creatinine serum - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.73 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

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

Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre).

Acute coronary syndrome (clinical) DSS Health, Superseded

07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre).

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre).

Date accuracy indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Date—accuracy indicator, code AAA
METeOR identifier:	294429
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	An indicator of the accuracy of the components of a reported date, as represented by a code.
Data Element Concept:	Date—accuracy indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AAA
Maximum character length:	3

Permissible values:

Value	Meaning
AAA	Day, month and year are accurate
AAE	Day and month are accurate, year is estimated
AAU	Day and month are accurate, year is unknown
AEE	Day is accurate, month and year are estimated
AEU	Day is accurate, month is estimated, year is unknown
AUU	Day is accurate, month and year are unknown
AUA	Day is accurate, month is unknown, year is accurate
AUE	Day is accurate, month is unknown, year is estimated
AEA	Day is accurate, month is estimated, year is accurate
EAA	Day is estimated, month and year are accurate
EAE	Day is estimated, month is accurate, year is estimated
EAU	Day is estimated, month is accurate, year is unknown
EEA	Day and month are estimated, year is accurate
EEE	Day, month and year are estimated
EEU	Day and month are estimated, year is unknown
EUA	Day is estimated, month is unknown, year is accurate
EUE	Day is estimated, month is unknown, year is estimated
EUU	Day is estimated, month and year are unknown

UAA	Day is unknown, month and year are accurate
UAE	Day is unknown, month is accurate, year is estimated
UAU	Day is unknown, month is accurate, year is unknown
UEA	Day is unknown, month is estimated, year is accurate
UEE	Day is unknown, month and year are estimated
UEU	Day is unknown, month is estimated, year is unknown
UUA	Day and month are unknown, year is accurate
UUE	Day and month are unknown, year is estimated
UUU	Day, month and year are unknown

Collection and usage attributes

Guide for use:

Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

This data element consists of a combination of three codes, each of which denotes the accuracy of one date component:

A – the referred date component is accurate

E – the referred date component is not known but is estimated

U – the referred date component is not known and not estimated.

This data element contains positional fields (DMY) that reflects the order of the date components in the format (DDMMYYYY) of the reported date:

Field 1 (D) – refers to the accuracy of the day component;

Field 2 (M) – refers to the accuracy of the month component;

Field 3 (Y) – refers to the accuracy of the year component.

Data domain	Date component (for a format DDMMYYYY)		
	(D)ay	(M)onth	(Y)ear
Accurate	A	A	A
Estimated	E	E	E
Unknown	U	U	U

This data element is valid only for use with dates that are reported/exchanged in the format (DDMMYYYY).

Example 1: A date has been sourced from a reliable source and is known as accurate then the Date accuracy indicator should be informed as (AAA).

Example 2: If only the age of the person is known and there is no certainty of the accuracy of this, then the Date accuracy indicator should be informed as (UUE). That is the day and month are "unknown" and the year is "estimated".

Example 3: If a person was brought in unconscious to an emergency department of a hospital and the only information available was from a relative who was certain of the age and the birthday's 'month' then the Date accuracy indicator should be informed as (UAA). A year derived from an accurate month

and accurate age is always an accurate year.

The Date accuracy indicator can be useful for operational purposes to indicate the level of accuracy that a date has been collected at any point in time. It can indicate whether the stored date needs to be followed up until it reaches the intended minimal required accuracy. For example, if a person was brought in unconscious to an emergency department of a hospital the level of accuracy of the date collected at that point may not be satisfactory. It is likely that the correct date of birth can be obtained at a later date. The Date accuracy indicator provides information on the accuracy of the entered dates that may require further action.

For future users of the data it may also be essential they know the accuracy of the date components of a reported date.

Data element attributes

Collection and usage attributes

Collection methods:

Collection constraints:

If constraints for the collection of the date are imposed, such as 'a valid date must be input in an information system for unknown date components', the Date accuracy indicator should be used along with the date as a way of avoiding the contamination of the valid dates with the same value on the respective date components.

Example:

Some jurisdictions use 0107YYYY and some use 0101YYYY when only the year is known. When month and year are known some use the 15th day as the date i.e. 15MMYYYY. Where this occurs in a data collection that is used for reporting or analysis purposes there will be dates in the collection with the attributes 0107YYYY etc that are accurate and some that are not accurate. Without a corresponding flag to determine this accuracy the analysis or report will be contaminated by those estimated dates.

Comments:

Provision of a date is often a mandatory requirement in data collections.

Most computer systems require a valid date to be recorded in a date field i.e. the month part must be an integer between 1 and 12, the day part must be an integer between 1 and 31 with rules about the months with less than 31 days, and the year part should include the century. Also in many systems, significant dates (e.g. date of birth) are mandatory requirements.

However, in actual practice, the date or date components are often not known (e.g. date of birth, date of injury) but, as stated above, computer systems require a valid date. This means that a date MUST be included and it MUST follow the rules for a valid date. It therefore follows that, while such a date will contain valid values according to the rules for a date, the date is in fact an 'unknown' or 'estimated' date. For future users of the data it is essential they know that a date is accurate, unknown or estimated and which components of the date are accurate, unknown or estimated.

Source and reference attributes

Submitting organisation:	Standards Australia
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Relational attributes

Related metadata references:	See also Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Date creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme measured date, DDMMYYYY
METeOR identifier:	284973
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the person's creatine kinase myocardial band isoenzyme (CK-MB) is measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of creatine kinase myocardial band (CK-MB) isoenzyme at any time point during this current event.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Date creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.71 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Date of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of birth, DDMMYYYY
METeOR identifier:	287007
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	The date of birth of the person.
Data Element Concept:	Person—date of birth

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth. For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.
Collection methods:	Information on date of birth can be collected using the one question: What is your/(the person's) date of birth? In self-reported data collections, it is recommended that the following response format is used: Date of birth: _ _ / _ _ / _ _ _ _ This enables easy conversion to the preferred representational layout (DDMMYYYY). For record identification and/or the derivation of other metadata items that require accurate date of birth information, estimated dates of birth should be identified by a date accuracy indicator to prevent inappropriate use of date of birth data. The

linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of an indicator of the accuracy of the date may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date—accuracy indicator, code AAA also be recorded at the time of record creation to flag the accuracy of the data.

Comments:

Privacy issues need to be taken into account in asking persons their date of birth.

Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age.

When date of birth is an estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

It is suggested that different rules for reporting data may apply when estimating the date of birth of children aged under 2 years because of the rapid growth and development of children within this age group which means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is suggested.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Person—date of birth, DDMMYYYY Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

See also Date—accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient care (antenatal) – length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

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

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

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

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

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

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

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

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

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

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Health care client identification DSS Health, Standard

04/05/2005

Information specific to this data set:
Date of birth must be less than of equal to the date of death.

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
Date of birth must be less than or equal to the date of death.

Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

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

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

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

Date of cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment cessation date, DDMMYYYY
METeOR identifier:	270067
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a treatment episode for alcohol and other drugs ceases.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment cessation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used. Refer to the glossary item **Cessation of treatment episode for alcohol and other drugs** to determine when a treatment episode ceases. The date must be later than or the same as the treatment commencement date for the episode of treatment for alcohol and other drugs.
Comments:	Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Date of cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.63 KB)
Implementation in Data Set Specifications:	Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

The date must be later than or the same as the treatment commencement date for the episode of treatment for alcohol and other drugs.

Date of change to qualification status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY
METeOR identifier:	270034
Registration status:	Health, Standard 01/03/2005
Definition:	The date, within a newborn episode of care, on which the newborn's **Qualification status** changes from acute (qualified) to unqualified or vice versa.
Data Element Concept:	Episode of admitted patient care (newborn)—date of change to qualification status

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Record the date or dates on which the newborn's **Qualification status** changes from acute (qualified) to unqualified or vice versa. If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status. Must be greater than or equal to admission date.

Relational attributes

Related metadata references:	Supersedes Date of change to qualification status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.88 KB) Is used in the formation of Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN] Health, Standard 01/03/2005

Date of commencement of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment commencement date, DDMMYYYY
METeOR identifier:	270069
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the first service contact within the treatment episode when assessment and/or treatment occurs.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

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

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

Comments:

Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Date of commencement of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.07 KB)

Supersedes Commencement of treatment episode for alcohol

and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.48 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

The date must be earlier than or the same as the treatment cessation date for the episode of treatment for alcohol and other drugs.

Date of completion of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy completion date, DDMMYYYY
METeOR identifier:	270002
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the pregnancy preceding the current pregnancy was completed.
Data Element Concept:	Pregnancy (last previous)—pregnancy completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Estimate day of month (DD), if first day is unknown.
Comments:	This metadata item is recommended by the World Health Organization. It is currently collected in some states and territories. Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low **birthweight**.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Date of completion of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.62 KB)

Date of death

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of death, DDMMYYYY
METeOR identifier:	287305
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date of death of the person.
Data Element Concept:	Person—date of death

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Recorded for persons who have died. Where Date of birth is collected, Date of death must be equal to or greater than Date of birth for the same person.
Collection methods:	It is recommended that in cases where all components of the date of death are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate. For record identification and/or the derivation of other metadata items that require accurate date of death information, estimated dates of death should be identified by a date accuracy indicator to prevent inappropriate use of date of death data . The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of Date accuracy indicator may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date accuracy indicator also be recorded at the time of record creation to flag the accuracy of the data.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Date of death, version 1, DE, NHDD, NHIMG,

Superseded 01/03/2005.pdf (13.54 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
This field must be greater than or equal to Date of diagnosis of primary cancer.

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Date of diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date, DDMMYYYY
METeOR identifier:	270544
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient is diagnosed with a particular condition or disease.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Comments:	Classification systems, which enable the allocation of a code to the diagnostic information, can be used in conjunction with this metadata item.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of diagnosis, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.89 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Date of diagnosis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (cancer), DDMMYYYY
METeOR identifier:	270061
Registration status:	Health, Standard 01/03/2005
Definition:	The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).
Context:	Patient administration system, cancer notification system, population cancer statistics, research.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Date of diagnosis must be: >= date of birth <= date of death Diagnosis of cancer after death: If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate. Incidental diagnosis of cancer: If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.
Collection methods:	Reporting rules: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence: Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer. Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached

to a letter of referral or a patient's medical record from an institution or hospital.

Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Source and reference attributes

Origin:

International agency for research on cancer

World Health Organisation

International Association of Cancer Registries

Reference documents:

Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Relational attributes

Related metadata references:

Supersedes Date of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.35 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Date of diagnosis of first recurrence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (first recurrence of cancer), DDMMYYYY
METeOR identifier:	288596
Registration status:	Health, Standard 04/06/2004
Definition:	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The term `recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
Comments:	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of diagnosis of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.85 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This field must:

- be greater than the date of diagnosis of cancer
- be greater than the cancer initial treatment - completion date (if less than cancer initial treatment - completion date, the patient was never disease-free)

Date of first angioplasty balloon inflation or stenting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—first angioplasty balloon inflation or stenting date, DDMMYYYY
METeOR identifier:	284979
Registration status:	Health, Standard 04/06/2004
Definition:	Date of the first angioplasty balloon inflation or stent placement.
Data Element Concept:	Person—first angioplasty balloon inflation or stenting date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Date of first angioplasty balloon inflation or stenting, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.95 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute Coronary Syndrome (ACS) reporting, refers to the date of first angioplasty balloon inflation or coronary stenting for this admission.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Date of first contact

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—first contact date, DDMMYYYY
METeOR identifier:	270190
Registration status:	Health, Standard 01/03/2005
Definition:	The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.
Data Element Concept:	Community nursing service episode—first contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

This should occur after a previous last contact date of a previous care episode and prior to or on the same as first service delivery date.

Includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home;
- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;
- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

This applies irrespective of whether the person is present or not.

Excludes:

- first visits where the visit objective is not met, such as first visit made where no one is home.

Collection methods:

The first contact date can be the same as first service delivery date and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date.

Comments:

This metadata item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment

services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This metadata item enables the capture of the commencement of care irrespective of the setting in which the activities took place.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.92 KB)

Date of first delivery of service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care (community setting)—first service delivery date, DDMMYYYY
METeOR identifier:	270210
Registration status:	Health, Standard 01/03/2005
Definition:	The date of first delivery of service to a person in a non-institutional setting.
Data Element Concept:	Episode of care—first service delivery date (community setting)

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Community nursing service episode—first contact date, DDMMYYYY.
Collection methods:	As long as contact is made with the person in a non-institutional setting, the Episode of care (community setting)—first service delivery date, DDMMYYYY must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.
Comments:	This metadata item is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting. This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing **hospital-in-the-home** services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first delivery of service, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.22 KB)

Date of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy date, DDMMYYYY
METeOR identifier:	284985
Registration status:	Health, Standard 04/06/2004
Definition:	The date intravenous (IV) fibrinolytic therapy was administered or initiated.
Data Element Concept:	Person—intravenous fibrinolytic therapy date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the date the initial bolus was administered should be reported.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Date of intravenous fibrinolytic therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.82 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* For Acute coronary syndrome (ACS) reporting, refers to coronary arteries. Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Date of last contact

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—last contact date, DDMMYYYY
METeOR identifier:	270191
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the last contact between a staff member of the community service and a person in any setting.
Data Element Concept:	Community nursing service episode—last contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

This could be the same as the date of discharge.

Includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;
- bereavement visits in any setting;
- visits made to the person's home to complete the service, including the collection of equipment.

Excludes:

- visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.

Comments:

If service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission metadata item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.

To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of last contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.11 KB)

Date of procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (procedure)—procedure commencement date, DDMMYYYY
METeOR identifier:	270298
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a procedure commenced during an inpatient episode of care.
Data Element Concept:	Episode of admitted patient care (procedure)—procedure commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patients: Record date of procedure for all procedures undertaken during an episode of care in accordance with the current edition of ICD-10-AM.
Collection methods:	Date of procedure >= admission date Date of procedure <= separation date
Comments:	The National Centre for Classification in Health advises the Health Data Standards Committee of relevant changes to the ICD-10-AM. Required to provide information on the timing of the procedure in relation to the episode of care.

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Data Committee
Reference documents:	Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998-1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Relational attributes

Related metadata references:	Supersedes Date of procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.14 KB)

Date of referral to rehabilitation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—referral to rehabilitation service date, DDMMYYYY
METeOR identifier:	269993
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a person is referred to a rehabilitation service.
Data Element Concept:	Health service event—referral to rehabilitation service date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If date of referral is not known then provision should be made to collect month and year as a minimum, using 01 as DD (as the date part) if only the month and year are known.
Collection methods:	To be collected at the time of commencement of rehabilitation.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of referral to rehabilitation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.17 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* Required to derive those referred to a rehabilitation service from those eligible to attend and who actually attend. This metadata item can be used to determine the time lag between referral and commencement of rehabilitation. Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Date of surgical treatment for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure date, DDMMYYYY
METeOR identifier:	288632
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the cancer-directed surgical treatment was performed.
Data Element Concept:	Cancer treatment—surgical procedure date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of surgical treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.47 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This field must be greater than or equal to the date of initial cancer diagnosis.

This item is collected for analyses of outcome by treatment type.

Date of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage date, DDMMYYYY
METeOR identifier:	313815
Registration status:	Health, Standard 07/12/2005
Definition:	The date on which the patient is **triaged**.
Data Element Concept:	Non-admitted patient emergency department service episode—triage date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode—**triage** time.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Triage—triage date, DDMMYYYY Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Date patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—presentation date, DDMMYYYY
METeOR identifier:	270393
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the patient/client presents for the delivery of a service.
Data Element Concept:	Health service event—presentation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

For community health care, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences.

The date of patient presentation at the **Emergency department** is the earliest occasion of being registered clerically or triaged.

The date that the patient presents is not necessarily:

- the listing date for care (see listing date for care), nor
- the date on which care is scheduled to be provided, nor
- the date on which commencement of care actually occurs (for admitted patients see admission date, for hospital non-admitted patient care and community health care see service commencement date).

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Date patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.32 KB)

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Date troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured date, DDMMYYYY
METeOR identifier:	285021
Registration status:	Health, Standard 04/06/2004
Definition:	Date the person's troponin assay is measured.
Data Element Concept:	Person—troponin level measured date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Date troponin measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.45 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Day program attendances

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of day centre attendances, total N[NNNN]
METeOR identifier:	270245
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of patient/client visits to day centres.
Data Element Concept:	Establishment—number of day centre attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Attendance

Data element attributes

Collection and usage attributes

Comments:	This metadata item is derived from components that are not currently specified in METeOR, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc. Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals. Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Day program attendances, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.86 KB)

Degree of spread of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—degree of spread of a cancer, code N
METeOR identifier:	270180
Registration status:	Health, Standard 01/03/2005
Definition:	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time, as represented by a code.
Data Element Concept:	Person with cancer—degree of spread of a cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Localised to the tissue of origin
2	Invasion of adjacent tissue or organs
3	Regional lymph nodes
4	Distant metastases
5	Not Applicable

Supplementary values:

9	Unknown

Collection and usage attributes

Guide for use:

The valid values for the variable are listed below.

CODE 1 Localised to the tissue of origin

Includes a primary cancer where the spread is contained within the organ of origin. Note: this includes in situ breast (D05.0-D05.9) and in situ melanoma (D03.0-D03.9)

Example 1: For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.

Example 3: For melanoma of the skin, the cancer has not invaded the subcutaneous fat layer (that is, it is contained within the dermis and epidermis).

Example 4: For lung cancer, the cancer has not invaded the pleura.

CODE 2 Invasion of adjacent tissue or organs

A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes sub-cutaneous fat or muscle and organs adjacent to the primary cancer site.

Example 1: For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2:For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.

Example 3: For melanoma of the skin, the cancer has invaded into subcutaneous fat or muscle.

Example 4: For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.

CODE 3 Regional lymph nodes

The primary cancer has metastasised to the nearby draining lymph nodes. The list below shows the regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).

Head and neck - Cervical nodes

Larynx - Cervical nodes

Thyroid - Cervical and upper mediastinal nodes

Stomach - Perigastric nodes along the lesser and greater curvatures

Colon and Rectum - Pericolic, perirectal, and those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal

Anal - Perirectal, internal iliac, and inguinal lymph nodes

Liver - Hilar nodes, e.g. the hepatoduodenal ligament

Pancreas - Peripancreatic nodes

Lung - Intrathoracic, scalene and supraclavicular

Breast - Axillary, interpectoral, internal mammary

Cervix - Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral

Ovary - Hypogastric (obturator), common iliac, external iliac, lateral, sacral, para-aortic and inguinal

Prostate and bladder - Pelvic nodes below the bifurcation of the common iliac arteries

Testes - Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes

Kidney - Hilar, abdominal, para-aortic or paracaval.

CODE 4 Distant metastases

The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 - Regional lymph nodes' above).

CODE 5 Not applicable

This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, leukaemias and lymphomas (C81.0 - C96.9) only.

CODE 9 Unknown

No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories.

Data element attributes

Source and reference attributes

Submitting organisation: World Health Organization
New South Wales Health Department

Origin: International Classification of Diseases for Oncology, Second Edition (ICD-O-2) New South Wales Inpatient Statistics Collection Manual-2000/2001

Relational attributes

Related metadata references: Supersedes Degree of spread of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.6 KB)

Department of Veterans' Affairs file number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNNA
METeOR identifier:	339127
Registration status:	Health, Standard 29/11/2006 Community services, Standard 31/08/2007
Definition:	A unique personal identifier issued to a veteran by the Department of Veterans' Affairs.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	AAXXNNNNA
Maximum character length:	9

Collection and usage attributes

Guide for use:	1st character is the state code (an alphabetic character) - N, V, Q, W, S or T for the appropriate state/territory. Australian Capital Territory is included in New South Wales (N) and Northern Territory with South Australia (S). Next 7 characters are the file number, made up of: War code + numeric digits, where: if War code is 1 alphabetic character, add 6 numeric characters (ANNNNNN) Where there is no war code as is the case with World War 1 veterans, insert a blank and add 6 numeric characters (NNNNNN) if War code is 2 alphabetic characters, add 5 numeric characters (AANNNNN) if War code is 3 alphabetic characters, add 4 numeric characters (AAANNNN) The 9th character is the segment link. For dependents of veterans, the 9th character is always an alphabetic character. The alphabetic code is generated in the order by which the cards are issued. For example A, B, C, D etc. CAUTIONARY NOTE: For veterans the 9th character is left blank

Data element attributes

Collection and usage attributes

Collection methods:	The Department of Veterans' Affairs file number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to

the appropriate government agency to reconcile payment for the service provided.

DVA card number:

This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the gold and white cards may be used in conjunction with the data element and an imprinter. This method records the DVA file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA file number for data linking unless specifically authorised by relevant privacy legislation.

This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.

Comments:

All veterans and veteran community clients are issued with a DVA file number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA file number.

Note that Veterans may have a Medicare card number and a Department of Veterans Affairs (DVA) number or only a DVA number.

DVA has three (3) types of health cards:

- Gold Card
- White Card
- Repatriation Pharmaceutical Benefits Card.

Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.

The Gold card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.

The White card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.

The white card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.

A white card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war related.

When a gold/white card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare card number is not required or relevant.

It should be noted that there are a number of gold card holders

who do not have a Medicare card.

The Repatriation Pharmaceutical Benefits card is an orange coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Source and reference attributes

Origin: Department of Veterans' Affairs

Relational attributes

Related metadata references: Supersedes Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNN[A] Health, Superseded 29/11/2006

Department of Veterans' Affairs patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—funding eligibility indicator (Department of Veterans Affairs), code N
METeOR identifier:	270092
Registration status:	Health, Standard 01/03/2005
Definition:	Whether an eligible person's charges for this hospital **admission** are met by the Department of Veterans' Affairs (DVA), as represented by a code.
Context:	Health services
Data Element Concept:	Episode of care—funding eligibility indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	Refer to the Veterans' Entitlements Act 1986 for details of eligible DVA beneficiaries.
Collection methods:	Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.
Comments:	Eligible veterans and war widow/widowers can receive free treatment at any public hospital, former Repatriation Hospitals (RHs) or a Veteran Partnering (VP) contracted private hospital as a private patient in a shared ward, with the doctor of their choice. Admission to a public hospital does not require prior approval from the DVA. When treatment cannot be provided within a reasonable time in the public health system at a former RH or a private VP hospital, there is a system of contracted non-VP private hospitals which will provide care. Admission to a contracted private hospital requires prior financial authorisation from DVA. Approval may be given to attend a non-contracted private hospital when the service is not available at a public or contracted non-VP private hospital. In an emergency a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to DVA.

If an eligible veteran or war widow/widower chooses to be treated under Veterans' Affairs arrangements, which includes obtaining prior approval for non-VP private hospital care, DVA will meet the full cost of their treatment.

To assist in analyses of utilisation and health care funding.

Relational attributes

Related metadata references:

Supersedes Department of Veterans' Affairs patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.86 KB)

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Dependency in activities of daily living—bathing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bathing), code N
METeOR identifier:	270413
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with bathing, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bed mobility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bed mobility), code N
METeOR identifier:	270416
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's need for assistance with bed mobility, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent) - a hoist is used
5	2 persons physical assist is required

Data element attributes

Collection and usage attributes

Guide for use: Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification,

	which can be mapped to other classifications and produce equivalent scores. Code 4: A hoist is used. Code 5: 2 persons physical assist is required.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bladder continence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bladder continence), code N
METeOR identifier:	270417
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's bladder continence, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Continent of urine (includes independence in use of device)
2	Incontinent less than daily
3	Incontinent once per 24 hour period
4	Incontinent 2-6 times per 24 hour period
5	Incontinent more than 6 times per 24 hour period
6	Incontinent more than once at night only

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional

	Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bowel continence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bowel continence), code N
METeOR identifier:	270418
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's bowel continence, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Continent of faeces (includes independence in use of device)
2	Incontinent less than daily
3	Incontinent once per 24 hour period
4	Incontinent regularly, more than once per 24 hour period
5	Incontinent more than once at night only

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

	Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—day-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (day-time), total minutes NNN
METeOR identifier:	270420
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for day-time technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of day-time technical care required per week.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—dressing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (dressing), code N
METeOR identifier:	270414
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with dressing, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—eating

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (eating), code N
METeOR identifier:	270415
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with eating, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)
5	Tube-fed only

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce

	equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—evening technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (evening), total minutes NNN
METeOR identifier:	270421
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for evening technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of evening technical care required per week.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—extra surveillance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (extra surveillance), code N
METeOR identifier:	270419
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for additional individual attention and/or planned intervention in carrying out activities of daily living, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	No additional attention required
2	Less than 30 minutes individual attention per day
3	More than 30 and more than or equal to 90 minutes individual attention per day
4	Requires at least two hours intervention per week on an episodic basis
5	More than 90 minutes but less than almost constant individual attention
6	Requires almost constant individual attention
7	Cannot be left alone at all

Data element attributes

Collection and usage attributes

Guide for use:

Extra surveillance refers to behaviour, which requires individual attention and/or planned intervention. Some examples are:

- aggressiveness
- wandering
- impaired memory or attention
- disinhibition and other cognitive impairment.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—infrequent technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (infrequent), total minutes NNN
METeOR identifier:	270423
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for infrequent technical nursing care per month measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of infrequent technical care required per month.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—mobility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (mobility), code N
METeOR identifier:	270410
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with mobility, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:

Applies to walking, walking aid or wheelchair.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce

	equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCN

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—night-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (night-time), total minutes NNN
METeOR identifier:	270422
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for night-time technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of night-time technical care required per week.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—toileting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (toileting), code N
METeOR identifier:	270411
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with toileting, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups, etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods: Commencement of care episode (there may be several visits in which assessment data is gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in the Guide for Use.

The Person - Dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Reference documents: ACCNS 1997. Community nursing minimum data set Australian version 2.0: data dictionary and guidelines. Melbourne: ACCNS.

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—transferring

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (transferring), code N
METeOR identifier:	270412
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with transferring, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)
5	Person is bedfast

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce

	equivalent scores. Code 5: Person is bedfast.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Depreciation expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—depreciation expenses, total Australian currency NNNNN.N
METeOR identifier:	359967
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting of consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—depreciation expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:	Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year. Depreciation expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million. When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006). Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.
Collection methods:	Depreciation expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements. *Health industry relevant organisation type* State and territory health authorities are **NOT** to report the following codes: Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments: In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references: Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications: Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Diabetes status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes mellitus status, code NN
METeOR identifier:	270194
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has or is at risk of diabetes, as represented by a code.
Data Element Concept:	Person—diabetes mellitus status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Type 1 diabetes
02	Type 2 diabetes
03	Gestational diabetes mellitus (GDM)
04	Other (secondary diabetes)
05	Previous gestational diabetes mellitus (GDM)
06	Impaired fasting glucose (IFG)
07	Impaired glucose tolerance (IGT)
08	Not diagnosed with diabetes
09	Not assessed

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Note that where there is a Gestational diabetes mellitus (GDM) or Previous GDM (i.e. permissible values 3 & 5) and a current history of Type 2 diabetes then record 'Code 2' Type 2 diabetes.

This same principle applies where a history of either Impaired fasting glycaemia (IFG) or Impaired glucose tolerance (IGT) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.

CODE 01 Type 1 diabetes

Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with Type 1 diabetes can be identified at earlier clinical stages than 'diabetes mellitus'.

CODE 02 Type 2 diabetes

Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

CODE 03 Gestational diabetes mellitus (GDM)

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy. Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines.

CODE 04 Other (secondary diabetes)

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.

CODE 05 Previous GDM

Where the person has a history of GDM.

CODE 06 Impaired fasting glycaemia (IFG)

IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.

CODE 07 Impaired glucose tolerance (IGT)

IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.

CODE 08 Not diagnosed with diabetes

The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).

CODE 09 Not assessed

The subject has not had their diabetes status assessed.

CODE 99 Not stated/inadequately described

This code is for unknown or information unavailable.

Collection methods: The diagnosis is derived from and must be substantiated by clinical documentation.

Source and reference attributes

Origin: Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and

Classifications of Diabetes Mellitus Provisional Report of a World Health Organization Consultation (Alberti & Zimmet 1998).

Data element attributes

Collection and usage attributes

Collection methods:

Diabetes (clinical):

A type of diabetes should be recorded and coded for each episode of patient care.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Relational attributes

Related metadata references:

Supersedes Diabetes status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (27.25 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

People with diabetes have two to five times increased risk of developing heart, stroke and vascular disease (Zimmet & Alberti 1997). Cardiovascular disease is the most common cause of death in people with diabetes.

Diabetes is also an important cause of stroke, and people with diabetes may have a worse prognosis after stroke.

Heart, stroke and vascular disease and diabetes share common risk factors, but also diabetes is an independent risk factor for heart, stroke and vascular disease.

During the 1995 National Health Survey, about 15 per cent of those with diabetes reported having heart disease, at almost six times the rate noted among people without diabetes. In 1996-97, almost one in six hospital separations, with coronary heart disease as any listed diagnosis, also had diabetes recorded as an associated diagnosis. Heart disease appears earlier in life and is more often fatal among those with diabetes.

Diabetes may accentuate the role of elevated blood pressure in stroke. The incidence and prevalence of peripheral vascular disease in those with diabetes increase with the duration of the peripheral vascular disease.

Mortality is increased among patients with peripheral vascular disease and diabetes, in particular if foot ulcerations, infection or gangrene occur. There is limited

information on whether the presence of heart, stroke and vascular disease promotes diabetes in some way.

High blood pressure, high cholesterol and obesity are often present along with diabetes. As well as all being independent cardiovascular risk factors, when they are in combination with glucose intolerance (a feature of diabetes) and other risk factors such as physical inactivity and smoking, these factors present a greater risk for heart, stroke and vascular disease.

Evidence is accumulating that high cholesterol and glucose intolerance, which often occur together, may have a common aetiological factor. Despite these similarities, trends in cardiovascular mortality and diabetes incidence and mortality are moving in opposite directions.

While the ageing of the population following reductions in cardiovascular mortality may have contributed to these contrasting trends, the role of other factors also needs to be clearly understood if common risk factor prevention strategies are to be considered. (From Commonwealth Department of Health & Aged Care and Australian Institute of Health and Welfare (1999) National Health Priority Areas Report: Cardiovascular Health).

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

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Uncontrolled diabetes leads to a variety of complications, often resulting in limitation of activity, disability, illness and premature mortality. Therefore ongoing assessment is required to identify people at risk of developing complications so that early preventive strategies can be applied. Although there is no cure for diabetes, with modern treatment most people can lead a full and active life and avoid long-term complications.

Aetiological classifications contained in the scientific paper 'Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a WHO Consultation (Alberti & Zimmet 1998)'.

Diabetes therapy type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes therapy type, code NN
METeOR identifier:	270236
Registration status:	Health, Standard 01/03/2005
Definition:	The type of diabetes therapy the person is currently receiving, as represented by a code.
Data Element Concept:	Person—diabetes therapy type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Diet and exercise only
02	Oral hypoglycaemic - sulphonylurea only
03	Oral hypoglycaemic - biguanide (eg metformin) only
04	Oral hypoglycaemic - alpha-glucosidase inhibitor only
05	Oral hypoglycaemic - thiazolidinedione only
06	Oral hypoglycaemic - meglitinide only
07	Oral hypoglycaemic - combination (eg biguanide & sulphonylurea)
08	Oral hypoglycaemic - other
09	Insulin only
10	Insulin plus oral hypoglycaemic
98	Nil - not currently receiving diabetes treatment

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 Diet & exercise only

This code includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.

CODE 98 Nil - not currently receiving diabetes treatment

This code is used when there is no current diet, tablets or insulin therapy(ies).

CODE 99 Not stated/inadequately described

Use this code when missing information.

Data element attributes

Collection and usage attributes

Collection methods: To be collected at the commencement of treatment and at each review.

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

The main use of this data element is to enable categorisation of management regimes against best practice for diabetes.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Cardiovascular Data Working Group

Reference documents: Berkow R, editor. The Merck Manual. 16th ed. Rahway (New Jersey, USA): Merck Research Laboratories; 1992.

Relational attributes

Related metadata references: Supersedes Diabetes therapy type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.14 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

The objectives and priorities of treatment must be tailored to the individual considering age, sex, weight and individual health status.

An individual management plan for each patient should include the following:

- establishment of targets of treatment
- healthy eating plan
- education in self-monitoring,
- adjustment of treatment and in approaches to coping with emergencies
- exercise program
- risk factor reduction, e.g. smoking cessation
- use of oral hypoglycaemic agents, if required
- use of insulin, if required
- screening for and treatment of complications of diabetes.

In addition to glycaemic control, management of diabetes of either type requires close attention to other risk factors for the development of complications, and the impact of lifestyle changes on blood glucose levels should be

monitored. In patients with Type 2 diabetes, an increase in physical activity is essential in management of lipids and glucose level. Increased physical activity has been recognised as perhaps the most feasible way of modifying glucose intolerance, a risk factor for developing diabetes and macrovascular disease (Guest & O'Dea 1992).

Diagnosis related group

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA
METeOR identifier:	270195
Registration status:	Health, Standard 01/03/2005
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, as represented by a code.
Data Element Concept:	Episode of admitted patient care—diagnosis related group

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 5.1
Representation class:	Code
Data type:	String
Format:	ANNA
Maximum character length:	4

Data element attributes

Collection and usage attributes

Comments:	The Australian Refined Diagnosis Related Group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in Related data elements.

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Data Committee

Relational attributes

Related metadata references:	See also Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005 Is formed using Episode of care—mental health legal status, code N Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005 Is formed using Person—weight (measured), total grams NNNN Health, Standard 01/03/2005 Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005 Is formed using Episode of care—additional diagnosis, code

(ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—procedure, code (ICD-10-AM 3rd edn) NNNNN-NN Health, Superseded 28/06/2004

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Person—sex, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Supersedes Diagnosis related group, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.02 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Difficulty with activities

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of difficulty with activities in life areas, code (ICF 2001) N
METeOR identifier:	320120
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The level of difficulty a person has in performing the tasks and actions involved in specified life areas, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—level of difficulty with activities in a life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
0	No difficulty
1	Mild difficulty
2	Moderate difficulty
3	Severe difficulty
4	Complete difficulty
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

In the context of health, an activity is the execution of a task or action by an individual. Activity limitations are difficulties an individual may have in executing an activity.

Difficulties with activities can arise when there is a qualitative or quantitative alteration in the way in which these activities are carried out. Difficulty includes matters such as 'with pain', 'time taken', 'number of errors', clumsiness', 'modification of manner in which an activity is performed' e.g. sitting to get dressed instead of standing. 'Difficulty' is a combination of the frequency with which the problem exists, the duration of the problem and the intensity of the problem. Activity limitations are assessed against a generally accepted population standard,

relative to cultural and social expectations.

Activity limitation varies with the environment and is assessed in relation to a particular environment; the absence or presence of **assistance**, including aids and equipment, is an aspect of the environment.

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of difficulty of the person for whom the data is recorded.

CODE 0 No difficulty in this life area

Is used when there is no difficulty in performing this activity. This scale has a margin of error of 5%. [0-4%]

CODE 1 Mild difficulty

Is recorded for example, when the level of difficulty is below the threshold for medical intervention, the difficulty is experienced less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days. [5-24%]

CODE 2 Moderate difficulty

Is used for example when the level of difficulty is experienced less than 50% of the time and/or with a significant, but moderate effect on functioning (Up to half the scale of total performance) which may happen regularly over the last 30 days. [25-49%]

CODE 3 Severe difficulty

Is used for example when performance in this life area can be achieved, but with only extreme difficulty, and/or with an extreme effect on functioning which may happen often over the last 30 days. [50-95%]

CODE 4 Complete difficulty

Is used when the person can not perform in this life area due of the difficulty in doing so. This scale has a margin of error of 5%. [96-100%]

CODE 8 Not specified

Is used where a person has difficulty with activities in a life area but there is insufficient information to use codes 0-4.

CODE 9 Not applicable

Is used where a life area is not applicable to this person, e.g. domestic life for a child under 5.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) AN[NNN], indicates the presence and extent of activity limitation in a given domain of activity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Activities and Participation cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Division of General Practice number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Division of general practice—organisation identifier, NNN
METeOR identifier:	270014
Registration status:	Health, Standard 01/03/2005
Definition:	The unique identifier for the Division of general practice number as designated by the Commonwealth Government of Australia. Each separately administered Division of general practice has a unique identifying number.
Data Element Concept:	Division of general practice—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNN
Maximum character length:	3

Data element attributes

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	The actual Division of General Practice numbers can be obtained by selecting the individual State or Territory from the *Divisions Directory* found within the Australian Division of General Practice website

Relational attributes

Related metadata references:	Supersedes Division of general practice number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.19 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Dyslipidaemia treatment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dyslipidaemia treatment with anti-lipid medication indicator (current), code N
METeOR identifier:	302440
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person is being currently treated for dyslipidaemia using anti-lipid medication, as represented by a code.
Data Element Concept:	Person—dyslipidaemia treatment with anti-lipid medication indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a person is being treated for dyslipidaemia using anti-lipid medication. CODE 2 No: Record if a person is not being treated for dyslipidaemia using anti-lipid medication.
Collection methods:	Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—dyslipidaemia treatment status (anti-lipid medication), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Dyslipidaemia is associated with many health problems including diabetes and hypertension. It is often related to overweight and obesity. Usually caused by inappropriate diet and sedentary lifestyle, dyslipidaemia has been reaching epidemic proportions. Active lifestyle and low calorie diets are the best way of prevention, however sometimes for the treatment of dyslipidaemia the use of pharmacotherapy is required. Abnormal levels of blood lipids are associated with increased risk of developing CHD especially in diabetic patients.

The risk of coronary and other macrovascular disorders is 2-5 times higher in people with diabetes than in non-diabetic subjects and increases in parallel with the degree of dyslipidaemia. Diabetes mellitus greatly modifies the significance of lipoprotein levels, particularly when associated with smoking, hypertension and family history of CVD. Poor metabolic control of diabetes seems to have impact on abnormal lipoprotein level. Primary dyslipidaemia, due to genetic and environmental (especially dietary) factors, is diagnosed if secondary causes have been excluded (hypothyroidism, nephrotic syndrome, cholestasis, anorexia nervosa, diabetes mellitus Type 2, renal impairment).

Electrocardiogram change location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—electrocardiogram change location, code N
METeOR identifier:	285071
Registration status:	Health, Standard 04/06/2004
Definition:	The area in which the change is located on the 12-lead electrocardiogram (ECG) of the person, as represented by a code.
Data Element Concept:	Person—electrocardiogram change location

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Inferior leads: II, III, aVF
	2	Anterior leads: V1 to V4
	3	Lateral leads: I, aVL, V5 to V6
	4	True posterior: V1 V2
	8	None
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 4 True posterior: V1 V2 True posterior is relevant only for tall R waves.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:	More than one code may be recorded. Report in order of significance. Record all codes that apply (codes 8 and 9 are excluded from multiple coding).

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Person—electrocardiogram change type, code N Health, Standard 04/06/2004 Supersedes Electrocardiogram (ECG) change - location, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.19 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Electrocardiogram change type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—electrocardiogram change type, code N
METeOR identifier:	285307
Registration status:	Health, Standard 04/06/2004
Definition:	The type of change to the heart rhythm seen on the person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Person—electrocardiogram change type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	ST-segment elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads
2	ST-segment elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads
3	ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)
4	T-wave inversion >= 1 mm (0.1 mV)
5	Significant Q waves
6	Bundle branch block (BBB)
7	Non-specific
8	No changes

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ST-segment elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads

ST-segment elevation indicates greater than or equal to 1 mm (0.1 mV) elevation in 2 or more contiguous limb leads.

CODE 2 ST-segment elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads

ST-segment elevation indicates greater than or equal to 2 mm (0.2 mV) elevation in 2 or more contiguous chest leads.

CODE 3 ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)

ST-segment depression of at least 0.5 mm (0.05 mV) in 2 or more contiguous leads (includes reciprocal changes).

CODE 4 T-wave inversion >= 1 mm (0.1 mV)

T-wave inversion of at least 1 mm (0.1 mV) including inverted T

waves that are not indicative of acute MI.

CODE 5 Significant Q waves

Q waves refer to the presence of Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1 mm (0.1 mV) in depth in at least 2 contiguous leads.

CODE 6 Bundle branch block (BBB)

Bundle branch block pattern

CODE 7 Non-specific

Changes not meeting the above criteria.

CODE 8 No changes

No ECG changes.

CODE 9 Not stated/inadequately described

Includes unknown.

Data element attributes

Collection and usage attributes

Guide for use:

More than one code may be recorded.

Record all that apply (codes 7, 8 and 9 are excluded from multiple coding).

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Steward:

The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

See also Person—electrocardiogram change location, code N Health, Standard 04/06/2004

Supersedes Electrocardiogram (ECG) change - type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.29 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Electronic communication address (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication address, text [X(250)]
METeOR identifier:	287469
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting a person, as represented by text.
Data Element Concept:	Person (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(250)]
Maximum character length:	250

Data element attributes

Collection and usage attributes

Guide for use:

Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

- Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
- Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.

Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 this data element is represented by 'Telephone number (client)'. In AS4846 this data element is represented by 'Provider electronic communication details'. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Electronic communication address (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—electronic communication address, text [X(250)]
METeOR identifier:	287480
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(250)]
Maximum character length:	250

Data element attributes

Collection and usage attributes

Guide for use:

Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.
Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 this data element is represented by 'Telephone number (client)'. In AS4846 this data element is represented by 'Provider electronic communication details'. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Electronic communication medium (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication medium, code N
METeOR identifier:	287519
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A type of communication mechanism used by a person, as represented by a code.
Data Element Concept:	Person (address)—electronic communication medium

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia In AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e−mail) may be recorded as required. Each instance should have an appropriate Electronic communication

medium and Electronic communication usage code assigned.

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Electronic communication medium (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—electronic communication medium, code N
METeOR identifier:	287521
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A type of communication mechanism used by an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address)—electronic communication medium

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Collection and usage attributes

Guide for use:	Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia In AS4846 alternative alphabetic codes are presented. Refer to

the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Electronic communication usage code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication usage, code N
METeOR identifier:	287579
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The manner of use that a person applies to an electronic communication address, as represented by a code.
Data Element Concept:	Person (address)—electronic communication usage code

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Business use only
2	Personal use only
3	Both business and personal use

Data element attributes

Collection and usage attributes

Guide for use:	Only applicable to individuals, and not organisations.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 an alternative data element is presented as 'Telephone number type (client)'. In AS4846 this data element is called 'Provider electronic communication type'. In both instances alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Emergency department arrival mode - transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—transport mode (arrival), code N
METeOR identifier:	270000
Registration status:	Health, Standard 01/03/2005
Definition:	The mode of transport by which the person arrives at the emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—transport mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ambulance, air ambulance or helicopter rescue service
2	Police/correctional services vehicle
8	Other

Supplementary values:

Value	Meaning
9	Not stated/unknown

Collection and usage attributes

Guide for use: CODE 8 Other

Includes walking, private transport, public transport, community transport, and taxi.

Data element attributes

Source and reference attributes

Submitting organisation: National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references: Supersedes Emergency department arrival mode - transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS
Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS
Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department date of commencement of service event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service commencement date, DDMMYYYY
METeOR identifier:	313801
Registration status:	Health, Standard 07/12/2005
Definition:	The date on which a non-admitted patient emergency department service event commences.
Context:	Emergency Department care
Data Element Concept:	Non-admitted patient emergency department service episode—service commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	In an Emergency Department the service event commences when the medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) provides treatment or diagnostic service. The date of triage is recorded separately. The commencement of a service event does not include contact associated with triage.
Collection methods:	Collected in conjunction with non-admitted patient emergency department service commencement time.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Health service event—service commencement date, DDMMYYYY Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department departure date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—physical departure date, DDMMYYYY
METeOR identifier:	322597
Registration status:	Health, Standard 24/03/2006
Definition:	The date on which a patient departs an emergency department after a stay.
Context:	Emergency department care.
Data Element Concept:	Emergency department stay—physical departure date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use: Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted then record the date the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.
- If the service episode is completed without the patient being admitted, including referral to another hospital, record the date the patient leaves the Emergency Department.
- If the patient did not wait record the date the patient leaves the Emergency Department or was first noticed as having left.
- If the patient left at their own risk record the date the patient leaves the Emergency Department.
- If the patient died in the Emergency Department record the date of death.
- If the patient was dead on arrival then record the date of presentation at the Emergency Department.

Collection methods: Collected in conjunction with emergency department stay

physical departure time.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department departure time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—physical departure time, hhmm
METeOR identifier:	322610
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which a patient departs an emergency department after a stay.
Context:	Emergency department care.
Data Element Concept:	Emergency department stay—physical departure time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:

Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted then record the time the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.
- If the service episode is completed without the patient being admitted, including referral to another hospital, record the time the patient leaves the Emergency Department.
- If the patient did not wait record the time the patient leaves the Emergency Department or was first noticed as having left.
- If the patient left at their own risk record the time the patient leaves the Emergency Department.
- If the patient died in the Emergency Department record the time of death.
- If the patient was dead on arrival then record the time of

presentation at the Emergency Department.

Collection methods: Collected in conjunction with emergency department stay physical departure date.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department episode end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end date, DDMMYYYY
METeOR identifier:	322616
Registration status:	Health, Standard 24/03/2006
Definition:	The date on which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Emergency department episode end time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end time, hhmm
METeOR identifier:	322621
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk. For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department service episode end status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end status, code N
METeOR identifier:	322641
Registration status:	Health, Standard 24/03/2006
Definition:	The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted to this hospital (including to units or beds within the emergency department)
2	Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital
3	Non-admitted patient emergency department service episode completed - referred to another hospital for admission
4	Did not wait to be attended by a health care professional
5	Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed
6	Died in emergency department as a non-admitted patient
7	Dead on arrival, not treated in emergency department

Collection and usage attributes

Guide for use:

CODE 2 Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital

This code includes patients who departed under their own care, under police custody, under the care of a residential aged care facility or other carer. Code 2 excludes those who died in the emergency department, which should be coded to Code 6.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Data element attributes

Collection and usage attributes

Guide for use: A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

Collection methods: Some data systems may refer to this data element as 'Departure status'.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—patient departure status, code N Health, Superseded 24/03/2006

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department time of commencement of service event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service commencement time, hhmm
METeOR identifier:	313806
Registration status:	Health, Standard 07/12/2005
Definition:	The time at which a non-admitted patient emergency department service event commences.
Context:	Emergency Department care
Data Element Concept:	Non-admitted patient emergency department service episode—service commencement time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	In an Emergency Department the service event commences when the medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) provides treatment or diagnostic service. The time of triage is recorded separately. The commencement of a service event does not include contact associated with triage.
Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode service commencement date.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Health service event—service commencement time, hhmm Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department waiting time to admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN
METeOR identifier:	270004
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed for each patient from presentation to the emergency department to **admission** to hospital.
Data Element Concept:	Non-admitted patient emergency department service episode—waiting time (to hospital admission)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Hour and minute

Collection and usage attributes

Guide for use:	HHMM

Data element attributes

Collection and usage attributes

Guide for use:	Calculated from admission date and time minus date and time patient presents for those emergency department patients who are admitted.
Collection methods:	To be collected on patients presenting to emergency department for unplanned care in public hospitals with emergency department and private hospitals providing contracted services for the public sector.
Comments:	This is a critical waiting times metadata item. It is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this metadata item will have many uses including to assist in the planning and management of hospitals and in health care research.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Health service event—presentation time,

hhmm Health, Standard 01/03/2005

Is formed using Non-admitted patient emergency department service episode—patient departure status, code N Health, Superseded 24/03/2006

Is formed using Episode of admitted patient care—admission time, hhmm Health, Standard 01/03/2005

Is formed using Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Emergency department waiting time to admission, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.55 KB)

Emergency department waiting time to service delivery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN
METeOR identifier:	270007
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed in minutes for each patient from presentation in the emergency department to a service occurrence of a specific event related to service delivery.
Data Element Concept:	Non-admitted patient emergency department service episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNN
Maximum character length:	5
Unit of measure:	Minute (m)

Data element attributes

Collection and usage attributes

Guide for use:	Calculated from date and time of service event minus date and time patient presents. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.
Comments:	It is recognised that at times of extreme urgency or multiple synchronous presentations, or if no medical officer is on duty in the emergency department, this service may be provided by a nurse.

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references:	Is formed using Health service event—service commencement time, hhmm Health, Superseded 07/12/2005 Is formed using Health service event—service commencement date, DDMMYYYY Health, Superseded 07/12/2005 Supersedes Emergency department waiting time to service delivery, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB) Is formed using Health service event—presentation time, hhmm Health, Standard 01/03/2005 Is formed using Health service event—presentation date,

	DDMMYYYY Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Employee expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—employee related expenses, total Australian currency NNNNN.N
METeOR identifier:	359947
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts, in Australian currency.
Data Element Concept:	Organisation—employee related expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Employee related expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- Salaries, wages and supplements for all employees of the organisation (including contract staff employed by an agency, provided staffing data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave.
- Superannuation employer contributions paid or, for an emerging cost scheme, that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a state health authority, to a superannuation fund providing

retirement and related benefits to establishment employees, for a financial year.

- Workers compensation premiums and payments

Collection methods:

Employee related expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:

Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Employment status (admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, acute hospital and private psychiatric hospital admission code N
METeOR identifier:	269948
Registration status:	Health, Standard 01/03/2005
Definition:	Self-reported employment status of a person, immediately prior to **admission** to an acute or private psychiatric hospital, as represented by a code.
Context:	The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Unemployed / pensioner
2	Other

Data element attributes

Collection and usage attributes

Collection methods:

In practice, this metadata item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student

- accountant

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - acute hospital and private psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications: Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Employment status—public psychiatric hospital admissions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, public psychiatric hospital admission code N
METeOR identifier:	269955
Registration status:	Health, Standard 01/03/2005
Definition:	Self-reported employment status of a person, immediately prior to **admission** to a public psychiatric hospital, as represented by a code.
Context:	The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Child not at school
2	Student
3	Employed
4	Unemployed
5	Home duties
6	Other

Data element attributes

Collection and usage attributes

Collection methods:

In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner

- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - public psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.63 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Environmental factor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—environmental factor, code (ICF 2001) AN[NNN]
METeOR identifier:	320207
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The physical, social and attitudinal environment in which people live and conduct their lives, as represented by a code.
Context:	The environment in which a person functions or experiences disability.
Data Element Concept:	Person—environmental factor

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNN]
Maximum character length:	5

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.

Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.

Facilitators are features of the environment that have a positive effect on **disability**. Barriers are features of the environment that have a negative effect on disability.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Attitudes' (chapter level) and 'Social, norms, practices and ideology' (3 digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with *Extent of environmental factor influence code [X]N* will use the codes as indicated. The full range of the permissible values together with definitions can be found in the *Environmental Factors* component of the ICF.

CODE e1 Products and technology

CODE e2 Natural environment and human-made changes to environment
CODE e3 Support and relationships
CODE e4 Attitudes
CODE e5 Services, systems and policies

Data collected at this level will provide a general description of the environmental factors and can only be compared with data collected at the same level.

An example of a value domain at the 3 digit level from the Environmental factors component may include:

CODE e225 Climate
CODE e240 Light
CODE e250 Sound
CODE e255 Vibration
CODE e260 Air quality

An example of a value domain at the 4 digit level from the the environmental factors component may include:

CODE e1151 Assistive products and technology for personal use in daily life
CODE e1201 Assistive products and technology for personal indoor and outdoor mobility and transportation
CODE e2151 Assistive products and technology for communication
CODE e1301 Assistive products and technology for education
CODE e1351 Assistive products and technology for employment
CODE e1401 Assistive products and technology for culture, recreation and sport
CODE e1451 Assistive products and technology for the practice of religion and spirituality

The prefix *e* denotes the domains within the component of *Environmental Factors*.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is a neutral list of environmental factors. It may be used, in conjunction with Person—extent of environmental factor influence, code (ICF 2001) [X]N, in health,

community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identification of environmental factors may assist in determining appropriate interventions to support the person to achieve optimum functioning.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—extent of environmental factor influence, code (ICF 2001) [X]N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Environmental factors cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Episode of residential care end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end date, DDMMYYYY
METeOR identifier:	270062
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a **resident** formally or statistically **ends an episode of residential care**.
Data Element Concept:	Episode of residential care—episode end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care end date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.57 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Data in this field must:

- be ≤ last day of reference period
- be ≥ first day of reference period
- be ≥ Episode of residential care start date

Episode of residential care end mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end mode, code N
METeOR identifier:	270063
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for **ending an episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode end mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Died
2	Left against clinical advice / at own risk
3	Commenced leave where there is no intention that the resident returns to overnight residential care within seven days
4	Other end of residential care at this establishment
5	End of reference period

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1 - 4 These codes refer to the formal episode of residential care end.

CODE 1 Died

CODE 2 Left against clinical advice / at own risk

CODE 3 Commenced leave where there is no intention that the resident returns to overnight residential care within seven days

CODE 5 End of reference period

This code refers to the statistical episode of residential care end.

CODE 9 Unknown/not stated/inadequately described

This code refers to other.

Data element attributes

Relational attributes

Related metadata references:	Supersedes Episode of residential care end mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.35 KB)
Implementation in Data Set	Residential mental health care NMDS 2005-2006 Health,

Specifications:

Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Episode of residential care start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start date, DDMMYYYY
METeOR identifier:	270064
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the **resident** formally or statistically **starts an episode of residential care**.
Data Element Concept:	Episode of residential care—episode start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.09 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Right justified and zero filled.

episode of residential care start date ≤ episode of residential care end date.

episode of residential care start date ≥ date of birth.

Episode of residential care start mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start mode, code N
METeOR identifier:	270075
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for starting an **episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode start mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days
2	Other (i.e. start of a new residential stay)
3	Start of a new reference period

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1-2 These codes refer to the formal episode of residential care start.

CODE 1 Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days

CODE 2 Other (i.e. start of a new residential stay)

CODE 3 Start of a new reference period

This code refers to the statistical episode of residential care start.

CODE 9 Unknown/not stated/inadequately described

This code refers to other.

Data element attributes

Relational attributes

Related metadata references:	Supersedes Episode of residential care start mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.86 KB)
Implementation in Data Set Specifications:	Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005
	Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Erectile dysfunction

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (male)—erectile dysfunction, code N
METeOR identifier:	270132
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a male individual has a history of erection failure or has received treatment to achieve erection sufficient for penetration in the last 12 months and prior, as represented by a code.
Data Element Concept:	Person (male)—erectile dysfunction

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Erectile dysfunction- developed in the last 12 months
	2	Erectile dysfunction- developed prior to the last 12 months
	3	No erectile dysfunction
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Determine whether this developed within or prior to the last 12 months.
Collection methods:	Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration.

Data element attributes

Collection and usage attributes

Guide for use:	Record for male patients only.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Erectile dysfunction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.14 KB)
Implementation in Data Set	Diabetes (clinical) DSS Health, Superseded 21/09/2005

Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Erectile problems occur in up to 50% of men with diabetes who are over 40 years old.

Erectile dysfunction may be due to psychological causes, macrovascular disease or pelvic autonomic neuropathy. An organic cause is more likely in the presence of other macro or micro vascular complications.

Establishment identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—organisation identifier (Australian), NNX[X]NNNNN
METeOR identifier:	269973
Registration status:	Health, Standard 01/03/2005
Definition:	The identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.
Data Element Concept:	Establishment—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNX[X]NNNNN
Maximum character length:	9

Data element attributes

Collection and usage attributes

Guide for use:	Concatenation of: Australian state/territory identifier (character position 1); Sector (character position 2); Region identifier (character positions 3-4); and Organisation identifier (state/territory), (character positions 5-9).
Comments:	Establishment identifier should be able to distinguish between all health care establishments nationally.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Establishment identifier, version 4, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.97 KB) Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005 Is formed using Establishment—organisation identifier (state/territory), NNNNN Health, Standard 01/03/2005 Is formed using Establishment—sector, code N Health, Standard 01/03/2005 Is formed using Establishment—region identifier, X[X] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Standard 04/05/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Outpatient care NMDS Health, Superseded 04/07/2007

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Establishment number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—organisation identifier (state/territory), NNNNN
METeOR identifier:	269975
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for an establishment, unique within the state or territory.
Data Element Concept:	Establishment—organisation identifier (state/territory)

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Comments:	Identifier should be a unique code for the health care establishment used in that state/territory.

Relational attributes

Related metadata references:	Supersedes Establishment number, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.61 KB) Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008 Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Standard 04/05/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Establishment sector

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—sector, code N
METeOR identifier:	269977
Registration status:	Health, Standard 01/03/2005
Definition:	A section of the health care industry with which a health care establishment can identify, as represented by a code.
Data Element Concept:	Establishment—sector

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Data element attributes

Collection and usage attributes

Guide for use:

Alcohol and other drug treatment services NMDS:

This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).

CODE 1 is to be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

CODE 2 is to be used only when the establishment:

- is not controlled by government,
- is directed by a group of officers, an executive committee or a similar body
- elected by a majority of members, and
- may be an income tax exempt charity.

Relational attributes

Related metadata references: Supersedes Establishment sector, version 4, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Standard 04/05/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

CODE 2 is to be used for private hospitals and residential mental health care services operated by non-government organisations. Code 2 will mean 'private' for specialised mental health services with a service setting of 'admitted' and 'non-government organisation' for specialised mental health services with a service setting of 'residential'.

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

CODE 1 is to be used for government-operated residential mental health care services.

CODE 2 to be used for residential mental health care services operated by non-government organisations.

Establishment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—establishment type, sector and services provided code AN.N{.N}
METeOR identifier:	269971
Registration status:	Health, Standard 01/03/2005
Definition:	Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment, as represented by a code.
Data Element Concept:	Establishment—establishment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AN.N{.N}
Maximum character length:	6

Permissible values:

Value	Meaning
R1.1	Public acute care hospital
R1.2	Private acute care hospital
R1.3.1	Veterans Affairs hospital
R1.3.2	Defence force hospital
R1.3.3	Other Commonwealth hospital
R2.1	Public psychiatric hospital
R2.2	Private psychiatric hospital
R3.1	Private charitable nursing home for the aged
R3.2	Private profit nursing home for the aged
R3.3	Government nursing home for the aged
R3.4	Private charitable nursing home for young disabled
R3.5	Private profit nursing home for young disabled
R3.6	Government nursing home for young disabled
R5.2	State government hostel for the aged
R4.1	Public alcohol and drug treatment centre
R4.2	Private alcohol and drug treatment centre
R5.1	Charitable hostels for the aged
R5.3	Local government hostel for the aged
R5.4	Other charitable hostel
R5.5	Other State government hostel
R5.6	Other Local government hostel
R6.1	Public hospice
R6.2	Private hospice

N7.1	Public day centre/hospital
N7.2	Public freestanding day surgery centre
N7.3	Private day centre/hospital
N7.4	Private freestanding day surgery centre
N8.1.1	Public community health centre
N8.1.2	Private (non-profit) community health centre
N8.2.1	Public domiciliary nursing service
N8.2.2	Private (non-profit) domiciliary nursing service
N8.2.3	Private (profit) domiciliary nursing service

Collection and usage attributes

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

CODE R1 Acute care hospitals

Establishments which provide at least minimal medical, surgical or obstetric services for inpatient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the state health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

CODE R2 Psychiatric hospitals

Establishments devoted primarily to the treatment and care of inpatients with psychiatric, mental, or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Cwlth) (now licensed/approved by each state health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

CODE R3 Nursing homes

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile inpatients. They must be approved by the Commonwealth Department of Health and Family Services and/or licensed by the State, or controlled by Government departments.

Private profit nursing homes are operated by private profit-making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated

by or on behalf of a state or territory Government.

CODE R4 Alcohol and drug treatment centres

Freestanding centres for the treatment of drug dependence on an inpatient basis.

CODE R5 Hostels and residential services

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Only hostels subsidised by the Commonwealth are included. Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

CODE R6 Hospices

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

CODE N7 Same-day establishments

This code includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

CODE N8 Non-residential health services

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

CODE N8.1 Community health centres

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

CODE N8.2 Domiciliary nursing service

Public or registered non-profit or profit-making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Comments: Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Data element attributes

Collection and usage attributes

Comments: In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This metadata item is currently under review by the Establishments Framework Working Group of the Health Data Standards Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Establishment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (31.17 KB)

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Extended wait patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—extended wait patient indicator, code N
METeOR identifier:	269964
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a patient is an extended wait patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—extended wait patient indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Extended wait patient
2	Other patient

Data element attributes

Collection and usage attributes

Guide for use:	A patient is classified as an extended wait patient if the patient is in clinical urgency category 3 at the time of admission or at a census time and has been waiting for the elective surgery for more than one year.
Comments:	This metadata item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an overdue patient as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Extended wait patient, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.78 KB) Is formed using Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005 Is formed using Elective surgery waiting list episode—waiting

time (at removal), total days N[NNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Extent of participation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of participation in a life area, code (ICF 2001) N
METeOR identifier:	320219
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree of participation by an individual in a specified life area, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—extent of participation in a life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Full participation
1	Mild participation restriction
2	Moderate participation restriction
3	Severe participation restriction
4	Complete participation restriction

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement of life situations.

This metadata item may be used to describe the extent of **participation** in life situations for an individual with a health condition. The standard or norm to which an individual's participation is compared is that of an individual without a similar health condition in that particular society. The participation restriction records the discordance between the experienced participation and the expected participation of an individual without a health condition. The definition of 'particular society' is not specified and will inevitably give rise to different interpretations. If limiting the interpretation, it will be necessary to state the factors which are taken into account,

for example, age, gender, ethnicity, religion, education, locality (town, state, rural, remote, urban).

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of participation of the person for whom the data is recorded.

CODE 0 Full participation

Used when the person participates in this life area in the same way in terms of duration, frequency, manner or outcome as other individuals without a similar health condition in that particular society

CODE 1 Mild participation restriction

Used for example, when the person is restricted in their participation less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days

CODE 2 Moderate participation restriction

Used for example, when the person is restricted in their participation between 26% and 50% of the time with a significant, and/or with a moderate effect on functioning (Up to half the total scale of performance) which may happen regularly over the last 30 days

CODE 3 Severe participation restriction

Used for example, when participation in this life area can be achieved, but only rarely and/or with an extreme effect on functioning which may happen often over the last 30 days

CODE 4 Complete participation restriction

Used when the person can not participate in this life area. This scale has a margin of error of 5%

CODE 8 Not specified

Used when a person's participation in a life area is restricted but there is insufficient information to use codes 0-4

CODE 9 Not applicable

Used when participation in a life area is not relevant, such as employment for an infant.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

Extent of participation is always associated with a health condition. For example, a restriction in participation in 'community, social and civic life' may be recorded when the person has had a stroke, but not when the restriction is associated only with personal preferences, without a related health condition. A value is attached to restriction of participation (i.e. a participation restriction is a disadvantage). The value is dependent on cultural norms, so that an individual may be disadvantaged in one group or location and not in another place.

This data element is used in conjunction with a specified Activities and participation life area (ICF 2001) AN[NNN]. For example, a 'mild restriction in participation in exchange of information'.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Activities and Participation cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

External cause (admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361926
Registration status:	Health, Standard 05/02/2008
Definition:	The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect, as represented by a code.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This code must be used in conjunction with an injury or poisoning code and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM classification. An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code. External cause codes V01 to Y34 must be accompanied by an activity code.
Comments:	Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes. An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Origin:

National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Injury event—external cause, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Implementation in Data Set Specifications:

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.

Injury surveillance DSS Health, Standard 05/02/2008

Information specific to this data set:
As a minimum requirement, the external cause codes must be listed in the ICD-10-AM (3rd edition) classification.

External cause (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, non-admitted patient code NN
METeOR identifier:	269988
Registration status:	Health, Standard 01/03/2005
Definition:	Environmental event, circumstance or condition as the cause of injury, poisoning or other adverse effect to a non-admitted patient.
Context:	Injury surveillance: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Motor vehicle - driver
02	Motor vehicle - passenger or unspecified occupant
03	Motorcycle - driver
04	Motorcycle - passenger or unspecified
05	Pedal cyclist or pedal cycle passenger
06	Pedestrian
07	Other or unspecified transport-related circumstance
08	Horse-related (includes fall from, struck or bitten by)
09	Fall - low (on same level or
10	Fall - high (drop of 1 metre or more)
11	Drowning, submersion - swimming pool
12	Drowning, submersion - other than swimming pool (excludes drowning associated with water craft)
13	Other threat to breathing (including strangling and asphyxiation)
14	Fire, flames, smoke
15	Hot drink, food, water, other fluid, steam, gas or vapour

16	Hot object or substance, not otherwise specified
17	Poisoning - drugs or medicinal substance
18	Poisoning - other substance
19	Firearm
20	Cutting, piercing object
21	Dog-related
22	Animal-related (excluding Horse and Dog)
23	(deleted)
24	Machinery in operation
25	Electricity
26	Hot conditions (natural origin) sunlight
27	Cold conditions (natural origins)
28	Other specified external cause
29	Unspecified external cause
30	Struck by or collision with person
31	Struck by or collision with object

Collection and usage attributes

Comments: This code list has been derived from the ICD-10-AM external cause classification.

Source and reference attributes

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd edition 2002)

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The external cause - non-admitted patient group must always be accompanied by an external cause - human intent code (see metadata item Injury event—external cause, non-admitted patient human intent code NN).

Comments: This metadata item has been developed to cater for the information requirements of the wide range of settings where injury surveillance is undertaken and do not have the capability of recording the complete ICD-10-AM external cause codes. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Origin: National Centre for Classification in Health
National Data Standards for Injury Surveillance Advisory

	Group National Health Data Committee
Reference documents:	International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2002) National Centre for Classification in Health, Sydney

Relational attributes

Related metadata references:	Supersedes External cause - non-admitted patient, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.95 KB)

External cause—human intent

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—human intent of injury, code NN
METeOR identifier:	268944
Registration status:	Health, Standard 01/03/2005
Definition:	The clinician's assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning, as represented by a code.
Data Element Concept:	Injury event—human intent of injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Accident - injury not intended
02	Intentional self-harm
03	Sexual assault
04	Maltreatment by parent
05	Maltreatment by spouse or partner
06	Other and unspecified assault
07	Event of undetermined intent
08	Legal intervention (including police) or operations of war
09	Adverse effect or complications of medical and surgical care
10	Other specified intent
11	Intent not specified

Collection and usage attributes

Guide for use:

Select the code which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. This metadata item must always be accompanied by an Injury event—external cause, non-admitted patient human intent code NN code.

This Value domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in emergency departments).

Data element attributes

Collection and usage attributes

Comments: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Source and reference attributes

Submitting organisation: National Data Standards for Injury Surveillance Advisory Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes External cause - human intent, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.35 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Standard 05/02/2008

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Family name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—family name, text X[X(39)]
Synonymous names:	Surname; Last name
METeOR identifier:	286953
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.
Data Element Concept:	Person (name)—family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The agency or establishment should record the person's full **family** name on their information systems. National Community Services Data Dictionary specific: In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.
Collection methods:	This metadata item should be recorded for all persons who receive services from or are of interest to an organisation. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals. Mixed case should be used. Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data. It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type (see

Comments).

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be the name on their Medicare card. The Person name type metadata item can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name?

_____

Are you known by any other family names that you would like recorded? If so, what are they

_____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the agency or establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, or a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the

full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering an unidentified person:

The default for unknown family name should be unknown in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of unknown.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias Name Type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (Alias name) in addition to the person's Medicare card name.

Baby for **adoption**:

The word adoption should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in client registers (for names) should also be changed to unknown. Contact your State or Territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate

that the person is a widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) 'Given name' and 'Family name'. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Standards Australia

Origin:

National Health Data Committee

National Community Services Data Committee

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Person (name)—family name, text X[X(39)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

See also Person (name)—given name, text [X(40)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is used in the formation of Person—letters of given name, text XX Community services, Standard 27/03/2007

Is used in the formation of Person—letters of family name, text XXX Community services, Standard 27/03/2007

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
When used for the purpose of positive identification or contact, agencies or establishments that collect Family name should also collect Person name type.

Fasting status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—fasting indicator, code N
METeOR identifier:	302941
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the patient was fasting at the time of an examination, test, investigation or procedure, as represented by a code.
Data Element Concept:	Health service event—fasting indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the patient is fasting at the time of an examination, test, investigation or procedure. CODE 2 No: Record if the patient is not fasting at the time of an examination, test, investigation or procedure.
Comments:	In settings where the monitoring of a person's health is ongoing and where management can change over time (such as general practice), the service contact date should be recorded.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Health service event—fasting status, code N Health, Superseded 21/09/2005 Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Candidate 04/03/2008

	Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Feedback collection indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection indicator, yes/no code N
METeOR identifier:	290438
Registration status:	Health, Standard 05/12/2007
Definition:	Whether feedback relating to services and service delivery is actively and routinely collected from clients and staff within a service provider organisation, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

The active and routine collection of feedback from clients and/or staff means that, as a matter of routine, the agency initiates and implements feedback mechanisms and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active mechanisms include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

CODE 1 Yes
The service provider organisation actively and routinely collects feedback relating to services and service delivery from clients and staff within the service provider organisation. If feedback is actively and routinely collected from clients only or staff only, this should be recorded as 'No' (Code 2).

CODE 2 No
The service provider organisation does not actively and routinely collect feedback relating to services and service delivery from clients and staff within the service provider organisation.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Information specific to this data set:
This information is required for the calculation of the national palliative care performance indicator number 3: 'The proportion of palliative care agencies, within their setting of care, that actively collect feedback from patients/consumers and staff (within the workforce) relating to services and service delivery'.

Feedback collection method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection method, code N
METeOR identifier:	290476
Registration status:	Health, Standard 05/12/2007
Definition:	The method the service provider organisation employs to actively and routinely collect feedback on services and service delivery, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection method

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Questionnaire - periodic face-to-face interview
2	Questionnaire - face-to-face interview on exit
3	Questionnaire - periodic telephone interview
4	Questionnaire - telephone interview on exit
5	Questionnaire - periodic written survey
6	Questionnaire - written survey on exit
7	Feedback focus group
8	Other

Data element attributes

Collection and usage attributes

Guide for use:

The active and routine collection of feedback means that, as a matter of routine, the agency initiates and implements feedback methods and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active methods include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

The aim of the method used must be to collect feedback on services and service delivery.

'Periodic' may mean at set intervals or at (a) specified points in time during the service episode.

'On exit' refers to the closure of the service episode (for clients

or related people), or (for staff) the time at which the staff member ceases to be employed by the agency.

CODE 7 Feedback focus group

An in-depth qualitative interview with a small number of persons, held specifically to collect feedback from the participants.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation—feedback collection indicator, yes/no code N* value is 'yes' (code 1).

Fibrinolytic drug used

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic drug administered, code N
METeOR identifier:	285079
Registration status:	Health, Standard 04/06/2004
Definition:	The fibrinolytic drug used, as represented by a code.
Data Element Concept:	Person—fibrinolytic drug administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Streptokinase
2	t-PA (Tissue Plasminogen Activator) (Alteplase)
3	r-PA (Reteplase)
4	TNK t-PA (Tenecteplase)

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Fibrinolytic drug used, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.04 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, this data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Fibrinolytic therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic therapy status, code NN
METeOR identifier:	285087
Registration status:	Health, Standard 04/06/2004
Definition:	The person's fibrinolytic therapy status, as represented by a code.
Data Element Concept:	Person—fibrinolytic therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - previous haemorrhagic stroke at any time; other strokes or cerebrovascular events within 1 year
24	Not given - known intracranial neoplasm
25	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses)
26	Not given - suspected aortic dissection
27	Not given - severe uncontrolled hypertension on presentation (blood pressure >180 mmHg systolic and/or 110 mmHg diastolic). Note: This could be an absolute contraindication in low-risk patients with MI.
28	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in 2.3 & 2.4 contraindications
29	Not given - current use of anticoagulants in therapeutic doses (INR greater than or equal to 2); known bleeding diathesis
30	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
31	Not given - pregnancy
32	Not given - other

Supplementary values:

90	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: CODES 23, 24, 25, 26, 27, 28, 29, 30 and 31

More than one code may recorded for the following codes: 23, 24, 25, 26, 27, 28, 29, 30 and 31.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Fibrinolytic therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.97 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, to be collected with the data elements Triage—triage date, DDMMYYYY, Triage—triage time, hhmm, Person—risk stratum, code N.

This data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

First day of the last menstrual period

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy—first day of the last menstrual period, date DDMMYYYY
METeOR identifier:	270038
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the first day of the mother's last menstrual period (LMP).
Data Element Concept:	Pregnancy—first day of the last menstrual period

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).
Comments:	The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes First day of the last menstrual period, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.56 KB) Is used in the formation of Female (pregnant)—estimated gestational age, total weeks NN Health, Standard 01/03/2005

Floor/level number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—floor/level identifier, [NNNA]
METeOR identifier:	270029
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the floor/level where a person can be located.
Data Element Concept:	Person (address)—floor/level identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[NNNA]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
Collection methods:	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Floor/level number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.91 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Floor/level number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—floor/level identifier, [NNNA]
METeOR identifier:	290264
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for floor/level, where an organisation can be located.
Data Element Concept:	Service provider organisation (address)—floor/level identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[NNNA]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
Collection methods:	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Floor/level type (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—floor/level type, code A[A]
METeOR identifier:	270024
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of floor/level where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—floor/level type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Guide for use:	Some floor/level identification may require the Floor/level type plus a Floor/level number to be recorded.
Collection methods:	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Floor/level type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.47 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

	Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Standard 04/07/2007

Floor/level type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—floor/level type, code A[A]
METeOR identifier:	290245
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of floor/level where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—floor/level type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Collection methods:	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard
04/07/2007

Foot deformity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot deformity indicator, code N
METeOR identifier:	302449
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a deformity is present on either foot, as represented by a code.
Data Element Concept:	Person—foot deformity indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a foot deformity is present on either foot. CODE 2 No: Record if no foot deformity is present on either foot. Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.
Collection methods:	Both feet to be examined for the presence of foot deformity.
Comments:	Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary
Reference documents:	Lesley V Campbell, Antony R Graham, Rosalind M Kidd, Hugh

F Molloy, Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42.

Reiber GE. Epidemiology of the diabetic foot. In: Levin ME, O'Neal LW, Bowker JH, editors. The diabetic foot. 5th ed. St Louis: Mosby Year Book, 1993; 1 - 5.

Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes Care 1983; 6: 87 - 91.

Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Relational attributes

Related metadata references:

Supersedes Person—foot deformity status, code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Foot deformities are frequently the result of diabetic motor neuropathy and diabetic foot disease is the most common cause of hospitalisation in people with diabetes.

Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45 - 74 years and sevenfold over 75 years. In people with diabetes, amputations are 15 times more common than in people without diabetes and 50% of all amputations occur in people with diabetes (Epidemiology of the diabetic foot; Report of the Diabetic Foot and Amputation Group). All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Specialised foot clinics appear to decrease further episodes of foot ulceration and decrease hospital admissions for amputations.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- feet should be examined every 6 months or at every visit if high risk foot or active foot problem.
- refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present.
- ensure that patients with 'high-risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems.
- to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of Peripheral neuropathy
- assessment outcome, peripheral vascular disease, or foot deformity or history of previous ulceration.

Foot lesion (active)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot lesion indicator (active), code N
METeOR identifier:	302437
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has an active foot lesion, other than an ulcer, on either foot, as represented by a code.
Data Element Concept:	Person—foot lesion indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if current active foot lesion other than ulceration is present on either foot. CODE 2 No: Record if no current active foot lesion other than ulceration is present on either foot. The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.
Collection methods:	Assess whether the individual has an active foot lesion on either foot.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—foot lesion status (active), code N Health, Superseded 21/09/2005
Implementation in Data Set	Diabetes (clinical) DSS Health, Standard 21/09/2005

Specifications:

Information specific to this data set:
Early detection and appropriate management of the 'high risk foot' and active foot problems can reduce morbidity, hospitalisation and amputation in people with diabetes.

Foot ulcer (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (history), code N
METeOR identifier:	302819
Registration status:	Health, Standard 21/09/2005
Definition:	Whether person has a previous history of ulceration on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if person has a previous history of ulceration on either foot. CODE 2 No: Record if person has no previous history of ulceration on either foot.
Collection methods:	Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Person—foot ulcer history status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005 *Information specific to this data set:*

Past history of foot ulceration, peripheral neuropathy and foot deformities have been associated with increased risk of foot ulceration and lower limb amputation for patients who suffer from diabetes. The aim is to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, individuals with a 'high-risk foot' or a significant active foot problem should be examined every six months or at every visit.

Assessment:

- ask patient about previous foot problems, neuropathic symptoms, rest pain and intermittent claudication
- inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'
- assess footwear
- check peripheral pulses
- examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

Foot ulcer (current)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (current), code N
METeOR identifier:	302445
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has a current foot ulcer on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a foot ulcer is currently present on either foot. CODE 2 No: Record if a foot ulcer is not currently present on either foot.
Collection methods:	Access whether the individual has a current foot ulcer on either foot. Assessment • ask the patient about previous or current foot problems, neuropathic symptoms, rest pain and intermittent claudication; • inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'; • assess footwear; • check peripheral pulses; • examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.
Comments:	Foot ulcer is usually situated on the edge of the foot or toes

because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.

Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.

Source and reference attributes

Submitting organisation: National diabetes data working group

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

Reference documents: The Diabetic Foot Vol 3 No 4. Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

Relational attributes

Related metadata references: Supersedes Person—foot ulcer status (current), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

The development of ulcers of the feet and lower extremities is a special problem in the diabetic patient, and appears to be due primarily to abnormal pressure distribution secondary to diabetic neuropathy.

Diabetic foot ulceration is a serious problem and the lack of pain does not mean that the ulcer can be ignored or neglected. The absence of pain is very common in people with diabetes due to peripheral neuropathy.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Early detection and appropriate management of the 'high-risk foot' and current foot ulceration can reduce morbidity, hospitalisation and amputation in people with diabetes.

Formal community support access status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—formal community support access indicator (current), code N
METeOR identifier:	270169
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person is currently accessing a formal community support service or services, as represented by a code.
Data Element Concept:	Person—formal community support access indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Currently accessing
	2	Currently not accessing
Supplementary values:	9	Not known/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1:

The person is currently accessing at least one paid community support service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc).

CODE 2:

The person is not currently accessing any paid community support service or services.

CODE 9:

The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Formal community support access status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.54 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded

04/07/2007
Cardiovascular disease (clinical) DSS Health, Standard
04/07/2007

Full-time equivalent staff (mental health)—all staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}]
METeOR identifier:	296553
Registration status:	Health, Standard 08/12/2004
Definition:	The aggregate full-time equivalent staff units paid for all staffing categories within a mental health establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	The total is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded. Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.
Collection methods:	Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one hospital (for Public hospitals NMDS) or service unit (for Mental health establishments NMDS), full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each

(salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: Must be supplied if the sub-categories cannot be supplied. Can also be supplied if the sub-categories are supplied.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

NOTE: Data for the sub-categories of Salaried medical officers and diagnostic and health professionals, and the categories of Carer consultants and Consumer consultants to be reported for Mental health establishments NMDS only.

Full-time equivalent staff—administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}]
METeOR identifier:	270496
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **administrative and clerical staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this metadata item. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then,

both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—average

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid), average N[NNN{.N}]
METeOR identifier:	270543
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all staffing categories within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Calculated by adding the full-time equivalents for each staffing category listed below:

C1.1 Salaried medical officers

C1.2 Registered nurses

C1.3 Enrolled nurses

C1.4 Student nurses

C1.5 Trainee/pupil nurses

C1.6 Other personal care staff

C1.7 Diagnostic and health professionals

C1.8 Administrative and clerical staff

C1.9 Domestic and other staff

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment,

full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Implementation in Data Set Specifications: Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Full-time equivalent staff—carer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}]
METeOR identifier:	296498
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **carer consultants** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (carer consultants)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}]
METeOR identifier:	287509
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **consultant psychiatrists and psychiatrists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure metadata items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments

and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—consumer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}]
METeOR identifier:	296496
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **consumer consultants** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (consumer consultants)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}]
METeOR identifier:	270495
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **diagnostic and health professionals** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This metadata item includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). This metadata item includes full-time equivalent staff units of occupational therapists, social workers, psychologists, and other diagnostic and health professionals.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—domestic and other staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}]
METeOR identifier:	270498
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **domestic and other staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (domestic and other staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

This metadata item also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)
Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—enrolled nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}]
METeOR identifier:	270497
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **enrolled nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (enrolled nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Enrolled nurses are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states). The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as

surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—occupational therapists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}]
METeOR identifier:	287603
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **occupational therapists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (occupational therapists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Occupational therapists are included when calculating all diagnostic and health professionals.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—other diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}]
METeOR identifier:	287611
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **other diagnostic and health professionals** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature. This metadata item covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments

and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—other medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}]
METeOR identifier:	287531
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **other medical officers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other medical officers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the state or territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure metadata items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Other medical officers are included when calculating salaried medical officers.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—other personal care staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}]
METeOR identifier:	270171
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **other personal care staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other personal care staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned

between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Steward: Australian Bureau of Statistics (ABS)

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—psychiatry registrars and trainees

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}]
METeOR identifier:	287529
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **psychiatry registrars and trainees** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Psychiatry registrars and trainees are included when calculating salaried medical officers.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—psychologists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (psychologists), average N[NNN{.N}]
METeOR identifier:	287609
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **psychologists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (psychologists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who are registered as psychologists with the relevant state and territory registration board. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Psychologists are included when calculating diagnostic and health professionals.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—registered nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}]
METeOR identifier:	270500
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **registered nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (registered nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health,

Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—salaried medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}]
METeOR identifier:	270494
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **salaried medical officers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (salaried medical officers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee for service basis.

This metadata item includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

If under the relevant award of agreement a full-time nurse is

paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Comments:

This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Relational attributes

Related metadata references:

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This data element should be derived from the following:

- Consultant psychiatrists and psychiatrists
- Medical officers who are registered to practise psychiatry under the relevant State or Territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry
- Psychiatry registrars and trainees
- Medial officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program

- Other medical officers
- Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the State or Territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—social workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (social workers), average N[NNN{.N}]
METeOR identifier:	287607
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **social workers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (social workers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—student nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (student nurses), average N[NNN{.N}]
METeOR identifier:	270499
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **student nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (student nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—trainee/pupil nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}]
METeOR identifier:	270493
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **trainee/pupil nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (trainee/pupil nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Functional stress test element

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—functional stress test element, code N
METeOR identifier:	285097
Registration status:	Health, Standard 04/06/2004
Definition:	The element included in an electrocardiogram stress test, as represented by a code.
Data Element Concept:	Person—functional stress test element

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	ECG monitoring
	2	Echocardiography
	3	Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	More than one code may be recorded (code 9 is excluded from multiple coding).

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Functional stress test element, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.68 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Functional stress test ischaemic result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—functional stress test ischaemic result, code N
METeOR identifier:	285105
Registration status:	Health, Standard 04/06/2004
Definition:	The result of the person's electrocardiogram stress in terms of ischaemic outcome, as represented by a code.
Data Element Concept:	Person—functional stress test ischaemic result

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	2	Positive
	3	Negative
	4	Equivocal
Supplementary values:	1	Not done
	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 2 Positive

On an exercise tolerance test, the patient developed either:

a. Both ischaemic discomfort and ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); or

b. new ST shift greater than or equal to 2 mm (0.2 mV) (horizontal or down-sloping) believed to represent ischaemia even in the absence of ischaemic discomfort.

On cardiac imaging investigation (e.g. exercise thallium or MIBI test, stress echocardiography, or dipyridamole, thallium, or adenosine radioisotope scan):

a. Evidence of reversible ischaemia on nuclear imaging of the myocardium.

b. Evidence of inducible ischaemic response during echocardiographic imaging of the myocardium.

If the patient had an equivalent type of exercise test but a definite evidence of ischaemia on cardiac imaging (e.g. an area of clear reversible ischaemia), this should be considered a positive test.

CODE 3 Negative

No evidence of ischaemia (i.e. no typical angina pain and no ST shifts).

CODE 4 Equivocal

Either:

a. Typical ischaemic pain but no ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); or

ST shift of 1 mm (0.1 mV) (horizontal or downsloping) but no ischaemic discomfort.

b. Defect on myocardial imaging of uncertain nature or significance.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Functional stress test ischaemic result, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.04 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Funding source for hospital patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—principal source of funding, hospital code NN
METeOR identifier:	339080
Registration status:	Health, Standard 29/11/2006
Definition:	The principal source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
Context:	Admitted patient care. Hospital non-admitted patient care.
Data Element Concept:	Episode of care—principal source of funding

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Australian Health Care Agreements
02	Private health insurance
03	Self-funded
04	Worker's compensation
05	Motor vehicle third party personal claim
06	Other compensation (e.g. public liability, common law, medical negligence)
07	Department of Veterans' Affairs
08	Department of Defence
09	Correctional facility
10	Other hospital or public authority (contracted care)
11	Reciprocal health care agreements (with other countries)
12	Other
13	No charge raised

Supplementary values:

Value	Meaning
99	Not known

Collection and usage attributes

Guide for use: CODE 01 Australian Health Care Agreements

Australian Health Care Agreements should be recorded as the funding source for Medicare eligible admitted patients who elect to be treated as public patients and Medicare eligible emergency department patients and Medicare eligible patients presenting at a public hospital outpatient department for whom there is not a third party arrangement.

Includes: Public admitted patients in private hospitals funded by state or territory health authorities (at the state or regional level).

Excludes: Inter-hospital contracted patients and overseas visitors who are covered by Reciprocal health care agreements and elect to be treated as public admitted patients.

CODE 02 Private health insurance

Excludes: overseas visitors for whom travel insurance is the major funding source.

CODE 03 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 10 Other hospital or public authority

Includes: Patients receiving treatment under contracted care arrangements (Inter-hospital contracted patient).

CODE 11 Reciprocal health care agreements (with other countries)

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, New Zealand and Ireland. The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Excludes: Overseas visitors who elect to be treated as private patients.

CODE 12 Other funding source

Includes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 No charge

Includes: Admitted patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare), and patients for whom a charge is raised but is subsequently waived.

Excludes: Admitted public patients (Medicare eligible) whose funding source should be recorded as Australian Health Care Agreements or Reciprocal Health Care Agreements. Also excludes Medicare eligible non-admitted patients, presenting to a public hospital emergency department and Medicare eligible patients (for whom there is not a third party payment arrangement) presenting at a public hospital outpatient department, whose funding source should be recorded as

Australian Health Care Agreements.

Also excludes patients presenting to an outpatient department who have chosen to be treated as a private patient and have been referred to a named medical specialist who is exercising a right of private practice. These patients are not considered to be patients of the hospital (see Guide for use).

Data element attributes

Collection and usage attributes

Guide for use:

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

Supersedes Episode of care—expected principal source of funding, hospital code NN Health, Superseded 29/11/2006

Implementation in Data Set Specifications:

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Geographical location of establishment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—geographical location, code (ASGC 2007) NNNNN
METeOR identifier:	362289
Registration status:	Health, Standard 05/02/2008
Definition:	The geographical location of the main administrative centre of an establishment, as represented by a code.
Data Element Concept:	Establishment—geographic location

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2007
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

The geographical location is reported using a five-digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC) (Australian Bureau of Statistics (ABS), catalogue number 1216.0). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA).

The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year.

The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or state can be used with the locality name to assign the SLA.

In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.

Source and reference attributes

Origin:	National Health Data Committee

Australian Standard Geographical Classification (Australian Bureau of Statistics Catalogue No. 1216.0)

Relational attributes

Related metadata references:

Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005

Supersedes Establishment—geographical location, code (ASGC 2006) NNNNN Health, Superseded 05/02/2008

Implementation in Data Set Specifications:

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Geographical location of service delivery outlet

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service delivery outlet—geographic location, code (ASGC 2007) NNNNN
METeOR identifier:	362295
Registration status:	Health, Standard 05/02/2008
Definition:	Geographical location of a site from which a health/community service is delivered, as represented by a code.
Data Element Concept:	Service delivery outlet—geographic location

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2007
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA). The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA. In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub- index of the NLI to assign the SLA.
Comments:	To enable the analysis of the accessibility of service provision in relation to demographic and other characteristics of the population of a geographic area.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum

	Data Set Working Group
Origin:	Australian Standard Geographical Classification (ABS Cat. No. 1216.0)

Relational attributes

Related metadata references:	Supersedes Service delivery outlet—geographic location, code (ASGC 2006) NNNNN Health, Superseded 05/02/2008 Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Gestational age

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—estimated gestational age, total weeks NN
METeOR identifier:	269965
Registration status:	Health, Standard 01/03/2005
Definition:	The estimated gestational age of the baby in completed weeks as determined by clinical assessment.
Data Element Concept:	Female (pregnant)—estimated gestational age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/unknown
Unit of measure:	Week	

Data element attributes

Collection and usage attributes

Guide for use:	This is derived from clinical assessment when accurate information on the date of the last menstrual period is not available for this pregnancy. Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992

Relational attributes

Related metadata references:	Supersedes Gestational age, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.66 KB) Is formed using Pregnancy—first day of the last menstrual period, date DDMMYYYY Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Perinatal NMDS Health, Superseded 06/09/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

The first day of the last menstrual period (LMP) is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Given name sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—given name sequence number, code N
METeOR identifier:	287595
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numerical order of the given names or initials of a person, as represented by a code.
Data Element Concept:	Person (name)—given name sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	2

Permissible values:

Value	Meaning
1	First given name
2	Second given name
3	Third given name
4	Fourth given name
5	Fifth given name
6	Sixth given name
7	Seventh given name
8	Eighth given name
9	Ninth and subsequent given name

Data element attributes

Collection and usage attributes

Guide for use:

To be used in conjunction with Given name.
Example: Mary Georgina Smith

In the example above 'Mary' would have a given name sequence number of 1 and 'Georgina' would have a given name sequence number of 2.

Example: Jean Claude Marcel Moreaux

If the person has recorded a single given name as more than one word, displaying spaces in between the words(e.g. Jean Claude), their given names are recorded in data collection systems in the same way (i.e. Jean Claude is one given name and Marcel is another given name). 'Jean Claude' would have a Given name sequence number of '1' and 'Marcel' would have a Given name sequence number of '2'.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Given name(s)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—given name, text [X(40)]
METeOR identifier:	287035
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	The person's identifying name within the family group or by which the person is socially identified, as represented by text.
Data Element Concept:	Person (name)—given name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	A person may have more than one Given name. All given names should be recorded. The agency or establishment should record the person's full given name(s) on their information systems. National Community Services Data Dictionary specific: In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. In situations where proof of identity is required, the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity. National Health Data Dictionary specific: Each individual Given name should have a Given name sequence number associated with it. Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording. A full history of names is to be retained.
Collection methods:	This metadata item should be recorded for all clients. Given name(s) should be recorded in the format preferred by the person. The format should be the same as that indicated by the person (e.g. written on a form) or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data. It is acknowledged that some people use more than one given name

(e.g. formal name, birth name, nick name or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Person name type metadata item (see Comments) can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

_____

Are you known by any other given names that you would like recorded?

If so, what are they

_____

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Whenever a person informs the agency or establishment of a change of given name (e.g. prefers to be know by their middle name), the former name should be recorded according to the appropriate name type. Do not delete or overwrite a previous given name e.g. 'Mary Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred given name and record 'Mary' as the Medicare card given name.

e.g. The establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred 'Given name'.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record unknown in the 'Given name' field and use alias Name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of unknown.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given name' field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a **family** name and a given name: they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Record complete information:

All of the person's given names should be recorded.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

Example - The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

Example - The person's given name is 'Giovanni' but he prefers to be called 'John'.

Record 'John' as the preferred 'Given name' and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

- Hyphen, e.g. Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces, e.g. Jean Claude Carcel Moreaux

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way (i.e. Jean Claude is one given name and Marcel is another given name).

Names not for continued use:

For cultural reasons, a person such as an Aboriginal or Torres Strait Islander may advise that they are no longer using the given name they previously used and are now using an alternative current name. Record their current name as their preferred given name and record their previously used name as an alias name (with a Name conditional use flag of 'not for continued use').

Composite name:

If a person identifies their first name as being a composite word, both parts should be recorded under the first Given Name (rather than the first and second Given Name).

e.g. 'Anne Marie Walker' notes her preferred Given Name to be 'Anne Marie', then 'Anne Marie' is recoded as (first) Given Name, and (second) Given Name is left blank.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the preferred 'Given name' field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple births. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first born baby, and 'Twin 2 of Fiona' in the 'Given name' field of the second born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman Numerals (I, II, III .....).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin:

use Twin i.e. Twin 1 of Fiona

- Triplet:

use Trip i.e. Trip 1 of Fiona

- Quadruplet:

use Quad i.e. Quad 1 of Fiona

- Quintuplet:

use Quin i.e. Quin 1 of Fiona

- Sextuplet:

use Sext i.e. Sext 1 of Fiona

- Septuplet:

use Sept i.e. Sept 1 of Fiona.

These names should be recorded under the newborn Person name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an agency or establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name.

Record their current name as the preferred 'Given name' and record their previous used given name as an alias name.

Ethnic Names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the given name in combination with selected letters of the family name, date of birth and sex may be used for **record linkage** for statistical purposes only.

National Health Data Dictionary specific:

Health care provider identification DSS and Health care client identification DSS
For the purpose of positive identification or contact, agencies or

establishments that collect Given name should also collect Given name sequence number. Given name sequence number is also a metadata item in Australian Standard AS4846-2004 Health care provider identification and is proposed for inclusion in the review of Australian Standard AS5017-2002 Health care client identification. AS5017 and AS4846 use alternative alphabetic codes for Given name sequence number. Refer to the current standards for more details.

Source and reference attributes

Submitting organisation:
Australian Institute of Health and Welfare
Standards Australia

Origin:
National Health Data Committee
National Community Services Data Committee
Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS
Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents:
AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:
See also Person (name)—family name, text X[X(39)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005
Supersedes Person (name)—given name, text [X(40)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Is used in the formation of Person—letters of given name, text XX Community services, Standard 27/03/2007

Implementation in Data Set Specifications:
Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Standard 07/12/2005
Health care client identification DSS Health, Standard 04/05/2005
Health care provider identification DSS Health, Superseded 04/07/2007
Health care provider identification DSS Health, Standard 04/07/2007

Glycoprotein IIb/IIIa receptor antagonist (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycoprotein IIb/IIIa receptor antagonist status, code NN
METeOR identifier:	285115
Registration status:	Health, Standard 04/06/2004
Definition:	The person's glycoprotein IIb/IIIa receptor antagonist therapy status, as represented by a code.
Data Element Concept:	Person—glycoprotein IIb/IIIa receptor antagonist status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	10	Given
	21	Not given - therapy not indicated
	22	Not given - patient refusal
	23	Not given - known intracranial neoplasm
	24	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses). Suspected aortic dissection
	25	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in contraindications
	26	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
	27	Not given - pregnancy
	28	Not given - other
Supplementary values:	90	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the administering of Glycoprotein IIb/IIIa receptor antagonist drugs at any time point during this current event. CODES 21 - 28 Not given

If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Glycoprotein IIb/IIIa receptor antagonist status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.08 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Glycosylated Haemoglobin—upper limit of normal range (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N
METeOR identifier:	270333
Registration status:	Health, Standard 01/03/2005
Definition:	Laboratory standard for the value of glycosylated haemoglobin (HbA1c) measured as a percentage that is the upper boundary of the normal range.
Data Element Concept:	Laboratory standard—upper limit of normal range of glycosylated haemoglobin

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the HbA1c normal reference range from the laboratory result.
Collection methods:	This value is usually notified in patient laboratory results and may vary for different laboratories.
Comments:	HbA1c results vary between laboratories; use the same laboratory for repeated testing.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	See also Person—glycosylated haemoglobin level (measured), percentage N[N].N Health, Standard 01/03/2005 Supersedes Glycosylated Haemoglobin (HbA1c) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.93 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions and is used as a standard for assessing overall blood glucose control. The target is to achieve an HbA1c within 1% of the upper limit of normal or achieve control as near to this target as possible without producing unacceptable hypoglycaemia as recommended from the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

If HbA1c is 2% above the upper limit of normal, explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise and review management:

- review and adjust treatment
- consider referral to diabetes educator
- consider referral to dietitian
- consider referral to endocrinologist or physician or diabetes centre.

Glycosylated haemoglobin level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycosylated haemoglobin level (measured), percentage N[N].N
METeOR identifier:	270325
Registration status:	Health, Standard 01/03/2005
Definition:	A person's glycosylated haemoglobin (HbA1c) level, measured as percentage.
Data Element Concept:	Person—glycosylated haemoglobin level

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

HbA1c results vary between laboratories; use the same laboratory for repeated testing.

When reporting, record absolute result of the most recent HbA1c level in the last 12 months.

Record the absolute result of the test (%).

Collection methods:

Test is performed in accredited laboratories:

- A single blood sample is sufficient and no preparation of the patient is required.
- Measure HbA1c ideally using High Performance Liquid Chromatography (HPLC).

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Koening, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. Diabetes 259 (1976): 230-232. Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. N. Eng. J. Med. 310 (1984): 341-346.

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range of

glycosylated haemoglobin, percentage N[N].N Health, Standard 01/03/2005

Supersedes Glycosylated Haemoglobin (HbA1c) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

The HbA1c along with regular blood glucose monitoring is the best way to see the overall picture of blood glucose levels.

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. The level of HbA1c is proportional to the level of glucose in the blood over a period of approximately two months, because glucose attaches to the haemoglobin (red blood cells) and remains there for the life of the red blood cell, approximately 120 days. The HbA1c gives an average of the blood glucose level over the past 6-8 weeks and therefore HbA1c is accepted as an indicator of the mean daily blood glucose concentration over the preceding two months.

HbA1c is formed by the non-enzymatic glycation of the N-terminus of the B- chain of haemoglobin Ao. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions used as a standard for assessing overall blood glucose control.

Research studies in the United States have found that for every 1% reduction in results of HbA1c blood tests, the risk of developing micro vascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40 percent.

The maintenance of good glycaemic control (in diabetes Type 1 and Type 2), significantly reduces progression of diabetes-related complications such as retinopathy, nephropathy and neuropathy, as indicated in the Diabetes Control and Complications Trial (DCCT 1993) and United Kingdom Prospective Diabetes Study (UKPDS 1997).

The target proposed by the Australian Diabetes Society for glycosylated haemoglobin (HbA1c)is 7.0% or less and a doctor may order this test about every 3 - 6 months.

Goal of care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—goal of care, code NN
METeOR identifier:	270225
Registration status:	Health, Standard 01/03/2005
Definition:	The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, as represented by a code.
Data Element Concept:	Community nursing service episode—goal of care

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Well person for preventative/maintenance/health promotion program
02	Person will make a complete recovery
03	Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required
04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home
05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die
06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time
07	For assessment only/not applicable

Collection and usage attributes

Guide for use:

CODE 01 Well person for preventative/maintenance/health promotion program

Service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.

CODE 02 Person will make a complete recovery

Describes those persons whose condition is self-limiting and

from which complete recovery is anticipated, or those with established or long-term health problems who are normally independent in their management.

Goal 2 service recipient includes:

- post-surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;
- persons recovering from an acute illness and referred from the general practitioner or other community-based facility;
- persons with **disability** or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

CODE 03 Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required

Refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.

CODE 04 Person has a long-term care need and the goal is aimed at on-going support to maintain at home

Refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.

CODE 05 Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die

Refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

CODE 06 Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time

includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.

- Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in Goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.

CODE 07 For assessment only/not applicable

Service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Data element attributes

Collection and usage attributes

Guide for use:	Only one option is permissible and where Code 07 is selected, Code 9 must be used in the metadata item Community nursing service episode—nursing interventions, code N.
Collection methods:	At time of formal review of the client, the original goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the date of first contact with community nursing service and date of last contact and in this format provides a focussing effect at the time of planning for care.
Comments:	Agencies who had previously implemented this metadata item should note changes to the code set in the Value domain.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services

Relational attributes

Related metadata references:	Supersedes Goal of care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.09 KB)

Grants to non-government organisations—accommodation services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296547
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of accommodation services, defined as housing services that are linked to support services for people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—accommodation services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Where the exact dollar amount, for accommodations services as a whole, is unable to be provided an estimate should be derived from available local information.

Note: Only subtypes 3 and 5 are included as 'Accommodation services' for the Mental Health Establishments NMDS. Subtypes 1, 2 and 4 are not included as 'Accommodation services' for this NMDS. Categories 3 and 5 listed below are to be reported in aggregate. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under the other and unspecified services grants to non-government organisations data element.

Accommodation services are subcategorised into 5 subtypes:

1. *Crisis/interim accommodation* - Short-term accommodation which may be staffed up to 24 hours a day, seven days a week for people affected by a mental health issue. Accommodation is facility based/residential with an average of 4-8 beds. Length of stay is generally limited to a maximum of three months.

2. *Transitional supported accommodation* - Short to medium accommodation (3-12 months) that is provided in a residential/facility based setting.
3. *Headleasing* - Provides a supportive landlord service that assists tenants to access and maintain suitable accommodation and maintains their tenancies and which is linked to support.
4. *Residential rehabilitation* - Short to long-term residential facility based accommodation provided to people with high needs. Staff support is provided.
5. *Long term supported accommodation* – Secure/tenured long-term accommodation with staff support as necessary or desired.

Collection methods:

Grants for accommodation services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

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Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Grants to non-government organisations—advocacy services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—advocacy services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	286911
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of advocacy services, defined as services that provide assistance to people affected by a mental health issue to access their human and legal rights and promote reform.
Data Element Concept:	Specialised mental health service organisation—advocacy services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Where the exact dollar amount for advocacy services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.

Advocacy services are subcategorised into 2 subtypes, however data are not expected to be reported at this level:

1. *Systemic* - The representation and promotion of the rights, views and responsibilities of people affected by mental health issues in the community, public and private sectors at both domestic and international levels.
2. *Individual* - The representation and promotion of the rights and views of the individual affected by a mental health issue.

Collection methods:

Grants for advocacy services are to be reported at the lowest statistical unit level which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

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Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Grants to non-government organisations—community awareness/health promotion services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations (financial year), total Australian currency N[N(8)]
METeOR identifier:	287011
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for community awareness/health promotion services, defined as services aimed at raising awareness about mental health/illness and those affected by mental health issues through the provision of information and/or education to the community, in order to enhance the community's capacity to support people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for community awareness/health promotion services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for community awareness/health promotion services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)]

Health, Standard 07/12/2005

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

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Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Grants to non-government organisations—counselling services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—counselling services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	287021
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for counselling services provided by professionals and non-professionals that provide emotional support, psychological support, assistance with achieving goals and the strengthening of community and social networks for people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—counselling services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for counselling services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for counselling services are to be reported only at the level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005 See also Specialised mental health service organisation—other

and unspecified services grants to non-government organisations, total Australian currency N[N(8)]] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

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Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

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Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Grants to non-government organisations—independent living skills support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296480
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for services that provide encouragement and support of people living with a mental health issue to participate actively in their day to day living in a community.
Data Element Concept:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for independent living skills support services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for independent living skills support services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005 See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health,

Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

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Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Grants to non-government organisations—other and unspecified mental health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	306250
Registration status:	Health, Standard 07/12/2005
Definition:	Grants made to non-government organisations for provision of mental health services not elsewhere classified and grants not allocatable to specific service types.
Data Element Concept:	Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for other and unspecified mental health services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific mental health service types, the value of grants not allocatable to specific mental health service types should be included. Grants for mental health services classified elsewhere are listed below under Relational metadata attributes.
Collection methods:	Grants to non-government organisations for mental health services not elsewhere classified are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005 See also Specialised mental health service organisation—self-help support groups services grants for non-government

organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—respite services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—recreation services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—psychosocial support services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—pre-vocational training services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—independent living skills support services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—counselling services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—advocacy services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

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Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

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Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Activities or programs for which the grant has been provided must have a primary function of providing

treatment, rehabilitation or community health and related support targeted towards people with a mental disorder or psychiatric disability. Therefore, grants provided, for example, for research into mental health, are not included.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Grants to non-government organisations—pre-vocational training services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—pre-vocational training services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296484
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for pre-vocational training services, defined as the provision of training and skill development to individuals affected by a mental health issue to facilitate their progress into employment of their choice.
Data Element Concept:	Specialised mental health service organisation—pre-vocational training services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for pre-vocational training services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for pre-vocational training expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005 See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health,

Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

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Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Grants to non-government organisations—psychosocial support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—psychosocial support services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296486
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for psychosocial support services, defined as services that work in partnership with the individual affected by a mental health issue and their carers to provide a range of support and skill development options addressing key issues in attainment of mental health and social competence goals.
Data Element Concept:	Specialised mental health service organisation—psychosocial support services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005 See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health,

Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

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Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Grants to non-government organisations—recreation services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—recreation services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296488
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for recreation services, defined as services that provide and/or facilitate a range of leisure and social opportunities to people affected by a mental health issue to enhance their social competence.
Data Element Concept:	Specialised mental health service organisation—recreation services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005 See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
Implementation in Data Set	Mental health establishments NMDS 2005-2006 Health,

Specifications:

Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Grants to non-government organisations—respite services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—respite services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296490
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for respite services, defined as the provision of services that allow a planned break from the usual caring environment.
Data Element Concept:	Specialised mental health service organisation—respite services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for respite services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for respite expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005 See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Grants to non-government organisations—self-help support group services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296492
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for self-help groups support services, defined as the provision of opportunities for people affected by a mental health issue to learn from and support each other.
Data Element Concept:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for self-help support groups services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for self-help support group expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005 See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health,

Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Gross capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270521
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of buildings and building services (including plant).
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270526
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of constructions (other than buildings).
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270525
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of equipment.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270527
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of information technology.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270522
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of intangible assets.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—land

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270528
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of land.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269968
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of major medical equipment.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270523
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270524
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of transport.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.36 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure—computer equipment/installations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (computer equipment/installations) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270520
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on computer equipment/installations.
Data Element Concept:	Establishment—gross capital expenditure (computer equipment/installations)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.35 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Gross capital expenditure—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270517
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, in relation to intangible assets.
Data Element Concept:	Establishment—gross capital expenditure (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.35 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Gross capital expenditure—land and buildings

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (land and buildings) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270519
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on land and buildings.
Data Element Concept:	Establishment—gross capital expenditure (land and buildings)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.35 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Gross capital expenditure—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269966
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on major medical equipment.
Data Element Concept:	Establishment—gross capital expenditure (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.35 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Gross capital expenditure—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (other capital expenditure) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270516
Registration status:	Health, Standard 01/03/2005
Definition:	Other gross capital expenditure, measured in Australian dollars, which are not included elsewhere.
Data Element Concept:	Establishment—gross capital expenditure (other capital expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.35 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Gross capital expenditure—plant and other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (plant and other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270518
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on plant and other equipment.
Data Element Concept:	Establishment—gross capital expenditure (plant and other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.35 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Group sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient group sessions
METeOR identifier:	270217
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric hospital or an alcohol and drug hospital.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	Emergency patients and outpatients are persons who receive non-admitted care. Group session non-admitted care is care provided to persons who receive direct care within the **emergency department** or other designated clinics within the hospital and who are not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.11 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community group sessions
METeOR identifier:	270219
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the outreach and community functional unit of a public psychiatric hospital or an alcohol and drug hospital.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.11 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded

23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—alcohol and other drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - alcohol and other drug group sessions
METeOR identifier:	270479
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the alcohol and drug functional unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the

current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—allied health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (allied health services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - allied health services group sessions
METeOR identifier:	270480
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in allied health services functional units or clinics of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Allied health services include units primarily concerned with physiotherapy, family planning, dietary advice, optometry, occupational therapy, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the

patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—community health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (community health services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - community health services group sessions
METeOR identifier:	270491
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the community health services functional unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Community health services include units primarily concerned with baby clinics, immunisation clinics, aged care assessment teams, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the

patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (dental), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - dental group sessions
METeOR identifier:	270488
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the dental unit of an establishment
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres

within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—dialysis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (dialysis), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - dialysis group sessions
METeOR identifier:	270368
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the dialysis unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Where patients receive treatment in a ward or clinic classified elsewhere (for example Emergency Department), they are to be counted as dialysis patients and are to be excluded from other categories. All forms of dialysis that are undertaken as a treatment necessary for renal failure are to be included. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—district nursing services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (district nursing services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - district nursing services group sessions
METeOR identifier:	270482
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients by the district nursing service of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

District nursing services:

- are for medical/nursing/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider
- exclude care provided by staff from a unit classified in the community health category.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods:

At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—emergency services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (emergency services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - emergency services group sessions
METeOR identifier:	270485
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the designated emergency department of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different

systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—endoscopy and related procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - endoscopy and related procedures group sessions
METeOR identifier:	270484
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of endoscopy and related procedures provided as group sessions to non-admitted patients.

Endoscopy and related procedures include:

- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—mental health

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (mental health), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - mental health group sessions
METeOR identifier:	270490
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated psychiatric or mental health units of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different

systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - other medical/surgical/diagnostic group sessions
METeOR identifier:	270487
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the medical/surgical/diagnostic functional unit of an establishment not defined elsewhere.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Includes ECG, obstetrics, nuclear medicine, general surgery, fertility, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—other outreach services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (other outreach services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - other outreach services group sessions
METeOR identifier:	270489
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients as outreach services not classified in allied health or community health services.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Includes units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and

diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—pathology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (pathology), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - pathology group sessions
METeOR identifier:	270481
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated pathology laboratories of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Occasions of pathology services to all patients from other establishments should be counted separately. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different

systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—pharmacy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (pharmacy), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - pharmacy group sessions
METeOR identifier:	270486
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the pharmacy unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Those drugs dispensed/administered in other departments such as the emergency or outpatient are to be counted by the respective department. department Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different

systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Group sessions—radiology and organ imaging

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - radiology and organ imaging group sessions
METeOR identifier:	270483
Registration status:	Health, Standard 01/03/2005
Definition:	A count of groups of patients/clients receiving radiology and organ imaging services in a health service establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Includes x-ray department as well as specialised organ imaging clinics carrying out ultrasound, computerised tomography and magnetic resonance imaging. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-

admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

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Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Health industry relevant organisation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health industry relevant organisation—main activity type, code NNN
METeOR identifier:	352204
Registration status:	Health, Standard 05/12/2007
Definition:	Describes a health industry relevant organisation based on its main activity, as represented by a code.
Data Element Concept:	Health industry relevant organisation—main activity type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
	Main Health Care Service organisation
101	Hospital – public
102	Hospital – private (excluding private free-standing day hospital facility)
103	Hospital – private free-standing day hospital facility (excluding private non free-standing day hospital facility)
104	Residential facility – mental health care
105	Residential facility – other
106	Provider of ambulance service
107	Medical and diagnostic laboratory
108	Clinical practice – medical – general
109	Clinical practice – medical – specialist
110	Clinical practice – medical – other
111	Clinical practice – dental
112	Clinical practice – other
113	Community health facility – substance abuse
114	Community health facility – mental
115	Community health facility – other
116	Blood and organ bank
117	Retail sale/supplier of medical goods – optical glasses and other vision products
118	Retail sale/supplier of medical goods – hearing aids
119	Retail sale/supplier of medical goods – dispensing community pharmacist

120	Retail sale/supplier of medical goods – other
121	Provision and administration of public health program
122	General health administration
123	Private health insurance provider
188	Main Health Care Services provider – other
198	Regional health service (not further defined)
199	State/territory health authority (not further defined)
	Secondary/non-Health Care Service organisation
201	Pharmaceutical industry provider
202	University
203	Non-health related insurance provider
288	Secondary/non-Health Care Service organisation – other

Collection and usage attributes

Guide for use:

Main Health Care Service organisation

CODE 101 Hospital – public

An organisation comprised of a health care facility or group of health care facilities established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit, and authorised to provide treatment and/or care to patients.

Comprises all health care facilities that are reported as public hospitals to the Public Hospital Establishments National Minimum Data Set (PHE NMDS). This includes organisations such as rehabilitation hospitals; psychiatric hospitals; mothercraft hospitals; and hospices and multi-purpose services defined as hospitals. The list of public hospitals reported to the PHE NMDS is available at www.aihw.gov.au/publications/index.cfm in the Australian Hospital Statistics annual report.

NOTE 1: Excludes providers of services where those providers are not captured in the hospital financial statements. For example, the provider of a pathology or pharmacy service may be co-located within the hospital, but as a private service, and will pay the hospital for use of the site. The provider of this service should be recorded under codes 106 to 112.

CODE 102 Hospital – private (excluding private free-standing day hospital facilities)

An organisation comprised of a health care facility or a group of health care facilities established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit, and authorised to provide treatment and/or care to patients.

Is derived from the Object class 'Hospital' and 'Hospital–public' Code 101 above.

Comprises hospitals that are NOT reporting to the PHE NMDS.

NOTE: State and territory data providers are to refer to the GHE NMDS Collection Guidelines for instructions on how to

report expenditure for this category.

Excludes private free-standing day hospital facilities reported under code 103.

CODE 103 Hospital - private free-standing day facility (excluding private non free-standing day hospital facilities)

An organisation comprised of one or more private free-standing day hospital facilities which provide investigation and treatment for acute conditions on a day-only basis and is approved by the Commonwealth as a hospital for the purposes of private health insurance benefits. The four main types of private free-standing day hospitals are specialist endoscopy, opthalmic, plastic/cosmetic and general. Excludes private non free-standing day hospital facilities reported under code 102.

CODE 104 Residential facility – mental health care

Specialised mental health facilities primarily engaged in providing residential care to persons requiring mental health diagnosis and treatment combined with either nursing, supervisory or other types of care as required (including medical) by the **residents**.

Includes all government-funded**residential mental health care services** in Australia, except those residential care services that are in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection). These should not be reported in this NMDS.

Excludes residential care facilities primarily providing care for persons requiring treatment for alcohol or other substance abuse or persons with a disability.

CODE 105 Residential facility – other

Includes all government-funded facilities primarily engaged in providing residential care to persons requiring diagnosis and treatment for alcohol and other substance abuse combined with either nursing, supervisory or other types of care as required (including medical) by the residents. Includes hospices that are not defined as hospitals and respite and transitional care services.

Excludes facilities primarily providing services to persons requiring mental health diagnosis and treatment or facilities in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection).

Also excludes residential care facilities that report under the Commonwealth, State and Territory Disability Agreement where the primary purpose is care for persons with a disability.

CODE 106 Provider of ambulance service

Organisations primarily engaged in providing transportation of patients by ground or air, along with health (or medical) care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are usually equipped with lifesaving equipment operated by medically trained personnel. Includes organisations providing public ambulance services or flying doctor services such as Royal Flying Doctor Service and Care Flight, and support programs to assist isolated patients with travel to obtain specialised health care.

NOTE 2: Excludes providers of services where those providers are captured in public or private hospital financial statements. For example, the provider of an ambulance, general practice, specialist medical, dental or other health practitioner service, or a medical or diagnostic laboratory, may be located within a hospital set of accounts and its expenditure recorded on the hospital financial statement. The provider of the ambulance or other service would then be recorded under codes 101 to 103.

CODE 107 Medical and diagnostic laboratory

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or the patient on referral from a health practitioner. Includes diagnostic imaging centres; dental or medical X-ray laboratories ultrasound services; medical testing laboratories; medical pathology laboratories; medical forensic laboratories; and X-ray clinic services. Includes public and private medical and diagnostic laboratories.

See NOTE 2 under code 106.

CODE 108 Clinical practice – medical – general

This item is not currently required to be reported by state and territory health authorities.

Organisations of registered medical practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of general medicine. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres.

Excludes General practitioner plus centres and multi-speciality community clinics reported under code 115.

See NOTE 2 under code 106.

CODE 109 Clinical practice – medical – specialist

This item is not currently required to be reported by state and territory health authorities.

Organisations of registered medical practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of specialist medicine or surgery, other than pathology and diagnostic imaging services. These practitioners operate a wide range of specialities in private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or health maintenance type medical centres. Includes for example:

- Anaesthetist service
- Dermatology service
- Ear, nose and throat specialist service
- Gynaecology service
- Neurology service
- Obstetrics service
- Paediatric service
- Psychiatry service
- Specialist medical clinic service

- Specialist surgical service

See NOTE 2 under code 106.

CODE 110 Clinical practice – medical – other

This item is not currently required to be reported by state and territory health authorities.

Includes organisations of physicians not able to be allocated to Codes 108 or 109.

CODE 111 Clinical practice – dental

Organisations of registered health practitioners holding the degree of Doctor of dental medicine or a qualification at a corresponding level primarily engaged in the independent practice of general or specialised dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals, medical centres or community health facilities. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialise in a single field of dentistry. Also included are dental hospitals providing **ambulatory** type services only. Includes for example:

- Cleft lip and palate services
- Community dental service
- Dental assessment and treatment
- Dental hospital (out-patient)
- Dental practice service
- Dental practitioner service
- Dental surgery service
- Endodontic service
- Oral and maxillofacial services
- Oral pathology service
- Oral surgery service
- Orthodontic service
- Pedodontic service
- Periodontic service

See NOTE 2 under code 106.

CODE 112 Clinical practice – other

This item is not currently required to be reported by state and territory health authorities.

Organisations of independent health practitioners (other than physicians and dentists), such as chiropractors, optometrists, mental health specialists, physical, occupational, and speech therapists and audiologists organisations primarily engaged in providing **ambulatory** health care. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres. Includes for example:

- Acupuncture service
- Aromatherapy service
- Audiology service
- Chiropractic service
- Clinical psychology service
- Dental hygiene service
- Dietician service

- Hearing aid dispensing
- Homoeopathic service
- Midwifery service
- Naturopathic service
- Nursing service
- Occupational therapy service
- Optometrist
- Osteopathic service
- Podiatry service
- Speech pathology service
- Therapeutic massage service

See NOTE 2 under code 106.

CODE 113 Community health facility – substance abuse

Organisations with health staff primarily engaged in providing **ambulatory** services related to the diagnosis and treatment of alcohol and other substance abuse. These are community-based organisations that treat patients who do not require admitted patient treatment. They may provide counselling staff and information regarding a wide range of substance abuse issues and/or refer patients to more extensive treatment programmes, if necessary. Includes only government-funded establishments such as:

- Community based alcoholism treatment centres and clinics (other than hospitals or residential care facilities);
- Community based detoxification centres and clinics (other than hospitals or residential care facilities);
- Community based drug addiction treatment centres and clinics (other than hospitals or residential care facilities);
- Community based substance abuse treatment centres and clinics (other than hospitals or residential care facilities).

CODE 114 Community health facility – mental

Specialised mental health services or facilities with health staff primarily engaged in providing **ambulatory** services related to the diagnosis and treatment of mental health disorders. These specialised mental health services generally treat patients who do not require admitted patient treatment. However, these services do include consultation/liaison services provided to admitted patients by community mental health services. They may provide counselling staff and information regarding a wide range of mental health issues and/or refer patients to more extensive treatment programmes, if necessary. They may also provide treatment both on and off site, for example through mobile units. Includes only government-funded specialised mental health services, such as community mental health centres and clinics.

Ideally, we would want to collect all expenditure by government-funded community specialised mental health services, including non-government services or facilities in receipt of government funding, however the Community Mental Health Care NMDS does not collect data form these non-government services.

Therefore, for now we will only be including expenditure on government-managed community specialised mental health services, plus the cost of the grants to non-government

organisations that provide community specialised mental health services, not the total expenditure by these non-government organisations.

Excludes mental health clinics in hospitals and residential mental health care facilities.

CODE 115 Community health facility – other

Organisations with health staff primarily engaged in providing general or specialised **ambulatory** care. Centres or clinics of medical or health practitioners with the same degree or with different degrees from more than one speciality practising within the same organisations i.e., doctor and physiotherapist) are included in this item. Includes only government-funded community health facilities such as:

- Community centres and clinics;
- General practitioner plus centres;
- Multi-speciality community clinics.

Excludes clinical practices that provide exclusively medical services or exclusively health services, ambulatory mental health and substance abuse centres, and free-standing **ambulatory** surgical centres (reported under codes 108 to 114) and kidney dialysis centres and clinics (reported under codes 101 to 103 if part of a hospital or code 109 if they are free-standing ambulatory centres).

CODE 116 Blood and organ bank

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in collecting, storing and distributing blood and blood products and storing and distributing body organs.

CODE 117 Retail sale/supplier of medical goods – optical glasses and other vision products

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the retail sale of optical glasses and other vision products to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with sales of optical glasses and other vision products.

Excludes organisations primarily engaged in providing optometric services.

CODE 118 Retail sale/supplier of medical goods – hearing aids

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the sale of hearing aids to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with the sale of hearing aids.

Excludes organisations primarily engaged in hearing testing where that also includes a component of hearing aid dispensing and fitting.

CODE 119 Retail sale/supplier of medical goods – dispensing community pharmacist

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the retail sale of pharmaceuticals to the general public for personal or household consumption or utilisation. Instances when the processing of medicine may be involved should be only incidental to selling. This includes both medicines with and without prescription.

Excludes organisations listed under code 201.

CODE 120 Retail sale/supplier of medical goods – other

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the sale of medical appliances other than optical goods and hearing aids to the general public with or without prescription for personal or household consumption or utilisation. Included are:

- Organisations primarily engaged in the manufacture of medical appliances but where the fitting and repair is usually done in combination with manufacture of medical appliances.
- Organisations engaged in the retail sale of other miscellaneous medical goods to the general public for personal or household consumption or utilisation (included are sales other than by shops, such as electronic shopping and mail-order houses).
- Illustrative examples
- sale of fluids (e.g. for home dialysis);
- all other miscellaneous health and personal care stores;
- all other sale of pharmaceuticals and medical goods;
- electronic shopping and mail-order houses specialised in medical goods.

CODE 121 Provision and administration of public health program

Organisations engaged in government or private administration and provision of public health programs such as health promotion, organised screening, immunisation and health protection programs.

CODE 122 General health administration

Organisations primarily engaged in the regulation of activities of agencies that provide health care, overall administration of health policy, and health insurance. This item comprises government administration (excluding social security) primarily engaged in the formulation and administration of government policy in health and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics, etc., including the regulation and licensing of providers of health services. For example:

- Department of Health;
- Agencies for the regulation of safety in the workplace.

Excludes organisations primarily engaged in the provision and administration of public health programs which is reported under code 121.

CODE 123 Private health insurance provider

This item is not currently required to be reported by state and territory health authorities.

Organisations engaged in insurance of health (other than social security funds and other social insurance funds) who provide

insurance cover for hospital, medical, dental, pharmaceutical or funeral expenses. This includes organisations primarily engaged in activities involved in or closely related to the management of private health insurance (activities of insurance agents, average and loss adjusters and actuaries.

CODE 188 Main Health Care Service organisation – other

Organisations mainly engaged in providing health care services that are not reported under codes 101 to 123. Includes health or health-related call centres or e-health sites such as Poisons Information Centre and centres that provide information on alcohol and other drugs, mental health or other health issues.

CODE 198 Regional health service (not further defined)

Organisations at an area health service or regional level that could be a combination of categories 101 to 188 but which could not be further disaggregated.

CODE 199 State/territory health authority (not further defined)

Organisations at the state or territory health authority level that could be a combination of categories 101 to 188 but which could not be further disaggregated.

Secondary/non-Health Care Service organisation

This item is not currently required to be reported by state and territory health authorities.

CODE 201 Pharmaceutical industry provider

This item is not currently required to be reported by state and territory health authorities

Organisations primarily engaged in wholesaling human pharmaceuticals, medicines, cosmetics, perfumes and toiletries. Also included are units mainly engaged in wholesaling veterinary drugs or medicines.

Excludes organisations listed under code 119.

CODE 202 University

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing undergraduate or postgraduate teaching but which also undertake health research activities. Also includes organisations primarily engaged in undertaking research in the agricultural, biological, physical or social sciences. Units may undertake the research for themselves or others.

Includes:

- Postgraduate school, university operation
- Research school, university operation
- Specialist institute or college
- Undergraduate school, university operation
- University operation

For reporting purposes include only the health or health related research component or other health services component of these organisations' activities.

CODE 203 Non-health related insurance

This item is not currently required to be reported by state and territory health authorities.

Units mainly engaged in providing general insurance cover (except life and health insurance).

Includes:

- Motor vehicle third party insurance provision
- Worker's compensation insurance provision

CODE 288 Secondary/non-Health Care Service organisation – other

This item is not currently required to be reported by state and territory health authorities.

This item comprises organisations that are not reported under codes 201 to 203 which provide health care as secondary providers or other providers. Included are providers of occupational health care and home care provided by private households.

Includes:

Occupational health care services not provided in separate health care establishments (all industries);

- Military health services not provided in separate health care establishments
- Prison health services not provided in separate health care establishments
- School health services
- Other organisations n.e.c.

Other providers of services which support the health care industry such as laundry or catering services.

Other providers of services unrelated to the health care industry such as the building or automotive industry.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Organisation for Economic Cooperation and Development 2000. A System of Health Accounts. Version 1.0. Paris: OECD.

Australian Bureau of Statistics 2006. Australian and New Zealand Standard Industry Classification. Cat. no. 1292.0. Canberra: ABS.

RACGP 6 September 2005 <www.racgp.org.au/whatisgeneralpractice>

Data element attributes

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Implementation in Data Set Specifications: Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Government health expenditure organisation revenue data element cluster Health, Standard 05/12/2007

Health professionals attended (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—health professionals attended for diabetes mellitus (last 12 months), code N
METeOR identifier:	270287
Registration status:	Health, Standard 01/03/2005
Definition:	The health professionals that a person has attended in the last 12 months in relation to issues arising from diabetes mellitus, as represented by a code.
Data Element Concept:	Person—health professionals attended for diabetes mellitus

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Diabetes educator
	2	Dietician
	3	Ophthalmologist
	4	Optometrist
	5	Podiatrist
	8	None of the above
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record a code sequentially for each health professional attended. A person may have attended several health professionals in the last 12 months, therefore, more than one code can be recorded sequentially. Example 1: If a person has attended a diabetes educator and a podiatrist in the last twelve months, the code recorded would be 15. Example 2: If all have been seen, the code recorded would be 12345. If the person answers 'NO' to all the health professionals specified, then code 8 should be applied. CODE 9 should only be used in situations where it is not practicable to ask the questions.
Collection methods:	The person should be asked about each type of health professional in successive questions, as follows:

Have you attended any of the following health professionals in relation to diabetes mellitus in the last 12 months?

Diabetes educator ___Yes ___ No

Dietician ___Yes ___ No

Ophthalmologist ___Yes ___ No

Optometrist ___Yes ___ No

Podiatrist ___Yes ___ No

The appropriate code should be recorded for each health professional attended.

Comments:

The health professional occupations are assigned the following codes at the occupation level of the Australian Standard Classification of Occupations, Second Edition, Australian Bureau of Statistics, 1997, Catalogue No. 1220.0

Diabetic educator 2512-13

Dietician 2393-11

Ophthalmologist 2312-19

Optometrist 2384-11

Podiatrist 2388-11

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Health professionals attended - diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.81 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Management of diabetes requires a team approach, comprising selected health professionals, to provide services specific to the individual with diabetes.

All patients with diabetes require diet therapy in conjunction with exercise and/or medication to achieve optimal control of blood glucose, body weight and blood lipids. In insulin treated diabetics, diet management aims to restrict variations in the timing, size or composition of meals that could result in hypoglycaemia or postprandial hyperglycaemia. Based on the Healthy Eating Pyramid, meals should be low in saturated fat, and rich in high-fibre carbohydrates with low glycaemic index (GI). Saturated fats have to be replaced with monounsaturated and polyunsaturated fats.

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

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

for patients whose diabetes onset was at age less than 30 years.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- Foot examination to be performed every 6 months or at every visit if high risk foot or active foot problem
- Refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present
- To identify the 'high risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of peripheral neuropathy, peripheral vascular disease, or foot deformity and history of previous ulceration
- Ensure that patients with 'high risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems.

Heart rate

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—heart rate, total beats per minute N[NN]
METeOR identifier:	285123
Registration status:	Health, Standard 04/06/2004
Definition:	The person's heart rate measured in beats per minute.
Data Element Concept:	Person—heart rate

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Cardiac arrest
998	Not recorded
999	Not stated/inadequately described

Unit of measure: Heart beats per minute

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Heart rate, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.92 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, collected at time of presentation. If heart rate is not recorded at the exact time of presentation, record the first heart rate measured closest to the time of presentation.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Heart rhythm type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—heart rhythm type, code N[N]
METeOR identifier:	285137
Registration status:	Health, Standard 04/06/2004
Definition:	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Person—heart rhythm type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Sinus rhythm
2	Atrial fibrillation
3	Atrial flutter
4	Second degree heart block
5	Complete heart block
6	Supraventricular tachycardia
7	Idioventricular rhythm
8	Ventricular tachycardia
9	Ventricular fibrillation
10	Paced
11	Other rhythm

Supplementary values:

99	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Heart rhythm type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.24 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, the ECG used for assessment on presentation.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Height (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—height (measured), total centimetres NN[N].N
METeOR identifier:	270361
Registration status:	Health, Standard 01/03/2005
Definition:	The height of a person measured in centimetres.
Context:	Public health and health care
Data Element Concept:	Person—height

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not measured

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Guide for use:

In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.

Measurements of height should be assessed in relation to children and adolescents' age and pubertal status.

Collection methods:

The measurement protocol described below are those recommended by the *International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996), and the World Health Organization (WHO Expert Committee 1995), which was adapted from Lohman et al. (1988).*

Measurement protocol:

Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.

The measurement of height requires a vertical metric rule, a horizontal headboard, and a non-compressible flat even surface on which the subject stands. The equipment may be fixed or portable, and should be described and reported.

The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm.

Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject stands on a platform scale is not recommended.

Adults and children who can stand:

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems). The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board. To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base board.

The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement. If the two measurements disagree by more than 0.5 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured height is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage & Berry 1994). For example, a mean value of 172.25 cm would be rounded to 172.2 cm, while a mean value of 172.35 cm would be rounded to 172.4 cm.

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs

remain flat on the table and must shift the movable board against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5 - 1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the date be recorded when the change is made from supine to standing height measure.

Validation and quality control measures:

All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level. Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

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

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men, women, children and adolescents although the range will depend on the population:

Height

70 cm = Height

75 cm = Height

... in 5 cm categories

185 cm = Height

Height => 190 cm

Relational attributes

Related metadata references:

Supersedes Height - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (28.74 KB)

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Disease, nutritional, genetic and environmental factors all exert an influence on the height of an individual, hence this variable, together with its related variable weight, is of unique value in health surveillance. It enables the calculation of body mass index which requires the measurement of height and weight (body mass) for adults as well as sex and date of birth for children and adolescents.

Stature is a major indicator of general body size and of bone length and of nutritional and health status of the individual and the community at large. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all-cause mortality, coronary

heart disease mortality in middle-aged men, and of less favourable gestational outcomes in women (Marmot et al. 1984, Kramer 1988).

Height (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—height (self-reported), total centimetres NN[N]
METeOR identifier:	270365
Registration status:	Health, Standard 01/03/2005
Definition:	A person's self-reported height, measured in centimetres.
Data Element Concept:	Person—height

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
888	Unknown
999	Not stated/inadequately described

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Collection methods:

The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their height is. For example, the Australian Bureau of Statistics National Health Survey 1995 included the question 'How tall are you without shoes?'. The data collection form should allow for both metric (to the nearest 1 cm) and imperial (to the nearest 0.5 inch) units to be recorded.

If practical, it is preferable to enter the raw data into the database before conversion of measures in imperial units to metric. However if this is not possible, height reported in imperial units can be converted to metric prior to data entry using a conversion factor of 2.54 cm to the inch.

Rounding to the nearest 1 cm will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 cm. The following rounding conventions are desirable to reduce systematic over-reporting (Armitage & Berry 1994):

NNN.x where x

NNN.x where x > 5 - round up, e.g. 172.7 cm would be rounded to 173 cm.

NNN.x where x = 5 - round to the nearest even number, e.g. 172.5 cm would be rounded to 172 cm, while 173.5 cm would be

rounded to 174 cm.

Comments:

This metadata item is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure height.

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

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

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

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

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140-190 cm.

Height <140 cm

140 cm = Height < 145 cm

145 cm = Height < 150 cm

... in 5 cm categories

185 cm = Height < 190 cm

Height => 190 cm

On average, height tends to be overestimated when self-reported by respondents. Data for Australian men and women aged 20-69 years in 1989 indicated that men overestimated by an average of 1.1 cm (SEM* of 0.04 cm) and women by an average of 0.5 cm (SEM of 0.05 cm) (Waters 1993). The extent of overestimation varied with age.

*Note: SEM is the standard error of measurement.

Relational attributes

Related metadata references:

Supersedes Height - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.03 KB)

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set

Acute coronary syndrome (clinical) DSS Health, Standard

Specifications:	07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Hip circumference (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—hip circumference (measured), total centimetres NN[N].N
METeOR identifier:	270366
Registration status:	Health, Standard 01/03/2005
Definition:	An adult's hip circumference at the level of maximum posterior extension of the buttocks measured in centimetres.
Data Element Concept:	Person—hip circumference

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NN[N].N	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	999.9	Not measured
Unit of measure:	Centimetre (cm)	

Data element attributes

Collection and usage attributes

Guide for use:	As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to collect this metadata item for those aged under 18 years.
Collection methods:	The measurement protocol described below is that recommended by the *World Health Organization (WHO Expert Committee 1995).* Measurement protocol: The data collection form should allow for up to three measurements of hip circumference to be recorded in centimetres to 1 decimal place. The data collection form should also have the capacity to record any reasons for the non-collection of hip circumference data. The measurement of hip circumference requires a narrow (The subject should wear only non-restrictive briefs or underwear, a light smock over underwear or light clothing. Belts and heavy outer clothing should be removed. Hip measurement should be taken over one layer of light clothing only. The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the two parts of the tape from which the circumference is to be

determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement.

All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured hip circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting. For example, a mean value of 102.25 cm would be rounded to 102.2 cm, while a mean value of 102.35 cm would be rounded to 102.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1-metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured hip circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Its main use is to enable the calculation of adult waist-to-hip ratio which requires the measurement of hip circumference and waist circumference.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in waist-to-hip ratio measurements.

Waist-to-hip ratio is therefore no longer a commonly used measure.

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

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

For some reporting purposes, it may be desirable to present hip circumference data in categories. It is recommended that 5 cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation.

Relational attributes

Related metadata references:

Supersedes Hip circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.1 KB)

Is used in the formation of Adult—waist-to-hip ratio, N.NN Health, Standard 01/03/2005

Histopathological grade

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—histopathological grade, code N
METeOR identifier:	288663
Registration status:	Health, Standard 04/06/2004
Definition:	The histopathological grade, differentiation or phenotype describes how little the tumour resembles the normal tissue from which it arose, as represented by a code.
Data Element Concept:	Person with cancer—histopathological grade

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Grade 1: Well differentiated, differentiated, NOS
	2	Grade 2: Moderately differentiated, moderately well differentiated, intermediate differentiation
	3	Grade 3: Poorly differentiated
	4	Grade 4: Undifferentiated, anaplastic
	5	T-cell: T-cell
	6	B-cell: B-cell, Pre-B, B-Precursor
	7	Null-cell: Null cell, Non T- non B
	8	NK: Natural killer cell
Supplementary values:	9	Grade/differentiation unknown: Grade/cell type not determined, not stated or not applicable

Data element attributes

Collection and usage attributes

Guide for use:	Only one code can be recorded.

Source and reference attributes

Origin:	World Health Organisation Commission on Cancer American College of Surgeons
Reference documents:	World Health Organisation International Classification of Diseases Oncology, Third edition (ICD-O-3) (2000) Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Histopathological grade, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.87 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Hospital insurance status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—hospital insurance status, code N
METeOR identifier:	270253
Registration status:	Health, Standard 01/03/2005
Definition:	Hospital insurance as represented by a code under one of the following categories: • Registered insurance - hospital insurance with a health insurance fund registered under the National Health Act 1953 (Cwlth) • General insurance - hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance • No hospital insurance or benefits coverage under the above.
Data Element Concept:	Patient—hospital insurance status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Hospital insurance
	2	No hospital insurance
Supplementary values:	9	Unknown

Data element attributes

Collection and usage attributes

Guide for use:	Persons covered by insurance for benefits of ancillary services only are included in 2 - no hospital insurance. The 'unknown' category should not be used in primary collections but can be used to record unknown insurance status in databases. This metadata item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.
Comments:	Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the Health Legislation (Private Health Insurance Reform) Amendment Act 1995. Employee health benefits schemes became illegal with the implementation of Schedule 2 of the private health insurance reforms, effective on 1 October 1995.

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Hospital insurance status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.63 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Hours on-call (not worked) by medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical practitioner—hours on-call, total NNN
METeOR identifier:	270138
Registration status:	Health, Standard 01/03/2005
Definition:	The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.
Data Element Concept:	Medical practitioner—hours on-call

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure:	Hour (h)

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item relates to each position (job) held by a medical practitioner.
Collection methods:	There are inherent problems in asking for information on number of hours on-call not worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours on-call not worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Relational attributes

Related metadata references:	Supersedes Hours on-call (not worked) by medical practitioner, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.52 KB)
Implementation in Data Set Specifications:	Health labour force NMDS Health, Standard 01/03/2005 *Implementation start date:* 01/07/2005 *Information specific to this data set:* Value must be less than 169 (except for 999).

Used in relation to issues of economic activity, productivity, wage rates, working conditions etc.

Used to develop capacity measures relating to total time available.

Assists in analysis of human resource requirements and labour force modelling.

Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Hours worked by health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—hours worked (in all jobs), total NNN
METeOR identifier:	270134
Registration status:	Health, Standard 01/03/2005
Definition:	Hours worked is the amount of time a person spends at work in a week in employment/self-employment. It may apply to hours actually worked in a week or hours usually worked per week, and the National Health Labour Force Collection collects hours usually worked. It includes all paid and unpaid overtime less any time off. It also: • includes travel to home visits or calls out • excludes other time travelling between work locations • excludes unpaid professional and/or voluntary activities. Total hours worked is the amount of time spent at work in all jobs. As well as total hours worked, for some professions the National Health Labour Force Collection asks for hours worked in each of the main job, second job and third job. Hours worked for each of these is the amount of time spent at work in each job.
Context:	Health labour force
Data Element Concept:	Health professional—hours worked

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Collection methods:	There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main

job and one or more additional jobs, it is important that a total for all jobs is included.

Comments: It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Hours worked by health professional, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.42 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

Value must be less than 127 (except for 999).

Important variable in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Hours worked by medical practitioner in direct patient care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical practitioner—hours worked (in direct patient care), total NNN
METeOR identifier:	270137
Registration status:	Health, Standard 01/03/2005
Definition:	The number of hours worked in a week by a medical practitioner on service provision to patients including direct contact with patients, providing care, instructions and counselling, and providing other related services such as writing referrals, prescriptions and phone calls.
Context:	Health labour force
Data Element Concept:	Medical practitioner—hours worked

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item relates to each position (job) held by a medical practitioner, not the aggregate of hours worked for all jobs.
Collection methods:	There are inherent problems in asking for information on number of hours usually worked per week in direct patient care, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked in direct patient care are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
Comments:	It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from

data on paid hours worked.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Hours worked by medical practitioner in direct patient care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.74 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

Value must be less than 127 (except for 999).

Used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling.

House/property number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—house/property identifier, text [X(12)]
METeOR identifier:	270030
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The identifier of a house or property where a person resides, as represented by text.
Data Element Concept:	Person (address)—house/property identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(12)]
Maximum character length:	12

Data element attributes

Collection and usage attributes

Guide for use:

Generally, only one house/property number is used. However, if the house/property number includes a number range, the range of applicable numbers should be included, separated by a hyphen (-), with no spaces between numerals, i.e. 17-19

- House/property number 1 - refers to physical House/property number and for ranges is the starting number (5 numeric characters)
- House/property number Suffix 1 - a single character identifying the House/property number suffix (1 alphanumeric character)
- House/property number 2 - refers to a physical House/property number and for ranges is the finishing number (5 numeric characters)
- House/property number suffix 2 - a single character identifying the House/property number suffix (1 alphanumeric character) with no space between the numeric and the alpha characters.

For example; '401A 403B'

'401' is House/property number first in range

'A' is the House/Property suffix 1

'403' is House/property number last in range

'B' is House/Property suffix 2

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes House/property number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.58 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

House/property number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—house/property identifier, text [X(12)]
METeOR identifier:	290241
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier of a house or property where an organisation is located.
Data Element Concept:	Service provider organisation (address)—house/property identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(12)]
Maximum character length:	12

Data element attributes

Collection and usage attributes

Guide for use:

Generally, only one house/property number is used. However, if the house/property number includes a number range, the range of applicable numbers should be included, separated by a hyphen (-), with no spaces between numerals, i.e. 17-19

- House/property number 1 - refers to physical House/property number and for ranges is the starting number (5 numeric characters)
- House/property number Suffix 1 - a single character identifying the House/property number suffix (1 alphanumeric character)
- House/property number 2 - refers to a physical House/property number and for ranges is the finishing number (5 numeric characters)
- House/property number suffix 2 - a single character identifying the House/property number suffix (1 alphanumeric character) with no space between the numeric and the alpha characters.

For example; '401A 403B'

'401' is House/property number first in range

'A' is the House/Property suffix 1

'403' is House/property number last in range

'B' is House/Property suffix 2

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Origin:	Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Household annual gross income range

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Household—gross income (annual), dollar range code N
METeOR identifier:	290737
Registration status:	Health, Standard 04/05/2005
Definition:	The value of gross annual income from all sources (before deductions for income tax, superannuation represented by a dollar range code.
Context:	Gross household income ranges are used as an indicator of the economic status of the household.
Data Element Concept:	Household—gross income

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Less than $ 20,000
2	$ 20,001-$ 30,000
3	$ 30,001-$ 50,000
4	$ 50,001 - $ 100,000
5	More than $ 100,000

Supplementary values:

Value	Meaning
6	Don't know/not sure
7	Not stated

Data element attributes

Collection and usage attributes

Guide for use: The main components of gross income are:

- current usual wages and salary;
- income derived from self-employment;
- government pensions, benefits and allowances; and
- other income comprising investments (including interest, dividends, royalties and rent) and othe superannuation, private scholarships received in cash, workers' compensation, accident compens any other allowances regularly received).

Gross income is regarded as all receipts which are received regularly and are of a recurring nature. C

receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria
Please note that this data element is not consistent with the ABS standards for cash income.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Reference documents: Refer to the ABS website Statistical Standards/Standards for Social, Labour and Demographic Variab
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DirClassManualsbyCatalogue/76CD93AA32E74B29

Relational attributes

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI), the suggested ques
I would now like to ask you about your household's income. We are interested in how income re
health services.
Before tax is taken out, which of the following ranges best describes your household's income, fr
months?
(Read options: Single response)

Less than $ 20,000
$ 20,000-$ 30,000
$ 30,001-$ 50,000
$ 50,001-$ 100,000
More than $ 100,000
Don't know/not sure
Refused
Where narrower ranges are required, household annual gross income may be collected in $ 10,00
Household annual gross income range ($ 10,000 range).

Household annual gross income range ($ 10,000 range)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Household—gross income (annual), ten thousand dollar range code N[N]
METeOR identifier:	290742
Registration status:	Health, Standard 04/05/2005
Definition:	The value of gross annual income from all sources (before deductions for income tax, superannuation represented by a ten thousand dollar range code.
Context:	Gross household income ($ 10,000 ranges) is used as an indicator of the economic status of the house
Data Element Concept:	Household—gross income

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Less than $ 10,000
2	$ 10,000 - $ 20,000
3	$ 20,001 - $ 30,000
4	$ 30,001 - $ 40,000
5	$ 40,001 - $ 50,000
6	$ 50,001 - $ 60,000
7	$ 60,001 - $ 70,000
8	$ 70,001 - $ 80,000
9	$ 80,001 - $ 90,000
10	$ 90,001 - $ 100,000
11	More than $ 100,000

Supplementary values:

Value	Meaning
12	Don't know / not sure
13	Not stated

Data element attributes

Collection and usage attributes

Guide for use: The main components of gross income are:

- current usual wages and salary;

- income derived from self-employment;
- government pensions, benefits and allowances; and
- other income comprising investments (including interest, dividends, royalties and rent) and othe superannuation, private scholarships received in cash, workers' compensation, accident compens any other allowances regularly received).

Gross income is regarded as all receipts which are received regularly and are of a recurring nature. C receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria

Please note that this data element is not consistent with the ABS standards for cash income.

Refer to the ABS website Standards for Social, Labour and Demographic Variables/Cash Income Var

http://www.abs.gov.au/AUSSTATS/abs@.nsf/DirClassManualsbyCatalogue/76CD93AA32E74B29

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Relational attributes

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI), the suggested ques

I would now like to ask you about your household's income. We are interested in how income re health services.

Before tax is taken out, which of the following ranges best describes your household's income, fr months?

(Read options: Single response)

Less than $ 10,000
$ 10,000 - $ 20,000
$ 20,001 - $ 30,000
$ 30,001 - $ 40,000
$ 40,001 - $ 50,000
$ 50,001 - $ 60,000
$ 60,001 - $ 70,000
$ 70,001 - $ 80,000
$ 80,001 - $ 90,000
$ 90,001 - $ 100,000
Over $ 100,000
Don't know/not sure
Refused

Hypertension - treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—hypertension treatment with antihypertensive medication indicator (current), code N
METeOR identifier:	302442
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person is currently being treated for hypertension (high blood pressure) using antihypertensive medication, as represented by a code.
Data Element Concept:	Person—hypertension treatment with antihypertensive medication indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes Record if a person is currently being treated for hypertension using antihypertensive medication. CODE 2 No Record if a person is not currently being treated for hypertension using antihypertensive medication.
Collection methods:	Ask the individual if he/she is currently treated with anti-hypertensive medications. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Pahor M, Psaty BM, Furberg CD. Treatment of hypertensive

patients with diabetes. Lancet 1998; 351:689-90. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group [erratum appears in Br Med J 1999; 318:29]. Br Med J 1998; 317:703-13.

Grossman E, Messerli FH, Goldbourt U, Curb JD, Pressel SL, Cutler JA, Savage PJ, Applegate WB, Black H, et al. Effect of diuretic-based antihypertensive treatment on cardiovascular disease risk in older diabetic patients with isolated systolic hypertension. Systolic Hypertension in the Elderly Program Cooperative Research Group. JAMA 1996; 276:1886-92.

Hypertension in diabetes[Australian Prescriber Feb 2002]. American Journal of Preventive Medicine 2002;21.

Relational attributes

Related metadata references:

Supersedes Person—hypertension treatment status (antihypertensive medication), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Hypertension is probably the most important public health problem in developed countries. It is common, asymptomatic, readily detectable, usually easily treatable, and often leads to lethal complications if left untreated.

Elevated blood pressure (Hypertension) is a recognised risk for microvascular and macro vascular complications of diabetes (coronary, cerebral and peripheral).

Hypertension is elevated arterial blood pressure above the normal range (130 to 139/85 to 89 mm Hg) and values above these are defined as hypertension. Lower levels of target blood pressure should be aimed for in specific groups, e.g. in diabetics aim for blood pressure less than 135/80 mm Hg.

Many diabetics fail to control high blood pressure. Among all the diabetics with high blood pressure, 29% were unaware that they had high blood pressure and only slightly more than half were receiving hypertensive medications as treatment.
Numbers of studies have shown that good management of blood pressure is at least as important as good control of blood glucose and the reduction of cholesterol in preventing the complications of diabetes.

Antihypertensives - Australian Medicines Handbook: February, 2001. Tight blood control in diabetes usually requires combination therapy as stated by (Australian Diabetes society) Therapeutic Guidelines Limited (05.04.2002).

People taking antihypertensives are also encouraged to make healthy lifestyle changes, such as quit smoking, lose weight and have regular physical activity.
The level of blood pressure should generally be established on at least two to four occasions prior to initiating antihypertensive medication.

Systematic reviews of studies that have reported outcomes in patients with diabetes and hypertension indicate that

combination therapy is frequently required and may be more beneficial than monotherapy. In the past multi-drug therapy to control hypertension has not been advocated much, but according to the special report published in the American Journal of Kidney Diseases, if ACE inhibitor therapy alone doesn't achieve good blood pressure control, multi-drug therapy should be implemented. (Heart Center Online)

Hypoglycaemia - severe

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—severe hypoglycaemia indicator, code N
METeOR identifier:	302825
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person has had **severe hypoglycaemia**, as represented by a code.
Data Element Concept:	Person—severe hypoglycaemia indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the person has a history of severe hypoglycaemia. CODE 2 No: Record if the person has no history of severe hypoglycaemia.
Collection methods:	Ask the individual if he/she has had a severe hypoglycaemia requiring assistance. Alternatively obtain the relevant information from appropriate documentation.
Comments:	The medications used in the treatment of diabetes may cause the blood glucose value to fall below the normal range and this is called hypoglycaemia.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Definition corresponds with the Diabetes Control and Complications Trial (DCCT): DCCT New England Journal of Medicine, 329(14), September 30, 1993. Report of the Health

Care Committee Expert Panel on Diabetes; Commonwealth of Australia 1991; ISBN 0644143207.

Relational attributes

Related metadata references: Supersedes Person—severe hypoglycaemia history, status code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Most hypoglycaemic reactions, however, do not cause long term problems, but the risks of permanent injury to the brain are greater in children under the age of 5 years, the elderly with associated cerebrovascular disease and patients with other medical conditions such as cirrhosis and coeliac disease. The serious consequences of hypoglycaemia relate to its effects on the brain. Rarely hypoglycaemia may cause death.

It is important to know how to recognise and react when someone is unconscious from hypoglycaemia. These people should be placed on their side and the airway checked so that breathing is unhampered and nothing should be given by mouth as food may enter the breathing passages. Treatment needs to be given by injection - either glucagon (a hormone which raises the blood glucose by mobilising liver stores) or glucose itself. Glucagon should be given by injection (usually intramuscular) at a dose of 0.5 units (or mg) in children under the age of 5 years and 1.0 units (mg) for all older age groups.

All diabetic patients at risk of developing hypoglycaemia should have glucagon at home. Their families need to be shown how to administer it in times of severe hypoglycaemia.

Impairment of body function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of impairment of body function, code (ICF 2001) N
METeOR identifier:	320138
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	A person's degree of impairment in a specified body function, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—extent of impairment of body function

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
0	No impairment
1	Mild impairment
2	Moderate impairment
3	Severe impairment
4	Complete impairment
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.

CODE 0 No impairment

Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].

CODE 1 Mild impairment

Used when there is a slight or low variation from accepted population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This coding is to be used in conjunction with specified Body Functions domains. For example, 'a mild impairment of functions related to the brain' to indicate the area of impairment and, potentially, the sorts of interventions that may result in improved functioning. The body function in which an individual experiences an impairment is indicated using the metadata item Person—body function, code (ICF 2001) AN[NNNN].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—body function, code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Body functions cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Impairment of body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320165
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	A person's degree of impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person—extent of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No impairment
1	Mild impairment
2	Moderate impairment
3	Severe impairment
4	Complete impairment

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.

CODE 0 No impairment

Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].

CODE 1 Mild impairment

Used when there is a slight or low variation from accepted population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical

status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with specified body structures, for example 'mild impairment of structures related to movement'. This data element may also be used in conjunction with Person—nature of impairment of body structure, code (ICF 2001) N and Person—location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—location of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—nature of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Body structures cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Indicator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—indicator procedure, code NN
METeOR identifier:	334976
Registration status:	Health, Standard 07/12/2005
Definition:	Indicator procedure for which an elective surgery patient is waiting, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—indicator procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 5th edition
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
07	Inguinal herniorrhaphy
08	Myringoplasty
09	Myringotomy
10	Prostatectomy
11	Septoplasty
12	Tonsillectomy
13	Total hip replacement
14	Total knee replacement
15	Varicose veins stripping and ligation

Supplementary values:

16	Not applicable

Data element attributes

Collection and usage attributes

Guide for use:	The procedure terms are defined by the Australian Classification of Health Interventions (ACHI) codes which are listed in comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is

because the intention is to count procedures rather than patients in this instance.

These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

Comments:

The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.

Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision. It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful. Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

The following is a list of ACHI (5th edition) codes, for the indicator procedures:

Cataract extraction:

42698-00 [195] 42702-00 [195] 42702-01 [195] 42698-01 [196]
42702-02 [196]
42702-03 [196] 42698-02 [197] 42702-04 [197] 42702-05 [197]
42698-03 [198]
42702-06 [198] 42702-07 [198] 42698-04 [199] 42702-08 [199]
42702-09 [199]
42731-01 [200] 42698-05 [200] 42702-10 [200] 42734-00 [201]
42788-00 [201]
42719-00 [201] 42731-00 [201] 42719-02 [201] 42791-02 [201]
42716-00 [202]
42702-11 [200] 42719-00 [201] 42722-00 [201]

Cholecystectomy:

30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965]
30446-00 [965]
30448-00 [965] 30449-00 [965]

Coronary Artery bypass graft:

38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672]
38497-04 [673]
38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674]
38503-00 [674]
38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676]
38500-03 [677]
38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679]
90201-01 [679]
90201-02 [679] 90201-03 [679]

Cystoscopy:

36812-00 [1089] 36812-01 [1089] 36836-00 [1098]

Haemorrhoidectomy:

32138-00 [941] 32132-00 [941] 32135-00 [941] 32135-01 [941]

Hysterectomy:
35653-00 [1268] 35653-01 [1268] 35653-02 [1268] 35653-03 [1268] 35661-00 [1268]
35670-00 [1268] 35667-00 [1268] 35664-00 [1268] 35657-00 [1269] 35750-00 [1269]
35756-00 [1269] 35673-00 [1269] 35673-01 [1269] 35753-00 [1269] 35753-01 [1269]
35756-01 [1269] 35756-02 [1269] 35667-01 [1269] 35664-01 [1269] 90450-00 [989] 90450-01 [989] 90450-02 [989]

Inguinal herniorrhaphy:
30614-03 [990] 30615-00 [997] 30609-03 [990] 30614-02 [990 30609-02 [990]

Myringoplasty:
41527-00 [313] 41530-00 [313] 41533-01 [313] 41542-00 [315] 41635-01 [313]

Myringotomy:
41626-00 [309] 31626-01 [309] 41632-00 [309] 41632-01 [309]

Prostatectomy:
37203-00 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01[1166]
37200-00 [1166] 37203-05 [1166] 37203-06 [1166] 37200-03[1167]
37200-04 [1167] 37209-00 [1167] 37200-05 [1167] 90407-00 [1168]
37201-00 [1165] 37203-03 [1166] 37203-04 [1166] 37224-00 [1162] 37224-01 [1162]

Septoplasty:
41671-02 [379] 41671-01 [379] 41671-02 [379] 41671-03 [379]

Tonsillectomy:
41789-00 [412] 41789-01 [412]

Total hip replacement:
49318-00 [1489] 49319-00 [1489] 49324-00 [1492] 49327-00 [1492] 49330-00 [1492]
49333-00 [1492] 49345-00 [1492]

Total knee replacement:
49518-00 [1518] 49519-00 [1518] 49521-00 [1519] 49521-01 [1519] 49521-02 [1519]
49521-03 [1519] 49524-00 [1519] 49524-01 [1519] 49527-00 [1524] 49530-00 [1523]
49530-01 [1523] 49533-00 [1523] 49554-00 [1523] 49534-00 [1519]

Varicose veins stripping and ligation:
32508-00 [727] 32508-01 [727] 32511-00 [727] 32504-01 [728] 32505-00 [728]
32514-00 [737]

Source and reference attributes

Origin:	National Health Data Committee
Reference documents:	National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Relational attributes

Related metadata references:	Supersedes Elective surgery waiting list episode—indicator procedure, code NN Health, Superseded 07/12/2005
Implementation in Data Set	Elective surgery waiting times (census data) NMDS Health,

Specifications: Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Indigenous status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Indigenous status, code N
METeOR identifier:	291036
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. This is in accord with the first two of three components of the Commonwealth definition.
Data Element Concept:	Person—Indigenous status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website as indicated in the Reference documents.

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

Indigenous:

- Aboriginal but not Torres Strait Islander origin.
- Torres Strait Islander but not Aboriginal origin.
- Both Aboriginal and Torres Strait Islander origin.

Non-indigenous:

- Neither Aboriginal nor Torres Strait Islander origin.

Not stated/ inadequately described:

This category is not to be available as a valid answer to the

questions but is intended for use:

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

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

Data element attributes

Collection and usage attributes

Collection methods:

The standard question for Indigenous Status is as follows:

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

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

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

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

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

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

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

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

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

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

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

Yes, both Aboriginal and Torres Strait Islander...

may be included if this better suits the data collection practices

of the agency or establishment concerned.

Comments:

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

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

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

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

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables. Cultural Diversity Variables, Canberra. Viewed 3 August 2005.

Relational attributes

Related metadata references:

Supersedes Person—Indigenous status, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI) the suggested questions are:

Q.1 Are you of Aboriginal or Torres Strait Islander origin?

Yes - go to Q.2

No – no more questions

Q.2 Are you of Aboriginal origin, Torres Strait Islander origin, or both?

Aboriginal

Torres Strait Islander

Both Aboriginal and Torres Strait Islander

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Health care client identification DSS Health, Standard 04/05/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions (public psychiatric, alcohol and drug hospital) - emergency and outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient individual sessions
METeOR identifier:	270216
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric or alcohol and drug hospital.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	Emergency patients and outpatients are persons who receive non-admitted care. Individual non-admitted care is care provided to a person who receives direct care within the **emergency department** or other designated clinics within the hospital and who is not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.
Comments:	A group is defined as two or more patients receiving a service together where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.11 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community individual sessions
METeOR identifier:	270218
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by outreach and community services units of a public psychiatric or alcohol and drug hospital.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.
Comments:	A group is defined as two or more patients receiving a service together where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Source and reference attributes

Submitting organisation:	National minimum data set working parities

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.11 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Public hospital establishments NMDS Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—alcohol and drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - alcohol and drug individual sessions
METeOR identifier:	270508
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the alcohol and drug functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of service as individual sessions to non-admitted patients attending designated drug and alcohol units within hospitals.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional

units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

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Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—allied health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (allied health services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - allied health services individual sessions
METeOR identifier:	270502
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by allied health services units or clinics of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

Allied health service units include those units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in

respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—community health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - community health services individual sessions
METeOR identifier:	270395
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated community health services units of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of service to non-admitted patients provided by designated community health units within the establishment.

Community health units include:

- baby clinics
- immunisation units
- aged care assessment teams
- other

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated

wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications:

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Implementation end date: 30/06/2007

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Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (dental), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - dental individual sessions
METeOR identifier:	270513
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated dental units of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of service as individual sessions to non-admitted patients attending designated dental units within hospitals.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of

service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

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Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—dialysis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (dialysis), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - dialysis individual sessions
METeOR identifier:	270503
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the dialysis functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

Dialysis:

This represents all non-admitted patients receiving dialysis within the establishment. Where patients receive treatment in a ward or clinic classified elsewhere (for example, an emergency department), those patients are to be counted as dialysis patients and to be excluded from the other category. All forms of dialysis which are undertaken as a treatment necessary for renal failure are to be included.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various

health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

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Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

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Individual sessions—district nursing services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - district nursing services individual sessions
METeOR identifier:	270512
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by the district nursing services functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of service as individual sessions by district nursing services to non-admitted patients.

District nursing services:

- are for medical/surgical/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider*
- are not provided by staff from a unit classified in the community health category above.

*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted

occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.
For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26

KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

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Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—emergency services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270506
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency services functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	Emergency services: Services to patients who are not admitted and who receive treatment that was either unplanned or carried out in designated emergency departments within a hospital. Unplanned patients are patients who have not been booked into the hospital before receiving treatment. In general it would be expected that most patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided in emergency departments these are to be included. The exceptions are for dialysis and endoscopy and related procedures which have been recommended for separate counting. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service. The list of Type of non-admitted

patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

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Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Individual sessions—endoscopy and related procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - endoscopy and related procedures individual sessions
METeOR identifier:	270507
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of endoscopy and related procedures provided as individual sessions to non-admitted patients.

Endoscopy and related procedures include:

- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy.

Where one of these procedures is carried out in a ward or clinic classified elsewhere, for example in the emergency department, the occasion is to be included under endoscopy and related procedures, and to be excluded from the other category. Care must be taken to ensure procedures for admitted patients are excluded from this category.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—mental health

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - mental health individual sessions
METeOR identifier:	270504
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the mental health functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of service as individual sessions to non-admitted patients attending designated psychiatric or mental health units within hospitals.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional

units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - other medical/surgical/diagnostic individual sessions
METeOR identifier:	270511
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other service provided to a patient in a medical/surgical/diagnostic unit of a health service establishment not defined elsewhere. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For any occasion of service to a non-admitted patient given at a designated unit primarily responsible for the provision of medical/surgical or diagnostic services which have not already been covered in other data elements.

Other medical/surgical/diagnostic services include:

- electrocardiogram (ECG)
- obstetrics
- nuclear medicine
- general medicine
- general surgery
- fertility and so on.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of

care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Public hospital establishments NMDS Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—other outreach services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270514
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients through the outreach services of an establishment not defined elsewhere.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of outreach services as individual sessions to non-admitted patients.

Other outreach services:

- involve travel by the service provider*
- are not classified in allied health or community health services above.

*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

It is intended that these activities should represent non-medical/surgical/psychiatric services. Activities such as home cleaning, meals on wheels, home maintenance and so on should be included.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted

occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

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Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—pathology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270505
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pathology functional unit of an establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For all occasions of service as individual sessions to non-admitted patients from designated pathology laboratories. Occasions of service to all patients from other establishments should be counted separately. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service. The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum

subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—pharmacy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270509
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pharmacy functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of service as individual sessions to non-admitted patients from pharmacy departments.

Those drugs dispensed/administered in other departments such as the emergency department, or outpatient departments, are to be counted by the respective departments.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in

respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual sessions—radiology and organ imaging

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270510
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the radiology and organ imaging functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of radiology and organ imaging services as individual sessions to non-admitted patients.

Radiology and organ imaging includes services undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI).

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum

subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Public hospital establishments NMDS Health, Superseded 23/10/2006

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Implementation end date: 30/06/2007

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Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Individual/group session indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service contact—group session status, individual/group session indicator code ANN.N
METeOR identifier:	291057
Registration status:	Health, Standard 04/05/2005
Definition:	Whether two or more patients received services at the same time from the same hospital staff, as represented by a code.
Data Element Concept:	Service contact—group session status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN.N
Maximum character length:	5

Permissible values:

Value	Meaning
A12.1	Individual sessions
A12.2	Group sessions

Data element attributes

Collection and usage attributes

Guide for use: This excludes the situation where individuals all belong to the same family. In such cases, the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

Relational attributes

Related metadata references: Supersedes Individual/group session, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.54 KB)

Infant weight, neonate, stillborn

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth weight, total grams NNNN
METeOR identifier:	269938
Registration status:	Health, Standard 01/03/2005
Definition:	The first weight, in grams, of the live-born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.
Data Element Concept:	Birth—birth weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Gram (g)

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Infant weight, neonate, stillborn, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.22 KB)
Implementation in Data Set Specifications:	Perinatal NMDS Health, Superseded 06/09/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Perinatal NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies this metadata item must be consistent with diagnoses and procedure codes for valid grouping.

Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants.

This metadata item is required to generate Australian National Diagnosis Related Groups.

Influence of environmental factor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of environmental factor influence, code (ICF 2001) [X]N
METeOR identifier:	320198
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree to which a specified environmental factor influences the body function or structure, the activity or participation of a person, as represented by a code.
Context:	The environment in which a person functions or experiences disability.
Data Element Concept:	Person—extent of environmental factor influence

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	[X]N
Maximum character length:	2

Permissible values:

Value	Meaning
0	No barrier
1	Mild barrier
2	Moderate barrier
3	Severe barrier
4	Complete barrier
+0	No facilitator
+1	Mild facilitator
+2	Moderate facilitator
+3	Substantial facilitator
+4	Complete facilitator

Supplementary values:

8	Barrier not specified
+8	Facilitator not specified
9	Not applicable

Collection and usage attributes

Guide for use: This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Extent of influence of environmental factors corresponds to the degree, strength or magnitude of the influence and the amount of time the influence is experienced by the person. It is

essentially a summary measure, in which are embedded the concepts of availability, quality and importance, that indicates the effect the specified environmental factor has on the person.

Whether, and by how much, environmental factors are influencing an individual's level of functioning, and whether the influence is a facilitator or barrier, may indicate the sorts of interventions that will optimise the individual's functioning. This information may be for policy development, service provision, or advocacy purposes. Preventative strategies could be indicated by this information.

This value domain can be used to collect information across the whole spectrum of influence, for example, tactile flooring may be a facilitator to a person with visual impairment and a barrier to a person with mobility impairments. In line with the ICF approach to functioning and disability, this value domain recognises, and gives the means to record, the positive influence of environmental factors as well as those factors that limit the level of functioning of a person.

The codes are mutually exclusive. The choice of codes depends on the context of the data collection. For example; if collecting information about the positive influence of an environmental factor such as a community service it would be appropriate to use Code 0 No facilitator if the service was not influencing the person's level of functioning (even if the service were not a barrier to the person's functioning).

Code +0 No facilitator:

Used when the environment factor does not impact in a positive way on the body structure or function, activity or participation of a person.

Code +1 Mild facilitator:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code +2 Moderate facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in the specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code +3 Substantial facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in the specified domain of functioning or has an extreme effect on the person's functioning.

Code +4 Complete facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or the person functions optimally with this environmental factor.

Code +8 Facilitator not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes +1 to

+4.

Code 0 No barrier:

Used when the environment factor does not impact in a negative way on the body structure or function, activity or participation of a person.

Code 1 Mild barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code 2 Moderate barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in that specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code 3 Severe barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in that specified domain of functioning or has an extreme effect on the person's functioning.

Code 4 Complete barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or is of such magnitude that the person is unable to function.

Code 8 Barrier not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes 1 to 4.

Code 9 Not applicable:

Used when environmental factors impacts in neither a positive or negative way on the body structure or function, activity or participation of a person or for between 0-4% of the time the person participates in that specified area and has minimal impact on the person's level of functioning in the specified domain.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.

The influence of environmental factors may be positive, increasing the level of functioning (a facilitator), or negative, decreasing the level of functioning (a barrier).

The extent of influence of the **Environmental factors** is affected both by the degree, strength of influence, and the amount of time the influence is experienced by the person.

This metadata item is recorded in conjunction with *Environmental factor code N* to indicate the extent to which specified environmental factors influence the body function or structure, the activity or participation of a person.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—environmental factor, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Environmental factors cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Informal carer existence indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—informal carer existence indicator, code N
Synonymous names:	Informal carer availability, Informal carer existence flag, Carer arrangements (informal)
METeOR identifier:	320939
Registration status:	Health, Standard 04/07/2007 Community services, Standard 29/04/2006
Definition:	Whether a person has an **informal carer**, as represented by a code.
Data Element Concept:	Person—informal carer existence indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	Informal carers may include those people who receive a pension or benefit for their caring role and people providing care under family care agreements. Excluded from the definition of informal carers are volunteers organised by formal services and paid workers. This metadata item is purely descriptive of a client's circumstances. It is not intended to reflect whether the informal carer is considered by the service provider to be capable of undertaking the caring role. The expressed views of the client and/or their carer should be used as the basis for determining whether the client is recorded as having an informal carer or not. When asking a client whether they have an informal carer, it is important for agencies or establishments to recognise that a carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the

client does not have to live with the client in order to be called an informal carer.

Collection methods:

Agencies or establishments and service providers may collect this item at the beginning of each service episode and /or assess this information at subsequent assessments.

Some agencies, establishments/providers may record this information historically so that they can track changes over time. Historical recording refers to the practice of maintaining a record of changes over time where each change is accompanied by the appropriate date.

Examples of questions used for data collection include:

Home and Community Care NMDS

'Do you have someone who helps look after you?'

Commonwealth State/Territory Disability Agreement NMDS

'Does the service user have an informal carer, such as family member, friend or neighbour, who provides care and assistance on a regular and sustained basis?

Comments:

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

This definition of informal carer is not the same as the Australian Bureau of Statistics (ABS) definition of principal carer, 1993 Disability, Ageing and Carers Survey and primary carer used in the 1998 survey. The ABS definitions require that the carer has or will provide care for a certain amount of time and that they provide certain types of care.

The ABS defines a primary carer as a person of any age who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self care). This may not be appropriate for community services agencies wishing to obtain information about a person's carer regardless of the amount of time that care is for, or the types of care provided.

Information such as the amount of time for which care is provided can of course be collected separately but, if it were not needed, it would place a burden on service providers.

Source and reference attributes

Origin:

Australian Institute of Health and Welfare

National Health Data Committee

National Community Services Data Committee

Reference documents:

Australian Bureau of Statistics (ABS) 1993 Disability, Ageing and Carers Survey and 1998 survey.

Australian Institute of Health and Welfare (2005)

Commonwealth State/Territory Disability Agreement National Minimum Data Set collection (CSTDA NMDS) Data Guide: 2005-06.

National HACC Minimum Data Set User Guide Version 2 July 2005. Home and Community Care (HACC) Program.

Relational attributes

Related metadata references:

Supersedes Person (requiring care)—carer availability status, code N Health, Superseded 04/07/2007, Community services, Superseded 29/04/2006

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

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

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

Initial visit indicator—diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—initial visit since diagnosis indicator (diabetes mellitus), code N
METeOR identifier:	302470
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the visit to a health professional is an initial visit for diabetes, or other related condition, after a diagnosis of diabetes, as represented by a code.
Data Element Concept:	Patient—initial visit since diagnosis indicator (diabetes mellitus)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if this is the initial visit of the patient for diabetes, or a related condition, after diagnosis. CODE 2 No: Record if this is not the initial visit of the patient for diabetes, or a related condition, after diagnosis.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Patient—initial visit since diagnosis status (diabetes mellitus), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Injecting drug use status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Client—injecting drug use status, code N
METeOR identifier:	270113
Registration status:	Health, Standard 01/03/2005
Definition:	The client's use of injection as a method of administering drugs, as represented by a code.
Data Element Concept:	Client—injecting drug use status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Last injected three months ago or less
2	Last injected more than three months ago but less than or equal to twelve months ago
3	Last injected more than twelve months ago
4	Never injected

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:

To be collected on commencement of treatment with a service.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Comments:

This metadata item has been developed for use in clinical settings. A code that refers to a three-month period to define 'current' injecting drug use is required as a clinically relevant period of time.

The metadata item may also be used in population surveys that require a longer timeframe, for example to generate 12-month prevalence rates, by aggregating Codes 1 and 2. However, caution must be exercised when comparing clinical samples with population samples.

This metadata item is important for identifying patterns of drug use and harms associated with injecting drug use.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Injecting drug use status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.76 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Intended length of hospital stay

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—intended length of hospital stay, code N
METeOR identifier:	270399
Registration status:	Health, Standard 01/03/2005
Definition:	The intention of the responsible clinician at the time of the patient's **admission** to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date, as represented by a code.
Data Element Concept:	Episode of admitted patient care—intended length of hospital stay

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Intended same-day
2	Intended overnight

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Intended length of hospital stay, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.41 KB) Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005 Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded

23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Intended place of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—setting of birth (intended), code N
METeOR identifier:	269980
Registration status:	Health, Standard 01/03/2005
Definition:	The intended place of birth at the onset of labour, as represented by a code.
Context:	Perinatal care
Data Element Concept:	Birth event—setting of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other

Supplementary values:

9	Not stated

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Code 1 Hospital, excluding birth centre Hospital, excluding birth centre, includes for women who have elective caesarean sections Code 4 Home Home, should be restricted to the home of the woman or a relative or friend. Code 8 Other Other, includes community (health) centres.
Comments:	Women who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Women who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Intended place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.85 KB)

Intention of treatment for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—intention of treatment, code N
METeOR identifier:	288690
Registration status:	Health, Standard 04/06/2004
Definition:	The intention of the initial treatment for cancer for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment—intention of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Prophylactic
2	Curative
3	Non-curative or palliative

Supplementary values:

Value	Meaning
0	Did not have treatment
9	Not stated

Collection and usage attributes

Guide for use:

CODE 0 Did not have treatment

This code is used when the patient did not have treatment as part of the initial management plan

CODE 1 Prophylactic

This code is used when the cancer has not developed

CODE 2 Curative

This code is used when treatment is given for control of the disease

CODE 3 Non-curative or Palliative

This code is used when the cure is unlikely to be achieved and treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to the patient's quality of life

CODE 9 Intention was not stated

Patient had treatment for cancer but the intention was not stated.

Data element attributes

Collection and usage attributes

Guide for use: This item is collected for surgical treatment, radiation therapy and systemic therapy agent treatment.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons New South Wales Health Department
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:	Supersedes Intention of treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.89 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

It is used for correlating outcome with original intent of the treatment.

Inter-hospital contracted patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—inter-hospital contracted patient status, code N
METeOR identifier:	270409
Registration status:	Health, Standard 01/03/2005
Definition:	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code.
Data Element Concept:	Episode of admitted patient care—inter-hospital contracted patient status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Inter-hospital contracted patient from public sector hospital
	2	Inter-hospital contracted patient from private sector hospital
	3	Not contracted
Supplementary values:	9	Not reported

Data element attributes

Collection and usage attributes

Guide for use:

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

This data element item will be derived as follows.

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

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

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Hospital—contract type, code N Health, Standard 01/03/2005

Is formed using Hospital—contract role, code A Health, Standard 01/03/2005

Supersedes Inter-hospital contracted patient, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.35 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Interpreter services required

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—interpreter service required, yes/no code N
Synonymous names:	Need for interpreter service
METeOR identifier:	304294
Registration status:	Health, Standard 08/02/2006 Community services, Standard 10/04/2006
Definition:	Whether an interpreter service is required by or for the person, as represented by a code.
Data Element Concept:	Person—interpreter service required

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Includes verbal language, non verbal language and languages other than English.

CODE 1 Yes

Use this code where interpreter services are required.

CODE 2 No

Use this code where interpreter services are not required.

Persons requiring interpreter services for any form of sign language should be coded as Interpreter required.

Collection methods:

Recommended question:

Do you [does the person] require an interpreter?

Yes

No

Relational attributes

Related metadata references:

Supersedes Person—interpreter service required status (health), code N Health, Superseded 08/02/2006

Killip classification code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Killip classification, code N
METeOR identifier:	285151
Registration status:	Health, Standard 04/06/2004
Definition:	The Killip class, as a measure of haemodynamic compromise, of the person at the time of presentation, as represented by a code.
Data Element Concept:	Person—Killip classification

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Class 1
2	Class 2
3	Class 3
4	Class 4

Supplementary values:

8	Other
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S_3 is an audible extra heart sound by cardiac auscultation.

CODE 1 Class 1

Absence of crepitations/rales over the lung fields and absence of S_3.

CODE 2 Class 2

Crepitations/rales over 50% or less of the lung fields or the presence of an S_3.

CODE 3 Class 3

Crepitations/rales over more than 50% of the lung fields.

CODE 4 Class 4

Cardiogenic Shock. Clinical criteria for cardiogenic shock are hypotension (a systolic blood pressure of less than 90 mmHg for at least 30 minutes or the need for supportive measures to maintain a systolic blood pressure of greater than or equal to 90 mmHg), end-organ hypoperfusion (cool extremities or a urine output of less than 30 ml/h, and a heart rate of greater than or equal to 60 beats per minute). The haemodynamic criteria are a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Killip classification code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.68 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute Coronary Syndrome (ACS) reporting, this data element describes the objective evidence of haemodynamic compromise by clinical examination at the time of presentation. Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S3 is an audible extra heart sound by cardiac auscultation.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Labour force status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, code N
METeOR identifier:	270112
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	The self reported status the person currently has in being either in the labour force (employed/unemployed) or not in the labour force, as represented by a code.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Employed
2	Unemployed
3	Not in the labour force

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Employed:

Persons aged 15 years and over who, during the reference week:

(a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers'); or

(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker'); or

(c) were 'Employees' who had a job but were not at work and were:

- on paid leave
- on leave without pay, for less than four weeks, up to the end of the reference week
- stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week
- on strike or locked out
- on workers' compensation and expected to be returning to their job, or
- receiving wages or salary while undertaking full-time study; or

(d) were 'Employers', 'Own Account Workers' or 'Contributing

Family Workers' who had a job, business or farm, but were not at work.

CODE 2 Unemployed:

Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:

(a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then; or

(b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown. Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 3 Not in the Labour Force:

Persons not in the labour force are those persons aged 15 years and over who, during the reference week, were not in the categories employed or unemployed, as defined. They include persons who were keeping house (unpaid), retired, voluntarily inactive, permanently unable to work, persons in institutions (hospitals, gaols, sanatoriums, etc.), trainee teachers, members of contemplative religious orders, and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Collection methods: For information about collection, refer to the ABS website:

http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open

Source and reference attributes

Origin: Australian Bureau of Statistics 1995. Directory of Concepts and Standards for Social, Labour and Demographic Variables. Australia 1995. Cat. no. 1361.0.30.001. Canberra: AGPS.

http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open (last viewed 21 December 2005)

Data element attributes

Collection and usage attributes

Comments: Labour force status is one indicator of the socio-economic status of a person and is a key element in assessing the circumstances and needs of individuals and families.

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references:	See also Person—occupation (main), code (ANZSCO 1st edition) N[NNN]{NN} Health, Standard 04/07/2007, Community services, Standard 27/03/2007, Housing assistance, Standard 10/08/2007 See also Person—occupation (main), code (ASCO 2nd edn) N[NNN]{-NN} Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007, Housing assistance, Superseded 10/08/2007 Supersedes Labour force status, version 3, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (19.53 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Laterality of primary cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—laterality of primary cancer, code [N]
METeOR identifier:	270177
Registration status:	Health, Standard 01/03/2005
Definition:	The side of a paired organ that is the origin of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—laterality of primary cancer

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Left
	2	Right
	3	Bilateral
Supplementary values:	9	Not known
	Null	Not applicable

Data element attributes

Collection and usage attributes

Guide for use:

The valid International Classification of Diseases for Oncology values for the variable are provided in the list below:

CODE 1 Left

Origin of primary site is on the left side of a paired organ.

Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)

CODE 2 Right

Origin of primary site is on the right side of a paired organ.

CODE 3 Bilateral

Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3)) Note: Bilateral cancers are very rare.

CODE 9 Unknown

It is unknown whether, for a paired organ the origin of the

	cancer was on the left or right side of the body.
Collection methods:	This information should be obtained from the patient's pathology report, the patient's medical record, or the patient's medical practitioner/nursing staff.

Source and reference attributes

Origin:	World Health Organization
Reference documents:	Percy C, Van Holten V, Muir C (eds). International Classification of Diseases for Oncology, 2nd edition. Geneva: WHO, 1990

Relational attributes

Related metadata references:	Supersedes Laterality of primary cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.37 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Leave days from residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of leave days, total N[NN]
METeOR identifier:	270304
Registration status:	Health, Standard 01/03/2005
Definition:	The number of days spent on leave from a residential care service during an episode of residential care.
Data Element Concept:	Episode of residential care—number of leave days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to midnight.

Leave days can occur for a variety of reasons, including:

- treatment by specialised mental health service
- treatment by a non-specialised health service
- time in the community.

The following rules apply in the calculation of leave days:

- the day the **resident** goes on leave is counted as a leave day
- days the resident is on leave is counted as leave days
- the day the resident returns from leave is not counted as a leave day
- if the resident starts a residential stay and goes on leave on the same day, this is not counted as a leave day
- if the resident returns from leave and then goes on leave again on the same day, this is counted as a leave day
- if the resident returns from leave and ends residential care on the same day, the day should not be counted as leave day
- leave days at the end of a residential stay after the commencement of leave are not counted.

If a period of leave is greater than seven days or the resident fails to return from leave, then the residential stay is formally ended.

Relational attributes

Related metadata references:

Supersedes Leave days from residential care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.64 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
Episode of residential care end date minus episode of residential care start date minus leave days from residential care must be >= 0 days.

Length of non-admitted patient emergency department service episode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN
METeOR identifier:	270404
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of time, measured in minutes, between when a patient presents at an emergency department for an emergency department service episode, and when the non-admitted component of the emergency department service episode has concluded.
Data Element Concept:	Non-admitted patient emergency department service episode—service episode length

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNN
Maximum character length:	5
Unit of measure:	Minute (m)

Data element attributes

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references:	Supersedes Length of non-admitted patient emergency department service episode, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.53 KB) Is formed using Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Health service event—presentation time, hhmm Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Length of stay

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (excluding leave days), total N[NN]
METeOR identifier:	269982
Registration status:	Health, Standard 01/03/2005
Definition:	The length of stay of a patient, excluding leave days, measured in days.
Data Element Concept:	Episode of admitted patient care—length of stay (excluding leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	Formula: LOS = Separation date - Admission date - Total leave days The calculation is inclusive of admission and separation dates.
Comments:	Perinatal length of stay metadata items include leave days and so are not included in this metadata item.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Length of stay, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.11 KB) Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—number of leave periods, total N[N] Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Length of stay (including leave days)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days), total N[NN]
METeOR identifier:	329889
Registration status:	Health, Standard 04/07/2007
Definition:	The total length of stay (LOS) of a patient, including leave days, measured in days.
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	Formula: LOS (including leave days) = separation date - admission date Total LOS is calculated by subtracting the patient's date of admission from their date of separation. It includes contract days and leave days. For babies born in hospital: 1) only calculate the total LOS of live births and 2) their admission date is the same as their date of birth. A **same-day patient** should be allocated a length of stay of one day. Total LOS relates to the episode of care associated with the birth. Babies born before arrival and still births are not within scope of this data element and should not have a total length of stay reported.
Comments:	All admitted patient episodes of care where it is required to know the total LOS in hospital (including leave days).

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—separation

date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Length of stay (including leave days) (antenatal)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN]
METeOR identifier:	290577
Registration status:	Health, Standard 04/07/2007
Definition:	The length of stay (LOS) of a woman before the birth of her baby, including leave days, measured in days.
Context:	Perinatal
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LOS (antenatal) = baby's date of birth - mother's admission date

Antenatal LOS is calculated by subtracting the mother's admission date from the baby's date of birth. It includes contract days and leave days.

If the mother's admission date and the baby's date of birth are on the same date, count the LOS as 1 day.

Antenatal length of stay refers only to the admission associated with the birth.

Antenatal LOS relates only to the episode of admitted patient care associated with the birth.

In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's antenatal LOS.

To calculate the total LOS, use the data element - Episode of admitted patient care - length of stay (including leave days) total.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard

25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Length of stay (including leave days) (postnatal)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN]
METeOR identifier:	300076
Registration status:	Health, Standard 04/07/2007
Definition:	The length of stay (LOS) of a woman following the birth of her baby, including leave days, measured in days.
Context:	Perinatal.
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LOS (postnatal) = mother's separation date - baby's date of birth

Postnatal LOS is calculated by subtracting the baby's date of birth from the mother's date of separation. It includes contract days and leave days.

If the mother's separation date and the baby's date of birth are on the same date, count the LOS as 1 day.

In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's postnatal LOS.

Postnatal length of stay refers only to the episode of care associated with the birth.

To calculate the total length of stay, use the data element - Episode of admitted patient care - length of stay (including leave days) total.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—separation

date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Supersedes Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Level of palliative care service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—level of service delivery, palliative care code N
METeOR identifier:	334508
Registration status:	Health, Standard 05/12/2007
Definition:	The level of specialisation of the palliative care service delivered by a **palliative care agency**, as represented by a code.
Data Element Concept:	Service provider organisation—level of service delivery

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Primary palliative care
2	Specialist palliative care level 1
3	Specialist palliative care level 2
4	Specialist palliative care level 3

Source and reference attributes

Origin:	Palliative Care Australia 2005. A guide to palliative care service development: A population-based approach. Canberra: Palliative Care Australia, p39.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Primary palliative care

Capability: Clinical management and care coordination including assessment, triage, and referral using a palliative approach for patients with uncomplicated needs associated with a life limiting illness and/or end of life care. Has formal links with a specialist palliative care provider for purposes of referral, consultation and access to specialist care as necessary.

Typical resource profile: General medical practitioner, nurse practitioner, registered nurse, generalist community nurse, aboriginal health worker, allied health staff. Specialist health care providers in other disciplines would be included at this level.

CODE 2 Specialist palliative care level 1

Capability: Provides palliative care for patients, primary carers and families whose needs exceed the capability of primary palliative care providers. Provides assessment and care

consistent with needs and provides consultative support, information and advice to primary palliative care providers. Has formal links to primary palliative care providers and level 2 and/or 3 specialist palliative care providers to meet the needs of patients, carers and families with complex problems. Has quality and audit program.

Typical resource profile: Multi–disciplinary team including medical practitioner with skills and experience in palliative care, clinical nurse specialist/consultant, allied health staff, pastoral care and volunteers. A designated staff member if available, coordinates a volunteer service.

CODE 3 Specialist palliative care level 2

Capability: As for level 1, able to support higher resource level due to population base (e.g. regional area). Provides formal education programs to primary palliative care and level 1 providers and the community. Has formal links with primary palliative care providers and level 3 specialist palliative care services for patients, primary carers and families with complex needs.

Typical resource profile: Interdisciplinary team including medical practitioner and clinical nurse specialist/consultant with specialist qualifications. Includes designated allied health and pastoral care staff.

CODE 4 Specialist palliative care level 3

Capability: Provides comprehensive care for the needs of patients, primary carers and families with complex needs. Provides local support to primary palliative care providers, regional level 1 and/or 2 services including education and formation of standards. Has a comprehensive research and teaching role. Has formal links with local primary palliative care providers and with specialist palliative care providers level 1 and 2, and relevant academic units including professorial chairs where available.

Typical resource profile: Interdisciplinary team including a medical director and clinical nurse consultant/nurse practitioner and allied health staff with specialist qualifications in palliative care.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Lipid-lowering therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lipid-lowering therapy status, code NN
METeOR identifier:	285159
Registration status:	Health, Standard 04/06/2004
Definition:	The person's lipid-lowering therapy status, as represented by a code.
Data Element Concept:	Person—lipid-lowering therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - true allergy to lipid lowering therapy
23	Not given - previous myopathy
24	Not given - hepatic dysfunction
25	Not given - other

Supplementary values:

90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 25 Not given

If recording `Not given', record the principal reason if more than one code applies.

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Lipid-lowering therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.12 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Listing date for care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—listing date for care, DDMMYYYY
METeOR identifier:	269957
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.
Data Element Concept:	Elective care waiting list episode—listing date for care

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list. The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral.
Comments:	The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil state/territory, local and national reporting requirements.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Listing date for care, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005 Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Living arrangement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—living arrangement, health sector code N
METeOR identifier:	299712
Registration status:	Health, Standard 14/06/2005
Definition:	Whether a person usually resides alone or with others, as represented by a code.
Context:	Client support needs and clinical setting.
Data Element Concept:	Person—living arrangement

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Lives alone
	2	Lives with others
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	This item does not seek to describe the quality of the arrangements but merely the fact of the arrangement. It is recognised that this item may change on a number of occasions during the course of an episode of care.
Comments:	Whether or not a person lives alone is a significant determinant of risk. Living alone may preclude certain treatment approaches (e.g. home dialysis for end-stage renal disease). Social isolation has also been shown to have a negative impact on prognosis in males with known coronary artery disease with several studies suggesting increased mortality rates in those living alone or with no confidant.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Living arrangement, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.03 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded

04/07/2007
Cardiovascular disease (clinical) DSS Health, Standard
04/07/2007

Location of impairment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—location of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320177
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The location of a person's impairment in a specified body structure, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—location of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	More than one region
1	Right
2	Left
3	Both sides
4	Front
5	Back
6	Proximal
7	Distal

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

Use only one code. Select the one that best describes the situation with this structure. Combinations are not possible.

CODE 0 More than one region (except both sides)

Used when the impairment is present in more than one body location (but not bilaterally see code 3); for example when burn scars affect many areas of skin.

CODE 1 Right

Used when the impairment is present to the right of the midline of the person's body.

CODE 2 Left

Used when the impairment is present to the left of the midline of the person's body.

CODE 3 Both sides (bilateral)

Used when the impairment is two-sided and disposed on opposite sides of the midline axis of the body, for example bilateral joint deformities.

CODE 4 Front

Used when the impairment is present in front of a line passing through the midline of the body when viewed from the side.

CODE 5 Back

Used when the impairment is present behind a line passing through the midline of the body when viewed from the side.

CODE 6 Proximal

Used when the impairment is situated towards the point of origin or attachment, as of a limb or bone (opposed to distal), for example the end of the structure that is closer to the centre of the body.

CODE 7 Distal

Used when the impairment is situated away from the point of origin or attachment, as of a limb or bone (opposed to proximal), for example the end of structure that is further away from the centre of the body.

CODE 8 Not specified

Used when there is an impairment of body structure but the location of the impairment is not recorded.

CODE 9 Not applicable

Used when it is not appropriate to code the location of an impairment of body structure.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is to be used in conjunction with specified body structures, for example, 'impairment of proximal structures related to movement'. This data element may also be used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N and Person—nature of impairment of body structure, code (ICF 2001).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—nature of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—extent of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Body structures cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Lot/section number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—lot/section identifier, N[X(14)]
METeOR identifier:	270031
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the lot/section of the location where a person resides.
Data Element Concept:	Person (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	N[X(14)]
Maximum character length:	15

Data element attributes

Collection and usage attributes

Guide for use:	This standard is suitable for postal purposes as well as the physical identification of addresses. A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property. For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space. Examples are as follows: Section 123456 Lot 716 Lot 534A Lot 17 Jones Street
Collection methods:	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
Comments:	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Lot/section number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.34 KB) Is used in the formation of Person (address)—address line, text

	[X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Standard 04/07/2007

Lot/section number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—lot/section identifier, N[X(14)]
METeOR identifier:	290230
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the lot/section of the location of an organisation.
Data Element Concept:	Service provider organisation (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	N[X(14)]
Maximum character length:	15

Data element attributes

Collection and usage attributes

Guide for use:	This standard is suitable for postal purposes as well as the physical identification of addresses. A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property. For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space. Examples are as follows: Section 123456 Lot 716 Lot 534A Lot 17 Jones Street
Collection methods:	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
Comments:	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard

	04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Standard 04/07/2007

Lower limb amputation due to vascular disease

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lower limb amputation due to vascular disease, code N
METeOR identifier:	270162
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has undergone an amputation of toe, forefoot or leg (above or below knee), due to vascular disease, as represented by a code.
Data Element Concept:	Person—lower limb amputation due to vascular disease

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Lower limb amputation - occurred in the last 12 months
	2	Lower limb amputation - occurred prior to the last 12 months
	3	Lower limb amputation - occurred both in and prior to the last 12 months
	4	No history of lower limb amputation due to vascular disease
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Collection methods:	Ask the individual if he/she has had an amputated toe or forefoot or leg (above or below knee), not due to trauma or causes other than vascular disease. If so determine when it was undertaken; within or prior to the last 12 months (or both). Alternatively obtain this information from appropriate documentation.

Data element attributes

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Duffy MD, John C and Patout MD, Charles A. 1990. Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease. Military Medicine, 155:575-579. Edmonds M, Boulton A, Buckenham T et al. Report of the Diabetic Foot and

Amputation Group. Diabet Med 1996; 13: S27-42. Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society. Colagiuri S, Colagiuri R, Ward J. National Diabetes Strategy and Implementation Plan. Canberra: Diabetes Australia, 1998.

Relational attributes

Related metadata references:

Supersedes Lower limb amputation due to vascular disease, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.61 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

In people with diabetes, amputations are 15 times more common than in people without diabetes, and 50% of all amputations occur in people with diabetes (The Lower Limb in People With Diabetes; 1997/98 Australian Diabetes Society).

Diabetic foot disease is the most common cause of hospitalisation in people with diabetes. Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45 - 74 years and sevenfold in population aged over 75 years. As stated by Duffy and authors the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

Main language other than English spoken at home

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—main language other than English spoken at home, code (ASCL 2005) NN{NN}
METeOR identifier:	304133
Registration status:	Health, Standard 08/02/2006 Community services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006
Definition:	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors, as represented by a code.
Data Element Concept:	Person—main language other than English spoken at home

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2005
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denote that it is an Eastern European language, while 31 denote that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denote that it is an Australian Indigenous language and 87 denote that the language is Western Desert language.

Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Collection methods:

Recommended question:

Do you/Does the person/Does (name) speak a language other than English at home? (If more than one language, indicate the one that is spoken most often.)

No (English only) ____

Yes, Italian ____

Yes, Greek ____

Yes, Cantonese ____

Yes, Mandarin ____

Yes, Arabic ____

Yes, Vietnamese ____

Yes, German ____

Yes, Spanish

Yes, Tagalog (Filipino) ____

Yes, Other (please specify) _____

This list reflects the nine most common languages other than English spoken in Australia.

Languages may be added or deleted from the above short list to reflect characteristics of the population of interest.

Alternatively a tick box for 'English' and an 'Other - please specify' response category could be used.

Comments:

This metadata item is consistent with that used in the Australian Census of Population and Housing and is recommended for use whenever there is a requirement for comparison with Census data.

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).

Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/ translation services.

Source and reference attributes

Origin:

Health Data Standards Committee

National Community Services Data Committee

Australian Bureau of Statistics 2005. Australian Standard Classification of Languages (ASCL) 2005. Cat. no. 1267.0. 2nd Edition, Canberra: ABS. Viewed 29 July 2005.

Relational attributes

Related metadata references:

See also Person—proficiency in spoken English, code N Health, Standard 01/03/2005, Community services, Standard 01/03/2005, Housing assistance, Standard 10/02/2006

See also Person—preferred language, code (ASCL 2005) NN{NN} Health, Standard 08/02/2006, Community services, Standard 29/04/2006

Supersedes Person—main language other than English spoken at home, code (ASCL 1997) NN{NN} Health, Superseded 08/02/2006, Community services, Superseded 29/04/2006, Housing assistance, Not progressed 13/10/2005

Main occupation of person

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	350899
Registration status:	Health, Standard 04/07/2007 Community services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007
Definition:	The job in which the person is principally engaged, as represented by a code.
Data Element Concept:	Person—occupation (main)

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	A job in any given establishment is a set of tasks designed to be performed by one individual in return for a wage or salary. For persons with more than one job, the main job is the one in which the person works the most hours. Caution is advised in its use with regard to service providers as their activity as a service provider may not be their main occupation.
Collection methods:	This metadata item should only be collected from people whose Labour force status is employed. Occupation is too complex and diverse an issue to fit neatly into any useable small group of categories. Therefore ABS recommend that this metadata item be collected by using the following two open-ended questions: Q1. In the main job held last week (or other recent reference period), what was your/the person's occupation? Q2. What are the main tasks that you/the person usually perform in that occupation? The information gained from these two questions can then be used to select an appropriate code from the ANZSCO at any of the available levels (see Guide for use section). If only one question is asked, question one should be used. The use of question one only, however, sometimes elicits responses which do not provide a clear occupation title and specification

of tasks performed. As a result accurate coding at unit group or occupation level may not be possible.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, due to the complexities of the metadata item 'Main occupation of person', this will result in inaccurate information. The recommended question should be used wherever possible.

Comments:

This metadata item may be useful in gaining an understanding of a client's situation and needs. For example, the occupation of a person with a disability may be directly relevant to the type of aids that they require.

National Health Data Dictionary (NHDD) specific:

Injury surveillance - There is considerable user demand for data on occupation-related injury and illness, including from WorkSafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability.

Source and reference attributes

Origin:

Australian Bureau of Statistics 2006. Australian New Zealand Standard Classification of Occupations (ANZSCO) (Cat. no. 1220.0) (First edition), Viewed 13 March 2007.

Relational attributes

Related metadata references:

Supersedes Person—occupation (main), code (ASCO 2nd edn) N[NNN]{-NN} Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007, Housing assistance, Superseded 10/08/2007

See also Person—labour force status, code N Health, Standard 01/03/2005, Community services, Standard 01/03/2005, Housing assistance, Standard 01/03/2005

Main treatment type for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment type (main), code N
METeOR identifier:	270056
Registration status:	Health, Standard 01/03/2005
Definition:	The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Support and case management only
6	Information and education only
7	Assessment only
8	Other

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

This code refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

CODE 2 Counselling

This code refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in Code 3.

CODE 3 Rehabilitation

This code refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and

tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes treatment episodes for clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

CODE 5 Support and case management only

Refers to when there is no treatment provided to the client other than support and case management (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.

CODE 6 Information and education only

Refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.

CODE 7 Assessment only

Refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.

Data element attributes

Collection and usage attributes

Guide for use:

Only one code to be selected.

To be completed at assessment or commencement of treatment.

The main treatment type is the principal activity as judged by the treatment provider that is necessary for the completion of the treatment plan for the principal drug of concern. The main treatment type for alcohol and other drugs is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.

For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Main treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.87 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Major diagnostic category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN
METeOR identifier:	270400
Registration status:	Health, Standard 01/03/2005
Definition:	The category into which the patient's diagnosis and the associated Australian refined diagnosis related group (ARDG) falls, as represented by a code.
Data Element Concept:	Episode of admitted patient care—major diagnostic category

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 5.1
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Data element attributes

Collection and usage attributes

Guide for use:	Version effective 1 July each year
Comments:	This metadata item has been created to reflect the development of Australian refined diagnosis related groups (AR-DRGs) (as defined in the metadata item Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA) by the Acute and Co-ordinated Care Branch, Commonwealth Department of Health and Ageing. Due to the modifications in the diagnosis related group logic for the AR-DRGs, it is necessary to generate the major diagnostic category to accompany each diagnosis related group. The construction of the pre-major diagnostic category logic means diagnosis related groups are no longer unique. Certain pre-major diagnostic category diagnosis related groups may occur in more than one of the 23 major diagnostic categories.

Source and reference attributes

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

Relational attributes

Related metadata references:	Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008 Is formed using Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded

05/02/2008

Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Major diagnostic category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.59 KB)

See also Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Is formed using Person—sex, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—procedure, code (ICD-10-AM 3rd edn) NNNNN-NN Health, Superseded 28/06/2004

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Is formed using Person—weight (measured), total grams NNNN Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Is formed using Episode of care—mental health legal status, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Marital status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—marital status, code N
METeOR identifier:	291045
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
Data Element Concept:	Person—marital status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married (registered and de facto)

Supplementary values:

6	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Refers to the current marital status of a person.

CODE 2 Widowed

This code usually refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 4 Separated

This code refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 5 Married (registered and de facto)

Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex.

CODE 6 Not stated/inadequately described

This code is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin: The ABS standards for the collection of Social and Registered marital status appear on the ABS Website. Australian Bureau of Statistics. Family, household and income unit variables. Cat. no. 1286.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item collects information on social marital status. The recommended question module is:

Do you/Does the person usually live with a partner in a registered or de facto marriage?

Yes, in a registered marriage

Yes, in a de facto marriage

No, never married

No, separated

No, divorced

No, widowed

It should be noted that information on marital status is collected differently by the ABS, using a set of questions. However, the question outlined above is suitable and mostly sufficient for use within the health and community services fields. See Source document for information on how to access the ABS standards.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Comments: The ABS standards identify two concepts of marital status:

- Registered marital status - defined as whether a person has, or has had, a registered marriage;
- Social marital status - based on a person's living arrangement (including de facto marriages), as reported by the person.

It is recommended that the social marital status concept be collected when information on social support/home arrangements is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection.

While marital status is an important factor in assessing the type and extent of support needs, such as for the elderly living in the home environment, marital status does not adequately address the need for information about social support and living arrangement and other data elements need to be formulated to capture this information.

Source and reference attributes

Origin: National Health Data Standards Committee

National Community Services Data Committee

Relational attributes

Related metadata references:

Supersedes Person—marital status, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI) the recommended question is:

Which of the following best describes your current marital status?

(Read options. Single response. Interviewer note: 'De facto' equals 'Living with partner')

Married

Living with partner

Widowed

Divorced

Separated

Never married

Not stated/inadequately described (this category is not read out by interviewer)

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Maternal medical conditions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—maternal medical condition, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361073
Registration status:	Health, Standard 05/02/2008
Definition:	Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Female (pregnant)—maternal medical condition

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.
Comments:	Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Female (pregnant)—maternal medical condition, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Medicare card number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Medicare card number N(11)
METeOR identifier:	270101
Registration status:	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
Definition:	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Context:	Medicare utilisation statistics. Persons eligible for Medicare services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	N(11)
Maximum character length:	11

Collection and usage attributes

Guide for use:	Full Medicare number for an individual (i.e. family number plus person (individual reference) number).
Comments:	The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person. Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card. Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related. A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.

Data element attributes

Collection and usage attributes

Guide for use:	The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage

should not be carried out unless specifically authorised by law.

Comments: Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health care client identification

Relational attributes

Related metadata references: Supersedes Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.62 KB)

Implementation in Data Set Specifications:
Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Standard 07/12/2005
Health care client identification Health, Superseded 04/05/2005
Health care client identification DSS Health, Standard 04/05/2005

Medicare eligibility status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—eligibility status, Medicare code N
METeOR identifier:	351922
Registration status:	Health, Standard 04/07/2007
Definition:	An indicator of a person's eligibility for Medicare at the time of the episode of care, as specified under the Commonwealth Health Insurance Act 1973, as represented by a code.
Context:	Admitted patient care: To facilitate analyses of hospital utilisation and policy relating to health care financing.
Data Element Concept:	Person—eligibility status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Eligible
	2	Not eligible
Supplementary values:	9	Not stated/unknown

Data element attributes

Collection and usage attributes

Guide for use:

Eligible persons are

- Permanent residents of Australia
- Persons who have an application for permanent residence (not an aged parent visa), and have either:

- a spouse, parent or child who is an Australian citizen or permanent resident, OR

- authority from Department of Immigration and Multicultural and Indigenous Affairs to work

- Foreign spouses of Australian residents:

- must have an application for permanent residence, as above

- Asylum seekers who have been issued with valid temporary visas. The list of visas is subject to changes which may be applied by the Department of Immigration and Multicultural Affairs.
- American Fulbright scholars studying in Australia (but not their dependents)
- Diplomats and their dependants from reciprocal health countries (excluding New Zealand and Norway) have full

access to Medicare without the restrictions for American Fulbright scholars.

Reciprocal health care agreements

Residents of countries with whom Australia has Reciprocal health care agreements are also eligible under certain circumstances. Australia has Reciprocal Health Care Agreements with Ireland, Italy, Finland, Malta, the Netherlands, New Zealand, Norway, Sweden and the United Kingdom. These Agreements give visitors from these countries access to Medicare and the Pharmaceutical Benefits Scheme for the treatment of an illness or injury which occurs during their stay, and which requires treatment before returning home (that is, these Agreements cover immediately necessary medical treatment, elective treatment is not covered). The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Eligible patients may elect to be treated as either a public or a private patient.

A newborn will usually take the Medicare eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother.

For example, if the mother of a newborn is an ineligible person but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

Not eligible/ineligible: means any person who is not Medicare eligible. Ineligible patients may not elect to be treated as a public patient.

Prisoners are ineligible for Medicare, under Section 19 (2) of the Health Insurance Act 1973.

Relational attributes

Related metadata references: Supersedes Person—eligibility status, Medicare code N Health, Superseded 04/07/2007

Mental health legal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—mental health legal status, code N
METeOR identifier:	270351
Registration status:	Health, Standard 01/03/2005
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 admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code.
Data Element Concept:	Episode of care—mental health legal status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Involuntary patient
2	Voluntary patient

Supplementary values:

3	Not permitted to be reported under legislative arrangements in the jurisdiction

Collection and usage attributes

Guide for use:

CODE 1 Involuntary patient

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

CODE 2 Voluntary patient

Voluntary patient to be used for reporting to the NMDS-Community mental health care, where applicable.

CODE 3 Not permitted to be reported under legislative arrangements in the jurisdiction

Not permitted to be reported under legislative arrangements in the jurisdiction, is to be used for reporting to the National

Minimum Data Set - Community mental health care, where applicable.

Data element attributes

Collection and usage attributes

Guide for use:

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

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

Similarly, the mental health legal status of residents treated within residential care services may change on multiple occasions throughout the episode of residential care or residential stay.

Collection methods:

Admitted patients to be reported as involuntary if the patient is involuntary at any time during the episode of care.

Residents in **residential mental health services** to be reported as involuntary if the resident is involuntary at any time during the episode of residential care.

Patients of ambulatory mental health care services to be reported as involuntary if the patient is involuntary at the time of a service contact.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard

05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Mental health service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact date, DDMMYYYY
METeOR identifier:	295481
Registration status:	Health, Standard 08/12/2004
Definition:	The date of each mental health service contact between a health service provider and patient/client.
Data Element Concept:	Mental health service contact—service contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record. For collection from community based (ambulatory and non-residential) agencies.
Comments:	The service contact is required for clinical audit and other quality assurance purposes.

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Collection of the date of each service contact with health service providers allows a description or profile of service utilisation by a person or persons during an episode of care.

The National Health Data Committee acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained from the data collected from this metadata item.

Mental health service contact duration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact duration, total minutes NNN
METeOR identifier:	286682
Registration status:	Health, Standard 08/12/2004
Definition:	The time from the start to finish of a service contact.
Data Element Concept:	Mental health service contact—mental health service contact duration

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	For group sessions the time for the patient/client in the session is recorded for each patient/client, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Writing up details of service contacts is not to be reported as part of the duration, except if during or contiguous with the period of patient/client or third party participation. Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as part of the duration of the service contact.
Comments:	Counting the duration for each patient/client in a group session means that this data element cannot be used to measure the duration of service contacts from the perspective of the service provider.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Mental health service contact—patient/client participation indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—patient/client participation indicator, yes/no code N
METeOR identifier:	286859
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the patient/client has participated in a service contact, as represented by a code.
Data Element Concept:	Mental health service contact—patient/client participation indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Service contacts are not restricted to in-person communication but can include telephone, video link or other forms of direct communication.

- Code 1 is to be used for service contacts between a specialised mental health service provider and the patient/client in whose clinical record the service contact would normally warrant a dated entry, where the patient/client is participating.
- Code 2 is to be used for service contacts between a specialised mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

Relational attributes

Implementation in Data Set Specifications:

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health,

Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Mental health service contact—session type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—session type, code N
METeOR identifier:	286832
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a service contact is provided for one or more patient(s)/client(s), as represented by a code.
Data Element Concept:	Mental health service contact—session type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Individual session
2	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A service contact is regarded as an individual session where the service is provided for one patient/client with or without third party involvement.

A service contact is regarded as a group session where two or more patients/clients are participating in the service contact with or without third parties and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

A service contact is also regarded as a group session where third parties for two or more patients/clients are participating in the service contact without the respective patients/clients and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health,

Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Mental health services grants to non-government organisations by non-health departments

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	State or Territory Government—mental health services grants to non-government organisations by non-health departments, total Australian currency N[N(8)]
METeOR identifier:	298940
Registration status:	Health, Standard 07/12/2005
Definition:	Total amount of money in the form of grants made by state or territory departments outside the health portfolios directly to non-government organisations specifically for the provision of mental health activities or programs (other than staffed residential services).
Data Element Concept:	State or Territory Government—mental health services grants to non-government organisations by non-health departments

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount is unable to be provided an estimate should be derived from information available to the state or territory health department.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Mental health establishments NMDS 2008-2009 Health,

Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Do not include grants made by the state or territory health departments.

Do not include grants to non-government organisations for provision of staffed residential services.

Activities or programs for which the grant has been provided must have a primary function of providing treatment, rehabilitation or community health and related support and information services for people with a mental disorder or psychiatric disability, their carers or the broader community. These include accommodation, advocacy, community awareness, health promotion, counselling, independent living skills, psychosocial, recreation, residential, respite and self-help services. Mental health-related research is excluded. These may include, for example, a coordinated approach to service provision for people with a mental disorder or psychiatric disability for which most funding is provided by the state or territory health department, but some funding provided by other agencies, such as housing.

Grants are only to be reported at the state or territory level and should not be reported at any other level.

Method of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth method, code N
METeOR identifier:	295349
Registration status:	Health, Standard 06/09/2006
Definition:	The method of complete expulsion or extraction from its mother of a product of conception in a birth event, as represented by a code.
Data Element Concept:	Birth event—birth method

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Vaginal - non-instrumental
	2	Vaginal - forceps
	4	Caesarean section
	5	Vaginal - vacuum extraction
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	In a vaginal breech with forceps to the after coming head, code as vaginal - forceps. In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental. Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section. Where a hysterotomy is performed to extract the baby, code as caesarean section.
Collection methods:	In the case of multiple births, method of birth should be recorded for each baby born.
Comments:	Note: Code 3, which had a meaning in previous versions of the data standard is no longer used. As is good practice, the code will not be reused.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—delivery method, code N Health, Superseded 06/09/2006

Implementation in Data Set Specifications: Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Method of use for principal drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Client—method of drug use (principal drug of concern), code N
METeOR identifier:	270111
Registration status:	Health, Standard 01/03/2005
Definition:	The client's self-reported usual method of administering the principal drug of concern, as represented by a code.
Data Element Concept:	Client—method of drug use (principal drug of concern)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ingests
2	Smokes
3	Injects
4	Sniffs (powder)
5	Inhales (vapour)
6	Other

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Refers to eating or drinking as the method of administering the principal drug of concern.
Collection methods:	Collect only for principal drug of concern. To be collected on commencement of treatment with a service.
Comments:	Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Method of use for principal drug of concern, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.73 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Microalbumin level—albumin/creatinine ratio (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N
METeOR identifier:	270339
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level, measured as an albumin/creatinine ratio.
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per millimole (mg/mmol)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate, and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300 mg/L; or
- timed urine (24 hour collection) 20 to 200 µg/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—micrograms per minute (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total micrograms per minute N[NNN].N
METeOR identifier:	270336
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in microgram per minute (µg/min).
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 µg/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

See also Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—milligrams per 24 hour (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total milligrams per 24 hour N[NNN].N
METeOR identifier:	270337
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in milligrams per 24 hours.
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Milligram per 24-hour period (mg/24h)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—milligrams per litre (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total milligrams per litre N[NNN].N
METeOR identifier:	270335
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in milligrams per litre (mg/L).
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are:

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—upper limit of normal range (albumin/creatinine ratio)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N
Synonymous names:	Albumin/creatinine ratio
METeOR identifier:	270344
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured as an albumin/creatinine ratio that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Milligram per millimole (mg/mmol)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references:

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

See also Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin level—upper limit of normal range (micrograms per minute)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N
METeOR identifier:	270341
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in micrograms per minute (µg/min), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

See also Person—microalbumin level (measured), total micrograms per minute N[NNN].N Health, Standard 01/03/2005

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin level—upper limit of normal range (milligrams per 24 hour)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N
METeOR identifier:	270343
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per 24 hour, that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per 24-hour period (mg/24h)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

See also Person—microalbumin level (measured), total milligrams per 24 hour N[NNN].N Health, Standard 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin level—upper limit of normal range (milligrams per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N
METeOR identifier:	270334
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per litre (mg/L), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

See also Person—microalbumin level (measured), total milligrams per litre N[NNN].N Health, Standard 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Minutes of operating theatre time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—operating theatre time, total minutes NNNN
METeOR identifier:	270350
Registration status:	Health, Standard 01/03/2005
Definition:	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation.
Data Element Concept:	Admitted patient hospital stay—operating theatre time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Minute (m)

Collection and usage attributes

Collection methods:	Right justified, zero filled.

Data element attributes

Collection and usage attributes

Comments:	This metadata item was recommended for inclusion in the *National Health Data Dictionary* by *Hindle (1988a, 1988b)* to assist with diagnosis related group costing studies in Australia. This metadata item has not been accepted for inclusion in the National Minimum Data Set (NMDS) - Admitted patient care.

Source and reference attributes

Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Minutes of operating theatre time, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.33 KB)

Mode of admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission mode, code N
METeOR identifier:	269976
Registration status:	Health, Standard 01/03/2005
Definition:	The mechanism by which a person begins an episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted patient transferred from another hospital
2	Statistical admission - episode type change
3	Other

Collection and usage attributes

Guide for use:

CODE 2 Statistical admission - episode type change

Use this code where a new episode of care is commenced within the same hospital stay.

CODE 3 Other

Use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Mode of admission, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.06 KB)
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Mode of separation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation mode, code N
METeOR identifier:	270094
Registration status:	Health, Standard 01/03/2005
Definition:	Status at **separation** of person (discharge/transfer/death) and place to which person is released, as represented by a code.
Data Element Concept:	Episode of admitted patient care—separation mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Discharge/transfer to (an)other acute hospital
2	Discharge/transfer to a residential aged care service, unless this is the usual place of residence
3	Discharge/transfer to (an)other psychiatric hospital
4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals)
5	Statistical discharge - type change
6	Left against medical advice/discharge at own risk
7	Statistical discharge from leave
8	Died
9	Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Collection and usage attributes

Guide for use:

CODE 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals)

In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1. If the residential aged care service is the patient's place of usual residence then they should have a mode of separation of Code 9.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Mode of separation, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.29 KB)

Is used in the formation of Episode of admitted patient care — major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care — diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Morphology of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—morphology of cancer, code (ICDO-3) NNNN/N
METeOR identifier:	270179
Registration status:	Health, Standard 01/03/2005
Definition:	The histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.
Data Element Concept:	Person with cancer—morphology of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	Number
Format:	NNNN/N
Maximum character length:	5

Collection and usage attributes

Guide for use:

ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.

In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.

Record morphology codes in accordance with ICDO coding standards. Use the 5th-digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Source and reference attributes

Origin:	International Classification of Diseases for Oncology, Third Edition (ICDO-3)

Data element attributes

Collection and usage attributes

Collection methods:

Cancer registry use:

In cancer registries morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.

Hospital morbidity use:

In hospitals, the morphology code is modified for use with ICD-10-AM. The morphology code consists of histologic type (4 digits) and behaviour code (1 digit) ranging from 8000/0 to 9989/9. The '/' between the fourth and fifth digits is not supplied.

Source and reference attributes

Origin:

World Health Organization

New South Wales Health Department

State and Territory Cancer Registries

Reference documents:

New South Wales Inpatient Statistics Collection Manual, 2000/2001

Esteban D, Whelan S, Laudico A and Parkin DM editors. International Agency for Research on Cancer World Health Organization and International Association of Cancer Registries: Manual for cancer registry personnel. IARC Technical Report No 10. Lyon: IARC,1995

Relational attributes

Related metadata references:

Supersedes Morphology of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.26 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This information is collected for the purpose of:

- classifying tumours into clinically relevant groupings on the basis of both their morphology (cell type) and their degree of invasion or malignancy as indicated by the behaviour code component (the last digit of the morphology code);
- monitoring the number of new cases of cancer for planning treatment services.

Most common service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—most common service delivery setting, code N
METeOR identifier:	297708
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which the service provider organisation most commonly delivers services, as represented by a code.
Data Element Concept:	Service provider organisation—most common service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Mostly community-based setting
2	Mostly inpatient setting
3	Similar proportion in both settings

Collection and usage attributes

Collection methods:	Record only one code.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Mostly community based setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in community settings. This includes residential settings such as private residences (including caravans, mobile homes, houseboats or units in a retirement village), residential aged care facilities, prisons, and community living environments (including group homes); and non-residential settings such as day respite centres or day centres. It includes hospital outreach services and outpatient settings where these are delivered in the community setting.

CODE 2 Mostly inpatient setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in inpatient settings. This includes hospitals, hospices or admitted patient settings. It excludes services delivered in outpatient settings and hospital outreach services delivered in the community setting.

CODE 3 Similar level in both settings

During the past 12 months, a similar proportion of service delivery time (between 40-60%) was estimated to have been spent on delivering services in community and inpatient settings.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—most valid basis of diagnosis of a cancer, code N
METeOR identifier:	270181
Registration status:	Health, Standard 01/03/2005
Definition:	The most valid basis of diagnosis of cancer, as represented by a code.
Data Element Concept:	Person with cancer—most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Death certificate only: Information provided is from a death certificate
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis
4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site
5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates
6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens
7	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour
8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified

Supplementary values:

9	Unknown.

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments:

In a hospital setting this metadata item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnosis technique is used during an admission, select the higher code from 1 to 8.

Data element attributes

Collection and usage attributes

Guide for use:

The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this metadata item should be revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the making of a morphological (histological) diagnosis is dependent upon a variety of factors, such as age, accessibility of the tumour, availability of medical services, and, last but not least, upon the beliefs of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, e.g., at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the Histology codes should be recorded instead);

b) the autopsy is macroscopic only, histological investigations having been carried out only during life (in which case, one of the Histology codes should be recorded instead);

c) the autopsy findings are not supported by any histological diagnosis.

Source and reference attributes

Origin: International Agency for Research on Cancer
International Association of Cancer Registries

Relational attributes

Related metadata references: Supersedes Most valid basis of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (46.95 KB)

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
Knowledge of the basis of a diagnosis underlying a cancer code is one of the most important aids in assessing the reliability of cancer statistics.

Mother's original family name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—mother's original family name, text [X(40)]
METeOR identifier:	270262
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The original family name of the person's mother as reported by the person, as represented by text.
Data Element Concept:	Person—mother's original family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only).
Collection methods:	See relevant paragraphs in the collection methods section of the metadata item Person (name)—family name, text X[X(39)].

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Mother's original family name, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (14.07 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005 Health care client identification DSS Health, Standard 04/05/2005

Multi-disciplinary team status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—multi-disciplinary team status, code N
METeOR identifier:	270104
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a non-admitted patient service event involved a multi-disciplinary team, as represented by a code.
Data Element Concept:	Non-admitted patient service event—multi-disciplinary team status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Non-admitted multi-disciplinary team patient service event
2	Other non-admitted patient service event

Data element attributes

Relational attributes

Related metadata references: Supersedes Multi-disciplinary team status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.68 KB)

Myocardial infarction (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—myocardial infarction (history), code N
METeOR identifier:	270285
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has had a myocardial infarction, as represented by a code.
Data Element Concept:	Person—myocardial infarction

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Myocardial infarction - occurred in the last 12 months
2	Myocardial infarction - occurred prior to the last 12 months
3	Myocardial infarction - occurred both in and prior to the last 12 months
4	No history of myocardial infarction

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:

Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both).Record if evidenced by ECG changes or plasma enzyme changes.

Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Long-term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study Circulation. 1999;99: 2626-2632.

Relational attributes

Related metadata references:	Supersedes Myocardial infarction - history, version 1, DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (16.68 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

Myocardial infarction (MI) generally occurs as a result of a critical imbalance between coronary blood supply and myocardial demand. Decrease in coronary blood flow is usually due to a thrombotic occlusion of a coronary artery previously narrowed by atherosclerosis. MI is one of the most common diagnoses in hospitalised patients in industrialised countries.

The most widely used in the detection of MI are creatinine kinase (CK) and (CK-MB), aspartate aminotransferase (AST) and lactate dehydrogenase (LD). Characteristic ECG changes include ST elevation, diminution of the R wave and a Q wave development. A recent study on Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI study) indicated that in diabetic patients with AMI, mortality is predicted by age, previous heart failure, and severity of the glycometabolic state at admission, but not by conventional risk factors or sex (American Heart Association 1999).

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Name context flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name conditional use flag, code N
Synonymous names:	Name conditional use flag
METeOR identifier:	287101
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	An indicator of specific conditions that may be applied to an individual's name, as represented by a code.
Data Element Concept:	Person (name)—name conditional use flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Unreliable information
2	Name not for continued use
3	Special privacy/security requirement

Data element attributes

Collection and usage attributes

Guide for use:

A single Person name may have multiple Name conditional use flags associated with it. Record as many as applicable.

CODE 1 Unreliable information: should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.

CODE 2 Name not for continued use, indicates that this name should NOT be used when referring to this person. The name is retained for identification purposes only. For Aboriginal and Torres Strait Islanders, certain tribal names may become 'not for continued use' due to the death of a relative.

CODE 3 Special privacy/security requirements– may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee

	National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—name context flag, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Name suffix

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name suffix, text [A(12)]
METeOR identifier:	287164
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name)—name suffix

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(12)]
Maximum character length:	12

Collection and usage attributes

Guide for use:	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin:	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only). Examples of name suffixes are 'Jr' for Junior and 'MP' for Member of Parliament.
Collection methods:	A person's name may have multiple Name suffixes. For the purpose of positive identification of a person, each Name suffix must have an associated Name suffix sequence number recorded.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—name suffix, text [A(12)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Name suffix sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name suffix sequence number, code N
METeOR identifier:	288226
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numeric order of any additional terms used at the conclusion of a name, as represented by a code.
Data Element Concept:	Person (name)—name suffix sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	First name suffix
2	Second name suffix
3	Third name suffix
4	Fourth name suffix
5	Fifth name suffix
6	Sixth name suffix
7	Seventh name suffix
8	Eighth name suffix
9	Ninth and subsequent name suffix

Data element attributes

Collection and usage attributes

Collection methods:

Multiple Name suffixes may be recorded. A Name suffix sequence number must be recorded for each Name suffix.

Example: For the name 'John Markham Jr MP', 'Jr' would have a name suffix sequence number of 1 and 'MP' would have a name suffix sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set	Health care client identification DSS Health, Standard

Specifications:	04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Name title

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name title, text [A(12)]
METeOR identifier:	287166
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name)—name title

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	A(12)
Maximum character length:	12

Collection and usage attributes

Guide for use:	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin:	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only). The Name title for Master should only be used for persons less than 15 years of age. Name titles for Doctor and Professor should only be applicable to persons of greater than 20 years of age. More than one Name title may be recorded e.g. Prof Sir John Markham.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002

Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Person (name)—name title, text [A(12)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:

For the purpose of positive identification of a person, each name title should be associated with a Name title sequence number.

Name title should not be confused with job title. An example of Name title is 'Mr' for Mister.

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:

For the purpose of positive identification of a person, each name title should be associated with a Name title sequence number.

Name title should not be confused with job title. An example of Name title is 'Mr' for Mister.

Name title sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name title sequence number, code N
METeOR identifier:	288263
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numeric order of an honorific form of address commencing a person's name, as represented by a code.
Data Element Concept:	Person (name)—name title sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	First name title
2	Second name title
3	Third name title
4	Fourth name title
5	Fifth name title
6	Sixth name title
7	Seventh name title
8	Eighth name title
9	Ninth and subsequent name title

Data element attributes

Collection and usage attributes

Collection methods:

Multiple Name titles may be recorded. For the purpose of positive identification of a person, each Name title must have a Name title sequence number recorded.

Example: Professor Sir John Markham

In the example above 'Professor' would have a name title sequence number of 1 and 'Sir' would have a name title sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Name type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name type, code N
METeOR identifier:	287203
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A classification that enables differentiation between recorded names for a person, as represented by a code.
Data Element Concept:	Person (name)—name type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Preferred name
2	Medicare name
3	Newborn name
4	Alias name

Data element attributes

Collection and usage attributes

Guide for use:

A person may have more than one name that they use. At least one name must be recorded for each person. Each name recorded must have one or more appropriate Person name type associated with it. Record all that are required.

One name is sufficient; however, where the person offers more than one name, clarification should be obtained from the person to ensure accurate identification of the person and recording of the various names. The currently used name, as well as names by which the person has previously been known, should be recorded if these are known.

Field value definitions for Person name type codes are:

CODE 1 Preferred name is the name by which the person chooses to be identified.
There should only be one preferred name recorded for a person. Where the person changes their preferred name, record the previously recorded preferred name as an Alias name.
Preferred name is the default name type (i.e. if only one name is recorded it should be the person's preferred name). There must be a preferred name recorded except for unnamed newborns where the newborn name is the only name recorded.
Also, if the person is a health care client, record his/her Medicare card name if different to the preferred name, and any

known alias names.

CODE 2 Medicare name for a health care client, this is the person's name as it appears on their Medicare card. The name stated on the Medicare card is required for all electronic Medicare claim lodgement. If the preferred name of the person is different to the name on the Medicare card, the Medicare card name should also be recorded. For an individual health care provider, this is the person's name registered by Medicare (Health Insurance Commission).

CODE 3 Newborn name: type is reserved for the identification of unnamed newborn babies.

CODE 4 Alias name is any other name that a person is also known by, or has been known by in the past; that is, all alias names. This includes misspelt names or name variations that are to be retained as they have been used to identify this person. More than one alias name may be recorded for a person.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia In AS5017 and AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:	Supersedes Person (name)—name type, code A Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Name type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (name)—name type, code N
METeOR identifier:	288937
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A classification that enables differentiation between recorded names for an establishment, agency or organisation, as represented by a code.
Data Element Concept:	Service provider organisation (name)—name type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Organisation unit/section/division
2	Service location name
3	Business name
4	Locally used name
5	Abbreviated name
6	Enterprise name
8	Other

Supplementary values:

9	Unknown

Collection and usage attributes

Guide for use:

CODE 1 Organisation unit/section/division

This code is used where a business unit, section or division within an organisation may have its own separate identity.

CODE 2 Service location name

This code is used where the service location name is an important part of the organisation name and is used for identification purposes, e.g. Mobile Immunisation Unit at Bankstown.

CODE 3 Business name

Business name used only for trading purposes.

CODE 4 Locally used name

This code is used where a local name is used, e.g. where a medical practice is known by a name that is different to the company registration name or business name.

CODE 5 Abbreviated name

A short name or an abbreviated name by which the organisation is known, e.g. HIC.

CODE 6 Enterprise name

Generally, the complete organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name.

CODE 8 Other

This code is used when the organisation name does not fit into any one of the categories listed above.

CODE 9 Unknown

This code is used when the organisation name type is unknown.

Data element attributes

Collection and usage attributes

Guide for use:

At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Narrative description of injury event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, text [X(100)]
METeOR identifier:	268946
Registration status:	Health, Standard 01/03/2005
Definition:	A textual description of the environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(100)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

Guide for use:	Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event); the mechanism by which this event led to injury; and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should be indicated.
Comments:	The narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data. This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Submitting organisation:	National Injury Surveillance Unit, Flinders University, Adelaide

Relational attributes

Related metadata references:	Supersedes Narrative description of injury event, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.35 KB)
Implementation in Data Set Specifications:	Injury surveillance DSS Health, Superseded 05/02/2008 Injury surveillance DSS Health, Standard 05/02/2008 Injury surveillance NMDS Health, Superseded 03/05/2006 *Implementation start date:* 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

National standards for mental health services review status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service unit—implementation of National standards for mental health services status, code N
METeOR identifier:	287800
Registration status:	Health, Standard 08/12/2004
Definition:	The extent of progress made by a specialised mental health service unit in implementing the National Standards for Mental Health Services by or at 30 June, as represented by a code.
Data Element Concept:	Specialised mental health service unit—implementation of National standards for mental health services status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the National standards
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the National standards
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review
5	The service unit was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review
6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards

8	The National standards are not applicable to this service unit

Collection and usage attributes

Guide for use:

Code 8 The National standards are not applicable to this service unit

This code should only be used for:

- non-government organisation mental health services and private hospitals (that receive some government funding to provide specialised mental health services) where implementation of National standards for mental health services has not been agreed with the relevant state or territory; or
- those aged care residential services (e.g. psychogeriatric nursing homes) in receipt of funding under the *Aged Care Act* and subject to Commonwealth residential aged care reporting and service standards requirements.

Data element attributes

Collection and usage attributes

Collection methods:

Report the review/accreditation status at 30 June for each service unit for the National standards for mental health services using the standard set of codes shown in the value domain.

For organisations that include more than one service unit the codes relating to each service should be completed. Reporting of progress at the individual service unit level recognises that parts rather than whole organisations may be implementing the standards.

NOTE: for admitted patient setting only, these data need to be disaggregated by specialised mental health service program type and specialised mental health service target population.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health,

Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Nature of main injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—nature of main injury, non-admitted patient code NN{.N}
METeOR identifier:	268947
Registration status:	Health, Standard 01/03/2005
Definition:	The nature of the injury chiefly responsible for the attendance of the non-admitted patient at the health care facility, at represented by a code.
Data Element Concept:	Injury event—nature of main injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN{.N}
Maximum character length:	4

Permissible values:

Value	Meaning
01	Superficial (excludes eye injury code 13)
02	Open wound (excludes eye injury code 13)
03	Fracture (excludes dental injury code 21)
04	Dislocation (includes ruptured disc, cartilage, ligament)
05	Sprain or strain
06	Injury to nerve (includes spinal cord; excludes intracranial injury code 20)
07	Injury to blood vessel
08	Injury to muscle or tendon
09	Crushing injury
10	Traumatic amputation (includes partial amputation)
11	Injury to internal organ
12	Burn or corrosion (excludes eye injury code 13)
13	Eye injury (includes burns, excludes foreign body in external eye code 14.1)
14.1	Foreign body in external eye
14.2	Foreign body in ear canal
14.3	Foreign body in nose
14.4	Foreign body in respiratory tract (excludes foreign body in nose code 14.3)
14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue

14.9	Foreign body, other/unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning immersion code 22)
24	Electrical injury
25	Poisoning, toxic effect (excludes effect of venom, or any insect bite code 26)
26	Effect of venom, or any insect bite
27	Other specified nature of injury
28	Injury of unspecified nature
29	Multiple injuries of more than one 'nature'
30	No injury detected

Data element attributes

Collection and usage attributes

Guide for use:

If the full ICD-10-AM code is used to code the injury, this metadata item is not required (see metadata items principal diagnosis and additional diagnosis) When coding to the full ICD-10-AM code is not possible, use this metadata item with the items external cause of injury-non admitted patient, external cause of injury-human intent and bodily location of main injury.

Select the code which best characterises the nature of the injury chiefly responsible for the attendance, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'.

If the nature of the injury code is 01 to 12 or 26 to 29 then the metadata item Bodily location of main injury should be used to record the bodily location of the injury. If another code is used, bodily location is implicit or meaningless. Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

Comments:

Injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This metadata item together with the metadata item bodily location of the main injury indicates the diagnosis.

This metadata item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see metadata item principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the metadata item Bodily location of main

injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

See also Person—bodily location of main injury, code NN Health, Standard 01/03/2005

Supersedes Nature of main injury - non-admitted patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.3 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Standard 05/02/2008

Information specific to this data set:
Left justified, zero filled.

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Neonatal morbidity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361928
Registration status:	Health, Standard 05/02/2008
Definition:	Conditions or diseases of the baby, as represented by an ICD-10-AM code.
Data Element Concept:	Admitted patient (neonate)—neonatal morbidity

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Conditions should be coded within chapter of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Net capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269969
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on buildings and building services (including plant).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Net capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270531
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on constructions (other than buildings).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Net capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270534
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on equipment.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Net capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270529
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on information technology.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Net capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270535
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on intangible assets.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Net capital expenditure (accrual accounting)—land

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270536
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on land.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Net capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270530
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on major medical equipment.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Net capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270533
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Net capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270532
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure measured in Australian dollars on transport.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

New/repeat status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—new/repeat status, code N
METeOR identifier:	270348
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a non-admitted patient service event is for a new problem not previously addressed at the same clinical service or for a repeat service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—new/repeat service event status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	New non-admitted patient service event
2	Repeat non-admitted patient service event

Collection and usage attributes

Guide for use:

CODE 1 New non-admitted patient service event:

New service events occur as each type of clinical service makes their full assessment consultation with the patient.

CODE 2 Repeat non-admitted patient service event:

Repeat visits include completion of an ambulatory procedure e.g. removal of sutures and removal of plaster casts.

Data element attributes

Relational attributes

Related metadata references: Supersedes New/repeat status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.37 KB)

Non-Australian state/province (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—non-Australian state/province, text [X(40)]
METeOR identifier:	288648
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of a person, as represented by text.
Data Element Concept:	Person (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare Standard Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007 *Information specific to this data set:* When used for identification purposes record this data element as part of an address.

Non-Australian state/province (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—non-Australian state/province, text [X(40)]
METeOR identifier:	288636
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of an establishment, as represented by text.
Data Element Concept:	Service provider organisation (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007 *Information specific to this data set:* When used for identification purposes record this data element as part of an address.

Number of available beds for admitted patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of available beds for admitted patients/residents, average N[NNN]
METeOR identifier:	270133
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of beds which are immediately available for use by an admitted patient or **resident** within the establishment. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.
Data Element Concept:	Establishment—number of available beds for admitted patients/residents

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest whole number.

Data element attributes

Collection and usage attributes

Guide for use:	The average bed is to be calculated from monthly figures.
Comments:	This metadata item was amended during 1996-97. Until then, both average and end-of-year counts of available beds were included, and the end-of-year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate characterisation of establishments and comparisons.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Number of available beds for admitted patients, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.24 KB)
Implementation in Data Set Specifications:	Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004 *Implementation start date:* 01/07/2004

Implementation end date: 30/06/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

These data are to be disaggregated by specialised mental health service setting (excluding ambulatory care). For the admitted patient care setting these records are to be disaggregated by specialised mental health service program type and specialised mental health service target population.

For the Mental health establishments national minimum data set, available beds are restricted to available beds that are intended for overnight stays only. That is, beds that are only available for same day stays are not included in the count.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Number of caesarean sections

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of caesarean sections, total count N[N]
METeOR identifier:	297820
Registration status:	Health, Standard 29/11/2006
Definition:	The total number of previous caesarean sections performed on the woman.
Data Element Concept:	Female—number of caesarean sections

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/Inadequately described
Unit of measure:	Caesarean sections	

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	In the case of multiple births, count the number of operations the mother has had, rather than the number of babies born. Exclude the current birth if by caesarean section. Record as 0 if no previous caesarean sections.
Comments:	Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Number of contacts—psychiatric outpatient clinic/day program

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN]
METeOR identifier:	270121
Registration status:	Health, Standard 01/03/2005
Definition:	Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.
Data Element Concept:	Patient—number of psychiatric outpatient clinic/day program attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Collection methods:	All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)
Comments:	This metadata item gives a measure of the level of service provided. In December 1998, the National Health Information Management Group decided that the new version of this metadata item (named Person—number of service contact dates, total N[NN]) would be implemented from 1 July 2000 in the Community Mental Health National Minimum Data Set (NMDS). Until then agencies involved in the Community mental health NMDS may report either Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN] or Person—number of service contact dates, total N[NN] with the expectation that agencies will make their best efforts to report against the new version of this metadata item (Person—number of service contact dates, total N[NN]) from 1 July 1999.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Number of contacts (psychiatric outpatient clinic/day program), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Number of days in special/neonatal intensive care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (special/neonatal intensive care), total days N[NN]
METeOR identifier:	270057
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).
Data Element Concept:	Episode of admitted patient care—length of stay (special/neonatal intensive care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	The number of days is calculated from the date the baby left the special/neonatal **intensive care unit** minus the date the baby was admitted to the special/neonatal intensive care unit.
Collection methods:	This item is to be completed if baby has been treated in an intensive care unit or a special care nursery (SCN).
Comments:	An indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities. SCN are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy. Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICN also provide consultative services to other hospitals.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Number of days in special / neonatal intensive

care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

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

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]}
METeOR identifier:	270305
Registration status:	Health, Standard 01/03/2005
Definition:	The number of **hospital-in-the-home** days occurring within an episode of care for an admitted patient.
Data Element Concept:	Episode of admitted patient care—number of days of hospital-in-the-home care

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	{N[NN]}
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The rules for calculating the number of **hospital-in-the-home** days are outlined below:

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

Comments:

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Number of days of hospital-in-the-home care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Number of episodes of residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of episodes of residential care, total N[NNN]
METeOR identifier:	287957
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of episodes of completed residential care occurring during the reference period (between 1 July and 30 June each year). This includes both formal and statistical episodes of residential care.
Data Element Concept:	Episode of residential care—number of episodes of residential care

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	The sum of the number of episodes of residential care where the Episode of residential care end date has a value: • Equal to or greater than the beginning of the reference period (01 July each year); and • Less than or equal to the end of the reference period (30 June each year at midnight).
Collection methods:	To be reported for all specialised residential mental health care services, including non-government residential mental health care services and

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Number of group sessions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group sessions, total N[NNNNN]
Synonymous names:	Group occasions of service
METeOR identifier:	336900
Registration status:	Health, Standard 04/07/2007
Definition:	The total number of groups of patients receiving services. Each group is to be counted once, irrespective of the size of the group of patients or the number of staff providing services.
Data Element Concept:	Establishment—number of group sessions

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A group is defined as two or more patients receiving the same services at the same time from the same hospital staff at the same clinics.

The following guides for use apply:

- a group session is counted only for two or more patients attending in the capacity of patients in their own right, even if other non-patient persons are present for the service.
- Spouses, parents or carers attending the session are counted for the group session only if they are also participating in the service as a patient.
- A group session is counted for staff attending clinics only if they are attending as a patient in their own right. Staff training and education is excluded.
- A group session may be delivered by more than one provider. A group session is counted for two or more patients receiving the same services, even if more than one provider delivers that service simultaneously.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people are receiving the same services at the same time.

Collection methods:

Where a patient receives multidisciplinary care within one booked clinic appointment as part of a group, one group

session shall be recorded, regardless of the number of providers involved. For example, if a group session is jointly delivered by a physiotherapist and an occupational therapist, one group session is counted for the patients attending that session.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: Supersedes Establishment—number of group sessions, total N[NNNNN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of leave periods

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of leave periods, total N[N]
METeOR identifier:	270058
Registration status:	Health, Standard 01/03/2005
Definition:	Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).
Data Element Concept:	Episode of admitted patient care—number of leave periods

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2
Unit of measure:	Period

Data element attributes

Collection and usage attributes

Guide for use:	If the period of leave is greater than seven days or the patient fails to return from leave, the patient is discharged.
Comments:	Recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and **separation** rates, particularly for long-stay patients who may have several leave periods. This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Number of leave periods, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.46 KB) Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Number of occasions of service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of occasions of service, total N[NNNNNN]
Synonymous names:	Individual occasions of service
METeOR identifier:	336947
Registration status:	Health, Standard 04/07/2007
Definition:	The total number of occasions of examination, consultation, treatment or other service provided to a patient.
Data Element Concept:	Establishment—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

The following guides for use apply:

- an occasion of service is counted for each person attending in the capacity of a patient in their own right, even if other non-patient persons are present for the service.
- spouses, parents or carers attending the session are only counted if they are also participating in the service as a patient.
- in the instance of a dependent child presenting to a clinic, the session is counted as a single Occasion of Service provided to the individual child for whom an event history is being recorded. Where parents/carers also attend in the capacity of patients themselves within a booked appointment, and receive the same services at the same time, the child and parent/carer can be counted as a group. In this instance a Group Session count would be recorded.
- An occasion of service is counted for staff attending clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.

Collection methods:

- Where a patient receives the occasion of service is counted at the clinic of the public hospital where the patient is

booked.

- Where a patient receives multidisciplinary care, within one booked clinic appointment by themselves, one occasion of service shall be recorded, regardless of the number of providers involved.
- Where patients have received more than one booked appointment, each appointment will be counted as one occasion of service. (Example: three booked appointments with all services provided on a single day will be counted as three occasions of service).
- The occasion of service count should be attributed to the clinic type associated with the booked appointment.
- Services to individual patients should be counted separately from services to groups of patients. An occasion of service is counted only for a service provided to an individual. Group sessions are reported separately under 'Establishment - number of group sessions total N[NNNNNN]'.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: See also Establishment—outpatient clinic type, code N[N] Health, Standard 04/07/2007

Supersedes Establishment—number of occasions of service, total N[NNNNNN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of qualified days for newborns

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN]
METeOR identifier:	270033
Registration status:	Health, Standard 01/03/2005
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Data Element Concept:	Episode of admitted patient care (newborn)—number of qualified days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the Episode of admitted patient care—admission date, DDMMYYYY, Episode of admitted patient care—separation date, DDMMYYYY and any Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY:

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

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

Relational attributes

Related metadata references:

Supersedes Number of qualified days for newborns, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.53 KB)

Is formed using Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY Health, Standard 01/03/2005

Is used in the formation of Establishment—number of patient

days, total N[N(7)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Number of service contact dates

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—number of service contact dates, total N[NN]
METeOR identifier:	270231
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of dates where a service contact was recorded for the patient/client.
Data Element Concept:	Person—number of service contact dates

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Service contact date

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once. For collection from community-based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.
Comments:	This metadata item gives a measure of the level of service provided to a patient/client.

Source and reference attributes

Submitting organisation:	National Mental Health Information Strategy Committee

Relational attributes

Related metadata references:	Is formed using Service contact—service contact date, DDMMYYYY Health, Standard 01/03/2005 Supersedes Number of service contact dates, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.91 KB)

Number of service contacts within a treatment episode for alcohol and other drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—number of service contacts, total N[NN]
METeOR identifier:	270117
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.
Data Element Concept:	Episode of treatment for alcohol and other drugs—number of service contacts

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Service contact

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is a count of service contacts related to treatment that are recorded on a client record. Any client contact that does not constitute part of a treatment should not be considered a service contact. Contact with the client for administrative purposes, such as arranging an appointment, should not be included. This item is not collected for residential clients. Where multiple service provider staff have contact with the client at the same time, on the same occasion of service, the contact is counted only once. When multiple service contacts are recorded on the same day, each independent contact should be counted separately.
Collection methods:	To be collated at the close of a treatment episode.
Comments:	This metadata item provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Number of service contacts within a treatment episode for alcohol and other drug, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Number of service events (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of non-admitted patient service events, total N[NNNNNN]
Synonymous names:	Non-admitted patient service event count
METeOR identifier:	270108
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.
Data Element Concept:	Establishment—number of non-admitted patient service events

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Service event

Data element attributes

Collection and usage attributes

Guide for use:

Count of non-admitted patient service events for each of the clinical service types listed in the value domain of the metadata item Non-admitted patient service event—service event type (clinical), code N[N].

For each Non-admitted patient service event count, specify the

- Non-admitted patient service event—service event type (clinical), code N[N]
- Non-admitted patient service event—multi-disciplinary team status, code N
- Service contact—group session status, individual/group session indicator code ANN.N
- Non-admitted patient service event—patient present status, code N
- Non-admitted patient service event—service mode, hospital code N{N}

Comments:

Public patients are defined in accordance with the *1998-2003 Australian Health Care Agreements*.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Non-admitted patient service event count, version

1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.49 KB)

Nursing diagnosis—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—nursing diagnosis (other), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]
METeOR identifier:	270466
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing diagnosis other than the principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme:	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
Representation class:	Code
Data type:	Number
Format:	N.N[{.N}{.N}{.N}{.N}]
Maximum character length:	6

Collection and usage attributes

Guide for use:	The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Minimum Data Set - Australia (CNMDSA).

Data element attributes

Collection and usage attributes

Guide for use:	Up to seven nursing diagnoses may be nominated, according to the following: 1. Nursing diagnosis most related to the principal reason for admission (one only) 2-6. Other nursing diagnoses or relevance to the current episode.
Collection methods:	In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place. Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and

viable options.

Comments: The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain North American Nursing Diagnosis Association (NANDA). The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing diagnosis—principal

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—nursing diagnosis (principal), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]
METeOR identifier:	270220
Registration status:	Health, Standard 01/03/2005
Definition:	The principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme:	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
Representation class:	Code
Data type:	Number
Format:	N.N[{.N}{.N}{.N}{.N}]
Maximum character length:	6

Collection and usage attributes

Guide for use:	The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Minimum Data Set - Australia (CNMDSA).

Data element attributes

Collection and usage attributes

Guide for use:	Up to seven nursing diagnoses may be nominated, according to the following: 1. Nursing diagnosis most related to the principal reason for admission (one only) 2-6. Other nursing diagnoses of relevance to the current episode.
Collection methods:	In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place. Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the code set or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Comments: The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain North American Nursing Diagnosis Association (NANDA). The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing interventions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—nursing intervention, code N
METeOR identifier:	270223
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing action intended to relieve or alter a person's responses to actual or potential health problems, as represented by a code.
Data Element Concept:	Community nursing service episode—nursing intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Coordination and collaboration of care
2	Supporting informal carers
3	General nursing care
4	Technical nursing treatment or procedure
5	Counselling and emotional support
6	Teaching/education
7	Monitoring and surveillance
8	Formal case management
9	Service needs assessment only

Collection and usage attributes

Guide for use:

The following definitions are to assist in coding:

CODE 1 Coordination and collaboration of care

This code occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).

CODE 2 Supporting information carers

This code includes activities, which the nurse undertakes to assist the carer in the delivery of the carer's role. This does not include care given directly to the person. Examples of tasks involved in supporting the carer include: counselling, teaching, informing, advocacy, coordinating, and grief or bereavement support.

CODE 3 General nursing care

This code includes a broad range of activities, which the nurse performs to directly assist the person; in many cases, this assistance will focus on activities of daily living. This assistance will help a person whose health status, level of dependency, and/or therapeutic needs are such that nursing skills are required. Examples of tasks include: assistance with washing, grooming and maintaining hygiene, dressing, pressure area care, assistance with toileting, bladder and bowel care, assistance with mobility and therapeutic exercise, attention to physical comfort and maintaining a therapeutic environment.

CODE 4 Technical nursing treatment or procedure

This code refers to technical tasks and procedures for which nurses receive specific training and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. Some examples of technical care activities are: medication administration (including injections), dressings and other procedures, venipuncture, monitoring of dialysis, and implementation of pain management technology.

CODE 5 Counselling and emotional support

This code focuses on non-physical care given to the person, which aims to address the affective, psychological and/or social needs. Examples of these include: bereavement, well being, decision-making support and values-clarification.

CODE 6 Teaching/education

This code refers to providing information and/or instruction about a specific body of knowledge and/or procedure, which is relevant to the person's situation. Examples of teaching areas include: disease process, technical procedure, health maintenance, health promotion and techniques for coping with a disability.

CODE 7 Monitoring and surveillance

This code refers to any action by which the nurse evaluates and monitors physical, behavioural, social and emotional responses to disease, injury, and nursing or medical interventions.

CODE 8 Formal case management

This code refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as formal case management.

CODE 9 Service needs assessment only

This code is for assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and/or inappropriate referrals. Selection of this option means that no other intervention may be nominated. Thus, if an assessment for the domiciliary care benefit is the reason for a visit, but other interventions such as, counselling and support; coordination/collaboration of care are carried out, then the assessment only is not an appropriate code.

Data element attributes

Collection and usage attributes

Guide for use:

Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 07 in Community nursing service episode—goal of care, code NN must also be selected.

Collection methods:

Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the Community Nursing Minimum Data Set Australia (CNMDSA) interventions enabling the option of a rich level of detail of activities or summarised information.

Comments:

For the purposes of the CNMDSA, the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person's need. These summary categories subsume a range of specific actions or tasks.

The CNMDSA nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, 'technical nursing treatment' or 'procedure' is the generic term for a broad range of nursing activities such as medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA data element Nursing interventions or other more relevant code sets.

To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of nursing interventions is critical information for health service monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Origin:

Australian Council of Community Nursing Services 1997. Community Nursing Minimum Data Set Australia (CNMDSA), version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Nursing interventions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.24 KB)

Occasions of service (residential aged care services) — outreach/community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outreach/community), total N[NN]
METeOR identifier:	270308
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of service delivered by a residential aged care service employees to the patient in the home, place of work or other non-establishment site.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:	Required to adequately describe the services provided to non-admitted patients. Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.04 KB)

Occasions of service (residential aged care services)—outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outpatient), total N[NN]
METeOR identifier:	270290
Registration status:	Health, Standard 01/03/2005
Definition:	The number of occasions of service delivered by residential aged care service employees. Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the residential aged care service.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:	Required to adequately describe the services provided to non-admitted patients. Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.04 KB)

Oestrogen receptor assay status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—oestrogen receptor assay results, code N
METeOR identifier:	291324
Registration status:	Health, Standard 13/06/2004
Definition:	The result of oestrogen receptor assay at the time of diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer—oestrogen receptor assay results

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Test done, results positive (oestrogen receptor positive)
	2	Test done, results negative (oestrogen receptor negative)
Supplementary values:	0	Test not done (test not ordered or not performed)
	8	Test done but results unknown

Data element attributes

Collection and usage attributes

Comments:

Hormone receptor status is an important prognostic indicator for breast cancer.

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:

Royal College of Pathologists of Australasia

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons

and radiologists Second Edition Sydney (2001)
Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Oestrogen receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.8 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Onset of labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour onset type, code N
METeOR identifier:	269942
Registration status:	Health, Standard 01/03/2005
Definition:	The manner in which labour started in a birth event, as represented by a code.
Data Element Concept:	Birth event—labour onset type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Spontaneous
2	Induced
3	No labour

Supplementary values:

4	Not stated

Collection and usage attributes

Guide for use:

Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

CODE 3 No labour
Can only be associated with a caesarean section.

Data element attributes

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Onset of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.62 KB)
Implementation in Data Set Specifications:	Perinatal NMDS Health, Superseded 06/09/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

How labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

Ophthalmological assessment—outcome (left retina)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmological assessment outcome (left retina) (last 12 months), code N
METeOR identifier:	270472
Registration status:	Health, Standard 01/03/2005
Definition:	The result of an ophthalmological assessment for the left retina during the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Normal
2	Diabetes abnormality
3	Non-diabetes abnormality
4	Not visualised

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods:

Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;

- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: See also Person—ophthalmological assessment outcome (right retina) (last 12 months), code N Health, Standard 01/03/2005

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.48 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

Many diabetes eye related problems are asymptomatic and require appropriate eye assessment to be detected. Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone complications and prevent blindness in people with diabetes.

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

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

Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye;
- at subsequent examinations if declining visual acuity is detected
- if any retinal abnormality is detected;
- if clear view of retina is not obtained.

References:

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

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

US National Eye Institute.

Ophthalmological assessment—outcome (right retina)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmological assessment outcome (right retina) (last 12 months), code N
METeOR identifier:	270363
Registration status:	Health, Standard 01/03/2005
Definition:	The result of an ophthalmological assessment for the right retina during the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Normal
2	Diabetes abnormality
3	Non-diabetes abnormality
4	Not visualised

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods:

Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;

- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: See also Person—ophthalmological assessment outcome (left retina) (last 12 months), code N Health, Standard 01/03/2005

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.48 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

Many diabetes eye related problems are asymptomatic and require appropriate eye assessment to be detected. Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone complications and prevent blindness in people with diabetes.

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

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

Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye;
- at subsequent examinations if declining visual acuity is detected
- if any retinal abnormality is detected;
- if clear view of retina is not obtained.

References:

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

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

US National Eye Institute.

Ophthalmoscopy performed indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmoscopy performed indicator (last 12 months), code N
METeOR identifier:	302821
Registration status:	Health, Standard 21/09/2005
Definition:	Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist, as a part of the ophthalmological assessment, has been undertaken in the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmoscopy performed indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a fundus examination of eye has occurred. CODE 2 No: Record if a fundus examination of eye has not occurred.
Collection methods:	Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes Person—ophthalmoscopy performed status (previous 12 months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

Eye examinations should be commenced at the time diabetes is diagnosed. If no retinopathy is present, repeat the eye examination at least every 2 years. Once retinopathy is identified more frequent observation is required.

Diabetic retinopathy is a leading cause of blindness. Retinopathy is characterised by proliferation of the retina's blood vessels, which may project into the vitreous, causing vitreous haemorrhage, proliferation of fibrous tissue and retinal detachment. It is often accompanied by microaneurysms and macular oedema, which can express as a blurred vision. The prevalence of retinopathy increases with increasing duration of diabetes. In the early stage, retinopathy is asymptomatic, however up to 20% of people with diabetes Type 2 have retinopathy at the time of diagnosis of diabetes. Cataract and glaucoma are also associated diabetic eye problems that could lead to blindness.

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

References:

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

Diabetes: complications: Therapeutic Guidelines Limited (05.04.2002).

Organisation end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation end date, DDMMYYYY
METeOR identifier:	288733
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an establishment, agency or organisation stopped or concluded operations or practice.
Data Element Concept:	Service provider organisation—organisation end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Organisation expenses, total Australian currency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—expenses, total Australian currency NNNNN.N
METeOR identifier:	359963
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts, purchases of goods and services and consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- Salaries, wages and supplements
- Superannuation employer contributions
- Workers compensation premiums and payments
- Consumption of fixed capital (depreciation).
- Administrative expenses (excluding workers compensation premiums and payouts)
- Domestic services
- Drug supplies
- Food supplies
- Grants
- Medical and surgical supplies

- Patient transport
- Payments to visiting medical officers
- Repairs and maintenance
- Social benefits
- Subsidy expenses
- Other expenses

Collection methods:

Expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, reference: http://www.aasb.com.au/

Relational attributes

Related metadata references:

Is formed using Organisation—depreciation expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Is formed using Organisation—employee related expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Is formed using Organisation—purchase of goods and services, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Organisation name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (name)—organisation name, text [X(200)]
METeOR identifier:	288917
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The appellation by which an establishment, agency or organisation is known or called, as represented by text.
Data Element Concept:	Service provider organisation (name)—organisation name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(200)]
Maximum character length:	200

Data element attributes

Collection and usage attributes

Guide for use:	Generally, the complete establishment, agency or organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name. However, in certain circumstances (e.g. internal use), a short name (i.e. an abbreviated name by which the organisation is known) or a locally used name (e.g. where a medical practice is known by a name that is different to the company registration name) can be used. Further, a business unit within an organisation may have its own separate identity; this should be captured (as the unit name – see Organisation name type). More than one name can be recorded for an organisation. That is, this field is a multiple occurring field. At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Organisation revenues

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—revenue, total Australian currency NNNNN.N
METeOR identifier:	357510
Registration status:	Health, Standard 05/12/2007
Definition:	Revenues of an organisation relating to **patient fees**, **recoveries**, and **other revenue** in Australian currency.
Data Element Concept:	Organisation—revenue

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Revenues are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

Revenue arises from:

- the sale of goods,
- the rendering of services, and
- the use by others of entity assets yielding interest, royalties and dividends.

Goods includes goods produced by the entity for the purpose of sale and goods purchased for resale, such as merchandise purchased by a retailer or land and other property held for resale.

The rendering of services typically involves the performance by the entity of a contractually agreed task over an agreed period of time. The services may be rendered within a single period or over more than one period. Some contracts for the rendering of services are directly related to construction contracts, for example, those for the services of project managers and architects. Revenue arising from these contracts is not dealt with in this Standard but is dealt with in accordance with the requirements for construction contracts as specified in AASB 111 Construction Contracts.

The use by others of entity assets gives rise to revenue in the form of:

(a) interest – charges for the use of cash or cash equivalents or

amounts due to the entity;

(b) royalties – charges for the use of long-term assets of the entity, for example, patents, trademarks, copyrights and computer software; and

(c) dividends – distributions of profits to holders of equity investments in proportion to their holdings of a particular class of capital.

Revenue is the gross inflow of economic benefits during the period arising in the course of the ordinary activities of an entity when those inflows result in increases in equity, other than increases relating to contributions from equity participants.

Revenue includes only the gross inflows of economic benefits received and receivable by the entity on its own account.

Amounts collected on behalf of third parties such as sales taxes, goods and services taxes and value added taxes are not economic benefits which flow to the entity and do not result in increases in equity. Therefore, they are excluded from revenue. Similarly, in an agency relationship, the gross inflows of economic benefits include amounts collected on behalf of the principal and which do not result in increases in equity for the entity. The amounts collected on behalf of the principal are not revenue. Instead, revenue is the amount of commission.

Collection methods:

Revenues are to be reported for the *Source of public and private revenue* and *Health industry relevant organisation type* data elements.

Source of public and private revenue

State and territory health authorities are NOT to report the following codes:

Codes 101–103; 204; 207; 301

Health industry relevant organisation type

State and territory health authorities are NOT to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no. 5514.0.55.001) 10/10/2003.

Australian Accounting Standards Board 118, July 2007, <www.aasb.com.au>.

Relational attributes

Implementation in Data Set Specifications:

Government health expenditure function revenue data cluster Health, Standard 05/12/2007

Government health expenditure organisation revenue data element cluster Health, Standard 05/12/2007

Organisation start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation start date, DDMMYYYY
METeOR identifier:	288963
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an establishment, agency or organisation started or commenced operations or service.
Data Element Concept:	Service provider organisation—organisation start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

This field must—

- be a valid date;
- be less than or equal to the Organisation end date.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:

If the date is estimated in some way, it is recommended that the metadata item *Date accuracy indicator* also be recorded at the time of record creation to flag the accuracy of the data.

For data exchange and /or manipulation of data from diverse sources the *Date accuracy indicator* metadata item

must be used in conjunction with the *Organisation start date* in all instances to ensure data integrity and accuracy of analysis.

Other drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN
METeOR identifier:	270110
Registration status:	Health, Standard 01/03/2005
Definition:	A drug apart from the principal drug of concern which the client states as being a concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2000
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use:

Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type.

More than one drug may be selected. There should be no duplication with the principal drug of concern.

Collection methods:

Any other drug of concern for the client should be recorded upon commencement of a treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Comments:

This item complements principal drug of concern. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Other drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.41 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Other treatment type for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment type (other), code [N]
METeOR identifier:	270076
Registration status:	Health, Standard 01/03/2005
Definition:	All other forms of treatment provided to the client in addition to the main treatment type for alcohol and other drugs, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	[N]
Maximum character length:	1

Permissible values:

Value	Meaning
1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Other

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

Refers to any form of withdrawal management, including medicated and non-medicated.

CODE 2 Counselling

Refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This selection excludes counselling activity that is part of a rehabilitation program as defined in Code 3.

CODE 3 Rehabilitation

Refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

Data element attributes

Collection and usage attributes

Guide for use:

To be completed at cessation of treatment episode.

Only report treatment recorded in the client's file that is in addition to, and not a component of, the main treatment type for alcohol and other drugs. Treatment activity reported here is not necessarily for principal drug of concern in that it may be treatment for other drugs of concern.

More than one code may be selected.

Collection methods:

This field should be left blank if there are no other treatment types for the episode.

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Other treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.72 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Outcome of initial treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—outcome of treatment, code N.N
METeOR identifier:	289304
Registration status:	Health, Standard 04/06/2004
Definition:	The response of the tumour at the completion of the initial treatment modalities, as represented by a code.
Data Element Concept:	Cancer treatment—outcome of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N.N
Maximum character length:	2

Permissible values:

Value	Meaning
1.0	Complete response
2.1	Partial response
2.2	Stable or static disease
2.3	Progressive disease
2.9	Incomplete response

Supplementary values:

9.0	Not assessed or unable to be assessed

Collection and usage attributes

Guide for use:

CODE 1.0 Complete response

Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease.

CODE 2.1 Partial response

A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.

CODE 2.2 Stable or static disease

No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.

CODE 2.3 Progressive disease

An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.

Data element attributes

Source and reference attributes

Origin:	New South Wales Health Department

Reference documents: Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: Supersedes Outcome of initial treatment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.79 KB)

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This item is collected for assessing disease status at the end of primary treatment.

Outcome of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy outcome, code N
METeOR identifier:	270006
Registration status:	Health, Standard 01/03/2005
Definition:	Outcome of the most recent pregnancy preceding this pregnancy, as represented by a code.
Data Element Concept:	Pregnancy (last previous)—pregnancy outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Single live birth - survived at least 28 days
2	Single live birth - neonatal death (within 28 days)
3	Single stillbirth
4	Spontaneous abortion
5	Induced abortion
6	Ectopic pregnancy
7	Multiple live birth - all survived at least 28 days
8	Multiple birth - one or more neonatal deaths (within 28 days) or stillbirths

Data element attributes

Collection and usage attributes

Guide for use:	In the case of multiple pregnancy with fetal loss before 20 weeks, code on outcome of surviving fetus(es) beyond 20 weeks.
Comments:	This data item is recommended by the World Health Organization. It is collected in some states and territories. Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Outcome of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.67 KB)

Outpatient clinic type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—outpatient clinic type, code N[N]
METeOR identifier:	336952
Registration status:	Health, Standard 04/07/2007
Definition:	The organisational unit or organisational arrangement through which a hospital provides healthcare services in an outpatient setting, as represented by a code.
Data Element Concept:	Establishment—outpatient clinic type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Allied Health
2	Dental
3	Gynaecology
4	Obstetrics
5	Cardiology
6	Endocrinology
7	Oncology
8	Respiratory
9	Gastroenterology
10	Medical
11	General practice/primary care
12	Paediatric medical
13	Endoscopy
14	Plastic surgery
15	Urology
16	Orthopaedic surgery
17	Ophthalmology
18	Ear, nose and throat
19	Pre-admission and pre-anaesthesia
20	Chemotherapy
21	Dialysis
22	Surgery
23	Paediatric surgery
24	Renal medical

Collection and usage attributes

Guide for use:

The rules for allocating (mapping) clinic services to the clinic codes structure is the responsibility of each State and Territory and these rules need to be applied consistently within each State and Territory.

In most cases, reference to the code guide of permissible values will be adequate to map a hospital's clinics to the data domain. If not, general principles for mapping existing clinics to the data domain should take account of (a) the nature of the specialty, (b) patient characteristics, e.g. age, and (c) the field of practice of the service provider.

Where the patient characteristics have determined that a paediatric clinic type is appropriate, then further differentiation between surgical and medical is determined by (a) the nature of the specialty, and (b) the field of practice of the service provider. That is, paediatric medical would include any investigations, treatment(s) or services provided to a child which do not pertain to the surgical care of diseases or injuries.

In paediatric hospitals, the full range of clinic types should be used.

A guide for the permissible values of codes for the outpatient clinic types is as follows:

CODE 1 Allied Health

- Audiology.
- Clinical Pharmacology.
- Neuropsychology.
- Dietetics.
- Occupational therapy.
- Optometry.
- Orthoptics.
- Orthotics.
- Physiotherapy.
- Podiatry.
- Prosthetics.
- Psychology.
- Social work.
- Speech pathology.

Includes clinics specified in mapping list above run solely by these Allied Health (AH) professionals. Example: A speech Pathologist conducting a clinic with booked patients for speech pathology services.

Excludes services provided by AH professionals in clinics classified in codes 2-23. Example: a physiotherapist running a cardiac rehabilitation clinic is classified to the Cardiology Clinic (see code 5).

CODE 2 Dental

- Dental.

CODE 3 Gynaecology

- Gynaecology.
- Gynaecological oncology (excluding chemotherapy).
- Menopause.
- Assisted reproduction, infertility.

- Family planning.

CODE 4 Obstetrics

- Obstetrics.
- Childbirth education.
- Antenatal.
- Postnatal.

Excludes gestational diabetes (see code 6).

CODE 5 Cardiology

- Cardiac rehabilitation.
- ECG.
- Doppler.
- Cardiac stress test.
- Hypertension.
- Pacemaker.

Excludes cardiac catheterisation (see code 22).

CODE 6 Endocrinology

- Endocrine.
- Gestational diabetes.
- Thyroid.
- Metabolic.
- Diabetes.
- Diabetes education.

CODE 7 Oncology

- Oncology.
- Lymphoedema.
- Radiation oncology.

Excludes chemotherapy (see code 20).

Excludes gynaecological oncology (see code 3).

CODE 8 Respiratory

- Asthma.
- Asthma education.
- Respiratory; excludes tuberculosis (see code 10).
- Cystic Fibrosis.
- Sleep.
- Pulmonary.

CODE 9 Gastroenterology

- Gastroenterology.

Excludes endoscopy (see code 13).

CODE 10 Medical

- Aged care, geriatric, gerontology.
- Allergy.
- Anti-coagulant.
- Clinical Measurement; include with relevant specialty clinic type where clinical measurement services are specific to a specialty (see codes 1-23) e.g. urodynamic analysis is counted with Urology (see code 15).
- Dementia.
- Dermatology.
- Development disability.

- Epilepsy.
- Falls.
- General medicine.
- Genetic.
- Haematology, haemophilia.
- Hepatobiliary.
- Hyperbaric medicine.
- Immunology, HIV.
- Infectious diseases; Communicable diseases; Hep B, C; includes tuberculosis.
- Men's Health.
- Metabolic bone.
- Excludes Nephrology (see code 24); excludes renal (see code 24); excludes dialysis (see code 21).
- Neurology, neurophysiology.
- Occupational medicine.
- Other.
- Pain management
- Palliative.
- Refugee clinic.
- Rehabilitation; excludes cardiac rehabilitation (see code 5).
- Rheumatology.
- Sexual Health.
- Spinal.
- Stoma therapy.
- Transplants (excludes kidney transplants see code 24).
- Wound, Dressing clinic.

CODE 11 General practice/primary care

- General Practice, Primary Care.

Excludes Medicare billable patients; defined specialty general practice clinics only.

CODE 12 Paediatric Medical

- Adolescent health.
- Neonatology.
- Paediatric medicine.

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 13 Endoscopy

Includes all occasions of service for endoscopy including cystoscopy, gastroscopy, oesophagoscopy, duodenoscopy, colonoscopy, bronchoscopy, laryngoscopy, sigmoidoscopy.

Care must be taken to ensure procedures for admitted patients are excluded from this category.

CODE 14 Plastic surgery

- Craniofacial.
- Melanoma.
- Plastic surgery.

CODE 15 Urology

- Urology.

Includes urodynamic measurement and IVPs.

CODE 16 Orthopaedic surgery

- Fracture.
- Hand.
- Orthopaedics Surgery.
- Other.
- Scoliosis.
- Neck of femur.

CODE 17 Ophthalmology

- Ophthalmology.
- Cataract extraction.
- Lens insertion.

CODE 18 Ear, nose and throat

- Ear, nose and throat.
- Otitis media.
- Oral.

CODE 19 Pre-admission and pre-anaesthesia

- Pre-admission.
- Pre-anaesthesia.

CODE 20 Chemotherapy

Includes all forms of chemotherapy.

CODE 21 Dialysis

Dialysis and includes renal dialysis education. See code 24 for Renal medicine

CODE 22 Surgery

- Cardiac.
- Vascular.
- Cardiac catheterisation.
- Colorectal.
- Upper GI surgery.
- General surgery.
- Neurosurgery.
- Other surgery.
- Thoracic surgery.

CODE 23 Paediatric surgery

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 24 Renal Medical

- Renal Medicine.
- Nephrology.
- Includes pre and post transplant treatment, support and education.
- Excludes dialysis and renal dialysis education. See code 21

Source and reference attributes

Origin: National Centre for Classification in Health consultant's report to Outpatients National Minimum Data Set Development Working Group, September 2004.

Data element attributes

Collection and usage attributes

Guide for use: Does not include services provided through community health settings (such as community and child health centres).

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Group, 2006

Relational attributes

Related metadata references: See also Establishment—number of occasions of service, total N[NNNNNN] Health, Standard 04/07/2007

Supersedes Establishment—outpatient clinic type, code N[N] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Overdue patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—overdue patient status, code N
METeOR identifier:	270009
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a patient is an overdue patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—overdue patient status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Overdue patient
2	Other

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is only required for patients in Elective surgery waiting list episode—clinical urgency, code N categories with specified maximum desirable waiting times. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] or Elective surgery waiting list episode —waiting time (at a census date), total days N[NNN] and the maximum desirable time limit for the Elective surgery waiting list episode—clinical urgency, code N classification.

A patient is classified as overdue if ready for care and waiting time at admission or waiting time at a census date is longer than 30 days for patients in Elective surgery waiting list episode—clinical urgency, code N category 1 or 90 days for patients in Elective surgery waiting list episode—clinical urgency, code N category 2.

Comments:

This metadata item is not used for patients in Elective surgery waiting list episode—clinical urgency, code N category 3 as there is no specified timeframe within which it is desirable that they are admitted. The metadata item Elective surgery waiting list episode—extended wait patient indicator, status code N identifies patients in Elective surgery waiting list episode—

clinical urgency, code N category 3 who have waited longer than one year at admission or at the time of a census.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

See also Elective surgery waiting list episode—clinical urgency, code N Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005

Supersedes Overdue patient, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.39 KB)

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Palliative care agency service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—service delivery setting, palliative care agency code N
METeOR identifier:	297661
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which a **palliative care agency** delivers palliative care services, as represented by a code.
Data Element Concept:	Service provider organisation—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Private residence
2	Residential - aged care setting
3	Residential - other setting
4	Non-residential setting
5	Inpatient - designated palliative care unit or hospice
6	Inpatient - other than a designated palliative care unit
7	Outpatient - in a hospital/hospice

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Private residence

This may include a caravan, a mobile home, a houseboat or a unit in a retirement village.

CODE 2 Residential - aged care setting

Includes high and low care residential aged care facilities. Does not include units in a retirement village.

CODE 3 Residential - other setting

Includes a residential facility other than an aged care facility; a prison; or a community living environment including a group home. This code does not include inpatient settings e.g. hospitals and hospices.

CODE 4 Non-residential setting

Includes day respite centres and day centres. It does not include hospital outpatient departments.

CODE 5 Inpatient - designated palliative care unit or hospice

A dedicated ward or unit that receives identified funding for palliative care and/or primarily delivers palliative care. The unit may be a standalone unit (i.e. a hospice).

CODE 6 Inpatient - other than designated palliative care unit

Includes all beds not in a unit designated for palliative care. These are usually located in acute hospital wards. Excludes designated palliative care units.

CODE 7 Outpatient - in a hospital/hospice

Includes palliative care services provided at a hospital/hospice in an outpatient setting. Excludes all inpatient settings.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Parity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—parity, total N[N]
METeOR identifier:	302013
Registration status:	Health, Standard 29/11/2006
Definition:	The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.
Data Element Concept:	Female—parity

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

This is to be recorded for each pregnancy.

This data element includes live births and stillbirths of 20 weeks gestation or 400 grams birthweight.

This data element excludes:

- the current pregnancy;
- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and
- ectopic pregnancies.

A primigravida (a woman pregnant for the first time) has a parity of 0.

Collection methods:

A pregnancy with multiple fetuses is counted as one pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Partner organisation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—partner organisation type, palliative care code N[N]
METeOR identifier:	290715
Registration status:	Health, Standard 05/12/2007
Definition:	The type of organisation with which a palliative care service provider organisation has formal working partnership(s) in place, as represented by a code.
Data Element Concept:	Service provider organisation—partner organisation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Palliative care services
2	Hospitals
3	Community nursing agencies
4	Residential aged care facilities
5	Allied health services
6	Aboriginal health services
7	Medical practices
8	Integrated health centres
9	Universities/research centres
10	Volunteer support services
99	Other

Data element attributes

Collection and usage attributes

Guide for use:

A formal working partnership involves arrangements between a service provider organisation and other service providers and organisations, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships

include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

Where partnerships exist for case conferencing purposes, record all partners involved.

CODE 1 Palliative care services

Includes services whose substantive work is with patients who have a life-limiting illness. These palliative care services may provide services in the community and/or in admitted patient settings (including hospices).

CODE 2 Hospitals

Includes emergency departments. Excludes hospices/designated palliative care units in a hospital, and other palliative care agencies as defined under Code 1. Also excludes hospital-based allied health services and individual medical practitioners.

CODE 7 Medical practices

Includes practices of general practitioners and individual specialist physicians such as specialists in palliative care, oncologists, urologists and neurologists.

CODE 8 Integrated health centres

Includes multipurpose centres, aged care centres and specialist care centres such as cancer centres.

CODE 9 Universities/research centres

Includes universities that may undertake research and development projects.

CODE 99 Other

Includes organisations based in the community such as schools, clubs, workplaces, organisations that provide respite care or pastoral care and 'Meals on wheels'.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation—working partnerships indicator, yes/no code N* is 'yes' (code 1).

Patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of patient days, total N[N(7)]
METeOR identifier:	270045
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
Data Element Concept:	Establishment—number of patient days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(7)]
Maximum character length:	8
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of patient days for **overnight stay patients**:

- The day the patient is admitted is a patient day
- If the patient remains in hospital from midnight to 2359 hours count as a patient day
- The day a patient goes on leave is counted as a leave day
- If the patient is on leave from midnight to 2359 hours count as a leave day
- The day the patient returns from leave is counted as a patient day
- The day the patient is separated is not counted as a patient day.

The following additional rules cover special circumstances and in such cases, override the basic rules:

- Patients admitted and separated on the same date (**same-day patients**) are to be given a count of one patient day
- If the patient is admitted and goes on leave on the same day, count as a patient day
- If the patient returns from leave and goes on leave on the same date, count as a leave day.
- If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.
- If a patient goes on leave the day they are admitted and does not return from leave until the day they are

discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

When calculating total patient days for a specified period:

- Count the total patient days of those patients separated during the specified period including those admitted before the specified period
- Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period
- Contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element: total contract patient days.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is formed using Episode of admitted patient care (newborn) — number of qualified days, total N[NNNN] Health, Standard 01/03/2005

Supersedes Patient days, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.19 KB)

Patient listing status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—patient listing status, readiness for care code N
METeOR identifier:	269996
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—patient listing status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ready for care
2	Not ready for care

Data element attributes

Collection and usage attributes

Guide for use:

A patient may be 'ready for care' or 'not ready for care'. Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time; or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability; for example, surgeon unavailable,

operating theatre time unavailable owing to emergency workload. These patients are still 'ready for care'.

Periods when patients are not ready for care should be excluded in determining 'Waiting time (at removal)' and 'Waiting time (at a census date)'.

Comments:

Only patients ready for care are to be included in the National Minimum Data Set - Elective surgery waiting times. The dates when a patient listing status changes need to be recorded. A patient's classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes **clinical review**. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (metadata item Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate the metadata items Patient listing status, readiness for care and Clinical urgency as the combination of these items had led to confusion.

Source and reference attributes

Submitting organisation:

Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Patient listing status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.69 KB)

Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Patient present status (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—patient present status, code N
METeOR identifier:	270081
Registration status:	Health, Standard 01/03/2005
Definition:	The presence or absence of a patient at a service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—patient present status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Patient present with or without carer(s)/relative(s)
2	Carer(s)/relative(s) of the patient only

Data element attributes

Collection and usage attributes

Guide for use:	A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Relational attributes

Related metadata references:	Supersedes Non-admitted patient service event - patient present status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.36 KB)

Patients in residence at year end

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—patients/clients in residence at year end, total N[NNN]
METeOR identifier:	270046
Registration status:	Health, Standard 01/03/2005
Definition:	A headcount of all formally admitted patients/clients in residence in long-stay facilities.
Data Element Concept:	Establishment—patients/clients in residence at year end

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Person

Data element attributes

Collection and usage attributes

Collection methods:	For public psychiatric hospitals and alcohol and drug hospitals, all states have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Ageing is able to carry out a statistical census from its residential aged care service databases. A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach. There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds. Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.
Comments:	The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

Source and reference attributes

Submitting organisation:	Morbidity working party

Relational attributes

Related metadata references: Supersedes Patients in residence at year end, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.89 KB)

Perineal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (mother)—postpartum perineal status, code N
METeOR identifier:	269939
Registration status:	Health, Standard 01/03/2005
Definition:	The state of the perineum following birth, as represented by a code.
Context:	Perinatal
Data Element Concept:	Female (mother)—postpartum perineal status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
6	Combined laceration and episiotomy
7	4th degree laceration
8	Other

Supplementary values:

9	Not stated

Collection and usage attributes

Guide for use:	Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.
Comments:	While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a new data domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing data domain identifier.

Data element attributes

Collection and usage attributes

Comments: Perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational attributes

Related metadata references: Supersedes Perineal status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.78 KB)

Period of residence in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—period of residence in Australia, years code NN
METeOR identifier:	270050
Registration status:	Health, Standard 01/03/2005
Definition:	Length of time in years a person has lived in Australia.
Data Element Concept:	Person—period of residence in Australia

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
00	Under one year residence in Australia
01-97	1 to 97 years residence in Australia
98	Born in Australia

Supplementary values:

99	Unknown

Data element attributes

Collection and usage attributes

Collection methods:

This information may be obtained either from:

- a direct question with response values as specified in the data domain; or
- derived from other questions about date of birth, birthplace and year of arrival in Australia.

Comments:

This metadata item was included in the recommended second-level data set by the National Committee on Health and Vital Statistics (1979) to allow analyses relating to changes in morbidity patterns of ethnic subpopulations related to length of stay in host country; for example, cardiovascular disease among Greek immigrants in Australia.

This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only the country of birth and Indigenous status are considered by the National Health Data Committee to be justified for inclusion in the National Minimum Data Set - Admitted patient care.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Period of residence in Australia, version 1, DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Peripheral neuropathy (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral neuropathy indicator, code N
METeOR identifier:	302457
Registration status:	Health, Standard 21/09/2005
Definition:	Whether peripheral neuropathy is present, as represented by a code.
Data Element Concept:	Person—peripheral neuropathy indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if peripheral neuropathy is present in the person. CODE 2 No: Record if peripheral neuropathy is not present in the person. Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a Biothesiometer) or Monofilament.
Collection methods:	Examine for neuropathy by testing reflexes and sensation preferably using tuning fork (standard vibration fork 128 hz), pinprick, 10g monofilament and/or biothesiometer. The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise. 1 The 'Touch-Test' Sensory Evaluation (Semmens-Weinstein Monofilaments) application guidelines: • Occlude the patient's vision by using a shield or by having

the patient look away or close his or her eyes.

- Instruct the patient to respond when a stimulus is felt by saying 'touch' or 'yes'.
- Prepare to administer the stimulus to the foot (dorsal or plantar surface).
- Press the filament of the Touch
- Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:

- The patient must not be able to view the administration of the stimuli so that false indications are avoided.
- The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
- If the patient does not feel the filament, then protective pain sensation has been lost.

2 Testing vibration sensation with a biothesiometer - application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30-40 volts.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

1997 North Coast Medical, INC. San Jose, CA 95125; 800 821 - 9319

Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. Military Medicine, 155:575-579

Bell- Krotovski OTR, FAOT, FAOTA, Judith and Elizabeth Tomancik LOTR. 1987.The Repeatability of testing with Semmens-Weinstein Monofilaments. 'The Journal of Hand Surgery,' 12A: 155 - 161

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42

Foot Examination -an interactive guide; Aust Prescr 2002; 25:8 - 10

Relational attributes

Related metadata references: Supersedes Person—peripheral neuropathy status, code N

Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

The most important aspect of grading diabetic neuropathy from a foot ulceration point of view is to assess the degree of loss of sensation in the feet.

Diabetic neuropathy tends to occur in the setting of long-standing hyperglycaemia.
Peripheral neuropathy, which affects about 30% of people with either type 1 or type 2 diabetes, is the major predisposing disorder for diabetic foot disease. Peripheral neuropathy in feet results in loss of sensation and autonomic dysfunction. Neuropathy can occur either alone (neuropathic feet) or in combination with peripheral vascular disease causing ischaemia (neuro-ischaemic feet). Purely ischaemic feet are unusual, but are managed in the same way as neuro-ischaemic feet (see Australian Diabetes Society - Position Statement - The Lower Limb in People With Diabetes).

As stated by Duffy and others, the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

Diabetes polyneuropathy is frequently asymptomatic but may be associated with numbness, tingling and paraesthesia in the extremities, and less often with hyperesthesias. The most common form is a distal, symmetric, predominantly sensory polyneuropathy, which begins and is usually most marked in the feet and legs.
If symptomatic neuropathy is present consult with endocrinologist or physician specialising in diabetes care since options are available for the relief of symptoms.

Peripheral nerve function should be checked at least yearly in the patient with diabetes.

Peripheral vascular disease in feet (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral vascular disease indicator (foot), code N
METeOR identifier:	302459
Registration status:	Health, Standard 21/09/2005
Definition:	Whether peripheral vascular disease is present in either foot, as represented by a code.
Data Element Concept:	Person—peripheral vascular disease indicator (foot)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if peripheral vascular disease is present in either foot. CODE 2 No: Record if peripheral vascular disease is not present in either foot.
Collection methods:	If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration. Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be impaired. Palpate pulses: The simplest method to estimate blood flow and to detect ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular

disease is small.

Test capillary return:

A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1 - 2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:

If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could be completed by measuring the ankle brachial index (ankle pressure/ brachial pressure). Normal ankle brachial index is 0.9 - 1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Person—peripheral vascular disease status (foot), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Peripheral vascular disease is the leading cause of occlusion of blood vessels of the extremities with increasing prevalence in individuals with hypertension, hypercholesterolemia and diabetes mellitus, and in cigarette smokers.

Peripheral vascular disease is estimated to occur 11 times more frequently and develop about 10 years earlier in people with diabetes.

Presence of symptomatic peripheral vascular disease requires an interdisciplinary approach including a vascular surgeon, an endocrinologist or physician specialising in diabetes care.

References:

Foot Examination - an interactive guide; Australian Prescriber

Person identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—person identifier, XXXXXX[X(14)]
METeOR identifier:	290046
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Person identifier unique within an establishment or agency.
Data Element Concept:	Person—person identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX[X(14)]
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use:	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems. Field cannot be blank.

Source and reference attributes

Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person—person identifier (within establishment/agency), XXXXXX[X(14)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008

Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:
Field cannot be blank.

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
Field cannot be blank.

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Person identifier type—health care (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (identifier)—identifier type, geographic/administrative scope code A
METeOR identifier:	270053
Registration status:	Health, Standard 01/03/2005
Definition:	A code based on the geographical or administrative breadth of applicability of Person identifier.
Data Element Concept:	Person (identifier)—identifier type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
L	Local
A	Area/region/district
S	State or territory

Collection and usage attributes

Guide for use:

CODE L Local

This code is for an identifier that is applicable only inside the issuing health care establishment

CODE A Area/region/district

This code is for an identifier that is applicable to:

- all the area/region/district health care services but not across all services in the state or territory; or
- all of a specific health care service (e.g. community mental health) in an area/region/district health care services but not across all those services in the state or territory

CODE S State or territory

This code is for identifiers that are applicable across all state or territory health care services.

Data element attributes

Collection and usage attributes

Guide for use:

A person can have more than one person identifier. Each Person identifier must have an appropriate person identifier type code recorded.

Use this field to record only identifier type. It must not be used to record any other person related information.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS5017 Health Care Client Identification

Relational attributes

Related metadata references:	Supersedes Person identifier type - health care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.73 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005 Health care client identification DSS Health, Standard 04/05/2005

Physical activity sufficiency status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—physical activity sufficiency status, code N
METeOR identifier:	270054
Registration status:	Health, Standard 01/03/2005
Definition:	Sufficiency of moderate or vigorous physical activity to confer a health benefit, as represented by a code.
Data Element Concept:	Person—physical activity sufficiency status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Sufficient
	2	Insufficient
	3	Sedentary
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:

CODE 1:

Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity.

Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.

CODE 2:

Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.

CODE 3:

Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.

CODE 9:

There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.

Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult.

Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.

Comments:

The above grouping subdivides a population into three mutually exclusive categories.

A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity - health benefit for vigorous physical activity is calculated by:

- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate and/or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.

A sedentary person is a person who does not engage in any regular weekly physical activity.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: The National Heart Foundation of Australia's Physical Activity Policy, April 2001. National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion

Relational attributes

Related metadata references: Supersedes Physical activity sufficiency status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.53 KB)

Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Place of occurrence of external cause of injury (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361677
Registration status:	Health, Standard 05/02/2008
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patient: Use External Causes of Morbidity and Mortality Place of Occurrence codes from the current edition of ICD-10-AM. Used with all ICD-10-AM external cause codes and assigned according to the Australian Coding Standards. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code. External cause codes V01 to Y34 must be accompanied by an activity code.
Comments:	Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Source and reference attributes

Origin:	National Health Data Committee National Centre for Classification in Health AIHW National Injury Surveillance Unit National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:	Supersedes Injury event—place of occurrence, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008
Implementation in Data Set Specifications:	Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008 *Information specific to this data set:* To be used with ICD-10-AM external cause codes. Injury surveillance DSS Health, Standard 05/02/2008

Place of occurrence of external cause of injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, non-admitted patient code N[N]
METeOR identifier:	268949
Registration status:	Health, Standard 01/03/2005
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

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

Supplementary values:

9	Unspecified place

Data element attributes

Collection and usage attributes

Guide for use:	To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the

one that comes first in the code list.

Source and reference attributes

Origin:

National Centre for Classification in Health

AIHW National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Place of occurrence of external cause of injury, version 6, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.14 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Standard 05/02/2008

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Postal delivery point identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	287220
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	A unique number assigned to a person's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Person (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Australia Post maintains a Postal Address File (PAF) database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a Delivery Point Identifier (DPID). While the PAF is concerned with postal address, for many persons' a postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data collection. The Postal Address File may be used at the time of data collection to confirm that the combined metadata items of address line, suburb/town/locality, Australian state/territory identifier and postcode - Australian are accurately recorded.
Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
Comments:	In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it

collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Is formed using Person (address)—suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Supersedes Person (address)—postal delivery point identifier, {N(8)} Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Postal delivery point identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	290141
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	A unique number assigned to a service provider organisation's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Service provider organisation (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
Comments:	In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses. The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information,

contact Australia Post.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Standards Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Is formed using Service provider organisation (address) – suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005, Community services, Standard 31/08/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Postal delivery service number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery service type identifier, [X(11)]
METeOR identifier:	270032
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for the postal delivery service where a person is located.
Data Element Concept:	Person (address)—postal delivery service type identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(11)]
Maximum character length:	11

Data element attributes

Collection and usage attributes

Guide for use:	The identification of a postal delivery service may be composed of a prefix, a number, and a suffix as per the following format: Prefix A(3) Number N(5) Suffix A(3) May optionally include a prefix and suffix which are non-numeric. The identification may also not be required for certain services. Examples: PO BOX C96 CARE PO RMB 123 GPO BOX 1777Q
Collection methods:	To be collected in conjunction with Postal delivery service type - abbreviation.

Source and reference attributes

Origin:	Health Data Standards Committee AS4590 Interchange of client information

Relational attributes

Related metadata references:	Supersedes Postal delivery service number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Postal delivery service type - abbreviation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—postal delivery service type, code AA[A(9)]
METeOR identifier:	270027
Registration status:	Health, Standard 01/03/2005
Definition:	Type of postal delivery service for a person, as represented by a code.
Data Element Concept:	Person—postal delivery service type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AA[A(9)]
Maximum character length:	11

Permissible values:

Value	Meaning
CARE PO	Care-of Post Office (also known as Poste Restante)
CMA	Community Mail Agent
CMB	Community Mail Bag
GPO BOX	General Post Office Box
LOCKED BAG	Locked Mail Bag Service
MS	Mail Service
PO BOX	Post Office Box
PRIVATE BAG	Private Mail Bag Service
RSD	Roadside Delivery
RMB	Roadside Mail Box/Bag
RMS	Roadside Mail Service

Collection and usage attributes

Collection methods:	To be collected in conjunction with Person (address)—postal delivery service type identifier, [X(11)] when applicable.

Source and reference attributes

Origin:	AS4590 Interchange of client information

Data element attributes

Source and reference attributes

Origin:	Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Postal delivery service type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.48 KB)

Postcode—Australian (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	287224
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Data Element Concept:	Person (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:

Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.

When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).

Data element attributes

Collection and usage attributes

Guide for use:

The postcode book is updated more than once annually; as postcodes are a dynamic entity and are constantly changing.

Collection methods:

Leave Postcode - Australian blank for:

- Any overseas address
- Unknown address
- No fixed address.

May be collected as part of Address line or separately. Postal

addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Reference documents: AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Australia Post Postcode book. Reference through:

http://www1.auspost.com.au/postcodes/

Relational attributes

Related metadata references: See also Person—Australian state/territory identifier, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Supersedes Person (address)—Australian postcode (Postcode datafile), code NNN[N] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Person—geographic location, community services code (ASGC 2004) NNNNN Community services, Superseded 02/05/2006

Is used in the formation of Dwelling—geographic location, remoteness structure code (ASGC 2004) N[N] Housing assistance, Retired 10/02/2006

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

The postcode can also be used in association with the Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA) index (Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA), Australia (CD-ROM) to derive socio-economic disadvantage, which is associated with cardiovascular risk.

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

This difference in death rates has existed since at least the 1970s.

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI) the suggested question is:

What is your postcode?

(Single response)

Enter Postcode

Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Postcode—Australian (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	290064
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:	Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).

Data element attributes

Collection and usage attributes

Collection methods:	May be collected as part of Address line or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee

	National Community Services Data Committee Australia Post Postcode book. Reference through: http://www1.auspost.com.au/postcodes/
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Postcode—international (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—international postcode, text [X(10)]
METeOR identifier:	288985
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of a person, as defined by the postal service of a country other than Australia, as represented by text.
Data Element Concept:	Person (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from a person and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Postcode—international (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—international postcode, text [X(10)]
METeOR identifier:	288987
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as defined by the postal service of a country other than Australia.
Data Element Concept:	Service provider organisation (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from an organisation and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Postpartum complication

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication (postpartum), code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361067
Registration status:	Health, Standard 05/02/2008
Definition:	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.
Data Element Concept:	Birth event—complication (postpartum)

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Comments:	Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	International Classification of Diseases - 10th Revision, Australian Modification (6th Edition 2005) National Centre for Classification in Health, Sydney.

Relational attributes

Related metadata references:	Supersedes Birth event—complication (postpartum), code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Preferred language

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—preferred language, code (ASCL 2005) NN{NN}
METeOR identifier:	304128
Registration status:	Health, Standard 08/02/2006 Community services, Standard 29/04/2006
Definition:	The language (including sign language) most preferred by the person for communication, as represented by a code.
Data Element Concept:	Person—preferred language

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2005
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denote that it is an Eastern European language, while 31 denote that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denote that it is an Australian Indigenous language and 87 denote that the language is Western Desert language.

Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Guide for use:

This may be a language other than English even where the person can speak fluent English.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS cat. no. 1267.0. Australian Standard Classification of Languages (ASCL), 2005-06. Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references: See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006

Supersedes Person—preferred language, code NN Health, Superseded 08/02/2006

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Pregnancy—current status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female— pregnancy indicator (current), code N
METeOR identifier:	302817
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the female person is currently pregnant, as represented by a code.
Data Element Concept:	Female— pregnancy indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the female individual currently pregnant. CODE 2 No: Record if the female individual not currently pregnant.
Collection methods:	Ask the individual if she is currently pregnant.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Female—current pregnancy status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005 *Information specific to this data set:* Pregnancy in women with pre-existing diabetes is a

potentially serious problem for both the mother and fetus. Good metabolic control and appropriate medical and obstetric management will improve maternal and fetal outcomes. The diagnosis or discovery of diabetes in pregnancy (gestational diabetes), identifies an at risk pregnancy from the fetal perspective, and identifies the mother as at risk for the development of type 2 diabetes later in life.

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus diabetes management during pregnancy includes:

- routine medical review every 2-3 weeks during the first 30 weeks and then every 1-2 weeks until delivery
- monitor HbA1c every 4-6 weeks or more frequently if indicated to ensure optimal metabolic control during pregnancy
- advise patients to monitor blood glucose frequently and urinary ketones
- initial assessment and on going monitoring for signs or progression of diabetes complications
- regular routine obstetric review based on the usual indicators.

Management targets

- Blood glucose levels:

  Fasting Post-prandial
- HbA1c levels within normal range for pregnancy. (The reference range for HbA1c will be lower during pregnancy).
- The absence of any serious or sustained ketonuria.

Normal indices for fetal and maternal welfare. Oral hypoglycaemic agents are contra-indicated during pregnancy and therefore women with pre-existing diabetes who are treated with oral agents should ideally be converted to insulin prior to conception.

What to do if unsatisfactory metabolic control:

- explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise, and review management,
- review and adjust treatment,
- consider referral to diabetes educator, dietician, endocrinologist or physician experienced in diabetes care, or diabetes centre.

Premature cardiovascular disease family history (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—premature cardiovascular disease family history status, code N
METeOR identifier:	270280
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years, as represented by a code.
Data Element Concept:	Person—premature cardiovascular disease family history status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
	3	Family history status not known
Supplementary values:	9	Not recorded

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1: Yes, the person has a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 2: No, the person does not have a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 3: Family history status not known, the existence of a premature family history for cardiovascular disease cannot be determined.

CODE 9: Not recorded, the information as to the existence of a premature family history for cardiovascular disease has not been recorded.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Guidelines Subcommittee of the World Health Organization/International Society of Hypertension (WHO-ISH): 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17: 151 - 83.

Relational attributes

Related metadata references:

Supersedes Premature cardiovascular disease family history - status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.46 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:
Having a family history of cardiovascular disease (CVD) is a risk factor for CVD and the risk increases if the event in the family member occurs at a young age. For vascular risk assessment a premature family history is considered to be present where a first-degree relative under age 60 years (woman or man) has had a vascular event/condition diagnosed. The evidence of family history being a strong risk factor for stroke only applies to certain limited stroke subtypes in certain populations.

Presentation at birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth presentation, code N
METeOR identifier:	299992
Registration status:	Health, Standard 06/09/2006
Definition:	The presenting part of the fetus at birth, as represented by a code.
Data Element Concept:	Birth event—birth presentation

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Vertex
2	Breech
3	Face
4	Brow
8	Other
Supplementary values: 9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	Compound presentations (where an extremity prolapses simultaneously alongside the presenting part) should be coded to '8 Other'. All other malpresentations, including for example, cord, shoulder or hand, should be coded to '8 Other'.
Collection methods:	In the case of multiple births, presentation should be recorded for each baby born.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—birth presentation, code N Health, Superseded 06/09/2006

Implementation in Data Set Specifications:

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Previous pregnancies—ectopic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (ectopic), total NN
METeOR identifier:	269936
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in ectopic pregnancy.
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Previous pregnancies, version 1, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (15.06 KB)

Previous pregnancies—induced abortion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (induced abortion), total NN
METeOR identifier:	269935
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in induced abortion (termination of pregnancy before 20 weeks' gestation).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.06 KB)

Previous pregnancies—live birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (live birth), total NN
METeOR identifier:	269931
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in **live birth**.
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Previous pregnancies, version 1, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (15.06 KB)

Previous pregnancies—spontaneous abortion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (spontaneous abortion), total NN
METeOR identifier:	269934
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g **birthweight** if gestational age is unknown).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

A previous history of spontaneous abortion identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.06 KB)

Previous pregnancies—stillbirth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (stillbirth), total N[N]
METeOR identifier:	269933
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in stillbirth (- at least 20 weeks' gestational age or 400 g **birthweight**).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

A previous history of stillbirth identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.06 KB)

Previous specialised treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—previous specialised treatment, code N
METeOR identifier:	270374
Registration status:	Health, Standard 01/03/2005
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, as represented by a code.
Data Element Concept:	Patient—previous specialised treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided

Supplementary values:

Value	Meaning
5	Unknown/not stated

Collection and usage attributes

Guide for use:

CODE 1 Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided

Use this code for admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission.

CODES 2-4 These codes include patients who have been seen at any time in the past within the speciality within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).

CODE 2 Patient has previous hospital admission(s) but no

service contact(s) for the specialised treatment now being provided

CODE 3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided

CODE 4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided

Data element attributes

Collection and usage attributes

Comments:

This metadata item was originally developed in the context of mental health institutional care data development (originally metadata item Problem status and later First admission for psychiatric treatment). More recent data development work, particularly in the area of palliative care, led to the need for this item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Previous specialised treatment, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.68 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
For palliative care, the value of this item is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this metadata item in this way would be improved by the reporting of this data by community-based services.

Primary site of cancer (ICD-10-AM code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary site of cancer, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361937
Registration status:	Health, Standard 05/02/2008
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.
Data Element Concept:	Person with cancer—primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer. In ICD-10-AM (5th edition), primary site is identified using a single 4 digit code Cxx.x or Dxx.x.

Source and reference attributes

Reference documents:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

Data element attributes

Collection and usage attributes

Collection methods:	In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department. Hospitals use Diagnosis codes from ICD-10-AM (6th edition). Valid codes must start with C or D. In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a Principal diagnosis or an Additional diagnosis as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10. Some ICD-10-AM (6th edition) diagnosis codes e.g. mesothelioma and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even

where the primary site is unknown.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes Person with cancer—primary site of cancer, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Primary site of cancer (ICDO-3 code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary site of cancer, code (ICDO-3) ANN{.N[N]}
METeOR identifier:	270178
Registration status:	Health, Standard 01/03/2005
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICDO-3 code.
Data Element Concept:	Person with cancer—primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:

Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.

In ICDO, primary site is identified using both the Cxx.x code identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Data element attributes

Collection and usage attributes

Collection methods:	Cancer registries use Site codes from ICDO 3rd edition.

Source and reference attributes

Origin:	World Health Organization

Relational attributes

Related metadata references:

Supersedes Primary site of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.45 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This information is collected for the purpose of:

- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type
- monitoring the number of new cases of cancer for planning treatment services
- epidemiological studies.

Principal area of clinical practice

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—area of clinical practice (principal), code ANN
METeOR identifier:	270144
Registration status:	Health, Standard 01/03/2005
Definition:	Principal area of clinical practice is defined as either the field of principal professional clinical activity or the primary area of responsibility, depending on the profession, as represented by a code.
Data Element Concept:	Health professional—area of clinical practice (principal)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A11	General Practitioner (GP)/primary medical care practitioner - general practice
A12	GP/primary medical care practitioner - a special interest area (specified)
A21	GP/primary medical care practitioner - vocationally registered
A22	GP/primary medical care practitioner - holder of fellowship of Royal Australian College of General Practitioners (RACGP)
A23	GP/primary medical care practitioner - RACGP trainee
A24	GP/primary medical care practitioner - other
B31	Non-specialist hospital (salaried) - Resident Medical Officer (RMO)/intern
B32	Non-specialist hospital (salaried) - other hospital career
B41	Non-specialist hospital (salaried) - holder of Certificate of Satisfactory Completion of Training
B42	Non-specialist hospital (salaried) - RACGP trainee
B44	Non-specialist hospital (salaried) - other
B51	Non-specialist hospital (salaried) - specialist (includes private and hospital)
B52	Non-specialist hospital (salaried) - specialist in training (e.g. registrar)

B90	Non-specialist hospital (salaried) - not applicable
C01	Nurse labour force - mixed medical/surgical nursing
C02	Nurse labour force - medical nursing
C03	Nurse labour force - surgical nursing
C04	Nurse labour force - operating theatre nursing
C05	Nurse labour force - intensive care nursing
C06	Nurse labour force - paediatric nursing
C07	Nurse labour force - maternity and obstetric nursing
C08	Nurse labour force - psychiatric/mental health nursing
C09	Nurse labour force - developmental disability nursing
C10	Nurse labour force - gerontology/geriatric nursing
C11	Nurse labour force - accident and emergency nursing
C12	Nurse labour force - community health nursing
C13	Nurse labour force - child health nursing
C14	Nurse labour force - school nursing
C15	Nurse labour force - district/domiciliary nursing
C16	Nurse labour force - occupational health nursing
C17	Nurse labour force - private medical practice nursing
C18	Nurse labour force - independent practice
C19	Nurse labour force - independent midwifery practice
C20	Nurse labour force - no one principal area of practice
C98	Nurse labour force - other (specify)
C99	Nurse labour force - unknown/inadequately described/not stated

Data element attributes

Collection and usage attributes

Guide for use: Specifics will vary for each profession as appropriate and will be reflected in the classification/coding that is applied. Classification within the National Health Labour Force Collection is profession-specific.

Comments: The nursing labour force-specific codes are subject to revision because of changes in the profession and should be read in the context of the comments below.

It is strongly recommended that, in the case of the nurse labour force, further disaggregation be avoided as much as possible.

The reason for this recommendation is that any expansion of the classification to include specific specialty areas (e.g. cardiology, otorhinolaryngology, gynaecology etc.) will only capture data from hospitals with dedicated wards or units; persons whose clinical practice includes a mix of cases within a single ward setting (as in the majority of country and minor metropolitan hospitals) will not be included in any single specialty count, leading to a risk of the data being misinterpreted. The data would show a far lower number of practitioners involved in providing services to patients with some of the listed specialty conditions than is the case.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Principal area of clinical practice, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.66 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

To analyse distribution of clinical service providers by the area of their principal clinical practice. Cross-classified with other data, this metadata item allows analysis of geographic distribution and profiles of population subsets. Required for health labour force modelling.

Principal diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361034
Registration status:	Health, Standard 05/02/2008
Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.
Data Element Concept:	Episode of care—principal diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM. For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups. Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes cannot be used as principal diagnosis.
Collection methods:	A principal diagnosis should be recorded and coded upon **separation**, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.
Comments:	The principal diagnosis is one of the most valuable health data

elements. It is used for epidemiological research, casemix studies and planning purposes.

Source and reference attributes

Origin:

Health Data Standards Committee

National Centre for Classification in Health

National Data Standard for Injury Surveillance Advisory Group

Reference documents:

Bramley M, Peasley K, Langtree L and Innes K 2002. The ICD-10-AM Mental Health Manual: an integrated classification and diagnostic tool for community-based mental health services. Sydney: National Centre for Classification in Health, University of Sydney

Relational attributes

Related metadata references:

Supersedes Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Implementation in Data Set Specifications:

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

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

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
Effective for collection from 01/07/2006

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

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

Effective for collection from 01/07/2006

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

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

The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).

Principal drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN
METeOR identifier:	270109
Registration status:	Health, Standard 01/03/2005
Definition:	The main drug, as stated by the client, that has led a person to seek treatment from the service, as represented by a code.
Context:	Required as an indicator of the client's treatment needs.
Data Element Concept:	Episode of treatment for alcohol and other drugs—drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2000
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499

categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use:

The principal drug of concern should be the main drug of concern to the client and is the focus of the client's treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client's referral should be chosen.

Collection methods:

To be collected on commencement of the treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Principal drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.54 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Principal role of health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—principal role, code N
METeOR identifier:	270145
Registration status:	Health, Standard 01/03/2005
Definition:	The principal role in which the health professional usually works the most hours each week, as represented by a code.
Data Element Concept:	Health professional—principal role

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Clinician
2	Administrator
3	Teacher/educator
4	Researcher
5	Public health/health promotion
6	Occupational health
7	Environmental health
Supplementary values: 9	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE 1 Clinician

A clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).

CODE 2 Administrator

An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, e.g. directors of nursing, medical superintendents, medical advisors in government health authorities, health profession union administrators (e.g. Australian Medical Association, Australian Nurses Federation).

CODE 3 Teacher/educator

A teacher/educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.

CODE 4 Researcher

A researcher in a health profession is a person whose main job

is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug companies and other bodies.

CODES 5 - 7

CODE 5 Public health/health promotion

CODE 6 Occupational health

CODE 7 Environmental health

Public health/health promotion, occupational health and environmental health are specialties in medicine, and fields of practice for some other health professions. They are public health rather than clinical practice, and hence are excluded from clinical practice.

Data element attributes

Collection and usage attributes

Collection methods: For respondents indicating that their principal professional role is in clinical practice, a more detailed identification of that role is established according to profession-specific categories.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Principal role of health professional, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.08 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

This metadata item provides information on the principal professional role of respondents who currently work within the broad context/discipline field of their profession (as determined by the metadata item Professional labour force status). Identification of clinicians provides comparability with other labour force collections that just include clinicians.

Procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—procedure, code (ACHI 6th edn) NNNNN-NN
METeOR identifier:	361687
Registration status:	Health, Standard 05/02/2008
Definition:	A clinical intervention represented by a code that: • is surgical in nature, and/or • carries a procedural risk, and/or • carries an anaesthetic risk, and/or • requires specialised training, and/or • requires special facilities or equipment only available in an acute care setting.
Data Element Concept:	Episode of admitted patient care—procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 6th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Collection methods:	Record and code all procedures undertaken during the episode of care in accordance with the ACHI (5th edition). Procedures are derived from and must be substantiated by clinical documentation.
Comments:	The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ACHI.

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Episode of admitted patient care—procedure, code (ACHI 5th edn) NNNNN-NN Health, Superseded 05/02/2008
Implementation in Data Set Specifications:	Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

As a minimum requirement procedure codes must be valid codes from the Australian Classification of Health Interventions (ACHI) procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and state and territory information systems.

An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Record all procedures undertaken during an episode of care in accordance with the ACHI (6th edition) Australian Coding Standards.

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

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

Profession labour force status of health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—labour force status, code N{.N}
METeOR identifier:	270476
Registration status:	Health, Standard 01/03/2005
Definition:	Employment status of a health professional in a particular profession at the time of registration, as represented by a code.
Data Element Concept:	Health professional—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:

Value	Meaning
1	Employed in the profession: working in/practising the reference profession - in reference State
2	Employed in the profession: working in/practising the reference profession - mainly in other State(s) but also in reference State
3	Employed in the profession: working in/practising the reference profession - mainly in reference State but also in other State(s)
4	Employed in the profession: working in/practising the reference profession - only in State(s) other than reference State
5.1	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking either full-time or part-time work
5.2	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking full-time work
5.3	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking part-time work
5.9	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking work (not stated)
6.1	Unemployed, looking for work in the profession: not in paid work but looking for

		work in the field of profession - seeking either full-time or part-time work
	6.2	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession - seeking full-time work
	6.3	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession - seeking part-time work
	6.9	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession - seeking work (not stated)
	7	Not in the labour force for the profession: not in work/practice in the profession and not looking for work/practice in the profession
	8	Not in the labour force for the profession: working overseas
Supplementary values:	9	Unknown/not stated

Data element attributes

Collection and usage attributes

Guide for use:

Employment in a particular health profession is defined by practice of that profession or work that is principally concerned with the discipline of the profession (for example, research in the field of the profession, administration of the profession, teaching of the profession or health promotion through public dissemination of the professional knowledge of the profession).

The term 'employed in the profession' equates to persons who have a job in Australia in the field of the reference profession.

A person who is normally employed in the profession but is on leave at the time of the annual survey is defined as being employed.

A health professional who is not employed but is eligible to work in, and is seeking employment in the profession, is defined as unemployed in the profession.

A health professional looking for work in the profession, and not currently employed in the profession, may be either unemployed or employed in an occupation other than the profession.

A registered health professional who is not employed in the profession, nor is looking for work in the profession, is defined as not in the labour force for the profession.

Registered health professionals not in the labour force for the profession may be either not employed and not looking for work, or employed in another occupation and not looking for work in the profession.

Collection methods:

For the national health labour force collection survey questionnaire, this is the key filter question. It excludes from further survey questions at this point:

- persons working overseas although working/practising in

the reference profession

- respondents working only in states other than the reference state
- respondents not working in the reference profession and not looking for work in the reference profession.

It also directs respondents working in the reference state and other states to respond to subsequent questions only in respect of work in the reference state. These distinctions are necessary in order to eliminate multiple counting for respondents renewing licenses to practise in more than one state.

Comments:

The definitions of employed and unemployed in this metadata item differ from Australian Bureau of Statistics (ABS) definitions for these categories defined in LFA2 'Employed persons', LFA8 'Labour force status', LFA9 'Looking for full-time work', LFA10 'Looking for part-time work', LFA12 'Not in the labour force', LFA13 'Status in employment', and LFA14 'Unemployed persons'.

The main differences are:

- The National Health Labour Force Collection includes persons other than clinicians working in the profession as persons employed in the profession. The ABS uses the Australian Standard Classification of Occupations where, in general, classes for health occupations do not cover non-clinicians. The main exception to this is nursing where, because of the size of the profession, there are classes for nursing administrators and educators.
- The labour force collection includes health professionals working in the Defence Forces; ABS does not, with the exception of the population census.
- ABS uses a tightly defined reference period for employment and unemployment; the labour force collection reference period is self-defined by the respondent as his/her usual status at the time of completion of the survey questionnaire.
- The labour force collection includes, among persons looking for work in the profession, those persons who are registered health professionals but employed in another occupation and looking for work in the profession; ABS does not.
- The labour force collection includes in the category not in the labour force health professionals registered in Australia but working overseas; such persons are excluded from the scope of ABS censuses and surveys.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Profession labour force status of health professional, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.76 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

This metadata item provides essential data for estimating the size and distribution of the health labour force, monitoring growth, forecasting future supply, and addressing work force planning issues. It was developed by the National Committee for Health and Vital Statistics during the 1980s and endorsed by the Australian Health Ministers Advisory Council in 1990 as a national minimum data set item for development of the national health labour force collections.

Proficiency in spoken English

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proficiency in spoken English, code N
METeOR identifier:	270203
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
Definition:	A person's self-assessed level of ability to speak English, as represented by a code.
Data Element Concept:	Person—proficiency in spoken English

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	0	Not applicable (persons under 5 years of age or who speak only English)
	1	Very well
	2	Well
	3	Not well
	4	Not at all
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 0 Not applicable (persons under 5 years of age or who speak only English) Not applicable, is to be used for people under 5 year of age and people who speak only English. CODE 9 Not stated/inadequately described Not stated/inadequately described, is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.
Comments:	The ABS advises that the most useful information provided by this metadata item is in the distinction between the two category groups of Very well/Well and Not well/Not at all.

Source and reference attributes

Reference documents:	Standards for Statistics on Cultural and Language Diversity 1999. Cat. no. 1289.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods:

This metadata item is only intended to be collected if a person has a main language other than English spoken at home; and/or first language spoken is not English.

Recommended question:

How well do you speak English? (tick one)

1. Very well
2. Well
3. Not well
4. Not at all

Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This metadata item is not relevant to and should not be collected for persons under the age of five years.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, this standard should be used wherever practically possible.

Comments:

This metadata item identifies those people who may suffer disadvantage in terms of their ability to access services due to lack of ability in the spoken English language. This information can be used to target the provision of services to people whose lack of ability in spoken English is potentially a barrier to gaining access to government programs and services.

In conjunction with Indigenous status, the main language other than English spoken at home and the country of birth, this metadata item forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Relational attributes

Related metadata references:

See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006

See also Person—country of birth, code (SACC 1998) NNNN Health, Standard 01/03/2005, Community services, Superseded 02/06/2008, Housing assistance, Standard 20/06/2005

Supersedes Proficiency in spoken English, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (18.55 KB)

Progesterone receptor assay results

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—progesterone receptor assay results, code N
METeOR identifier:	291341
Registration status:	Health, Standard 13/06/2004
Definition:	The results of progesterone receptor assay at the time or diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer—progesterone receptor assay results

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Test done, results positive (progesterone receptor positive)
	2	Test done, results negative (Progesterone receptor negative)
Supplementary values:	0	Test not done (test not ordered or not performed)
	8	Test done but results unknown
	9	Unknown

Data element attributes

Collection and usage attributes

Collection methods: The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include:

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high), and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:	Royal College of Pathologists of Australasia Australian Cancer Network Commission on Cancer American College of Surgeons
Reference documents:	Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001) Australian Cancer Network Working Party The pathology

reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

Supersedes Progesterone receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.94 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
Hormone receptor status is an important prognostic indicator for breast cancer.

Proteinuria status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proteinuria status, code N{.N}
METeOR identifier:	270346
Registration status:	Health, Standard 01/03/2005
Definition:	Whether there is a presence of excessive protein in the urine of the person, as represented by a code.
Data Element Concept:	Person—proteinuria status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:

Value	Meaning
1	Negative for protein
1.1	Microalbuminuria present
1.2	Microalbuminuria not present
1.3	Microalbuminuria not tested
2	Proteinuria
3	Not tested

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Negative for protein

Negative for proteinuria - less than 1 plus on dipstick-testing or excretion of 300 mg or less of protein from 24-hour urine collection.

CODE 1.1 Microalbuminuria present

Microalbuminuria present

CODE 1.2 Microalbuminuria not present

Microalbuminuria not present

CODE 1.3 Microalbuminuria not tested

Microalbuminuria not tested

CODE 2 Proteinuria

Proteinuria - one or more pluses of protein in dipstick urinalysis or for a 24-hour urine collection, where the patient excretes more than 300 mg/per day of protein.

CODE 3 Not tested

Not tested - no urinalysis for proteinuria was taken.

Collection methods:

Where laboratory testing is used to determine Proteinuria status the categorisation must be substantiated by clinical documentation such as an official laboratory report.

Data element attributes

Collection and usage attributes

Collection methods:

Dipstick testing can be used to test for protein in a urine specimen. Proteinuria (i.e. excessive protein in the urine) on dipstick urinalysis is described as one or more pluses of protein and for a 24-hour urine collection where the patient excretes more than 300 mg/day of protein.

Microalbuminuria can be determining using any one of the following tests: spot urine, timed urine (24-hour collection) or albumin/creatinine ratio. Although the presence of microalbuminuria does not warrant categorisation as proteinuria, it is clinically significant in the diagnosis and treatment of diabetes.

Comments:

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Relational attributes

Related metadata references:

Supersedes Proteinuria - status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.72 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Provider occupation category (self-identified) (ANZSCO 1st edition)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation (self-identified), code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	350896
Registration status:	Health, Standard 04/07/2007 Community services, Standard 27/03/2007
Definition:	A health care occupation that an individual provider identifies as being one in which they provide a significant amount of services, as represented by a code.
Data Element Concept:	Individual service provider—occupation (self-identified)

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	The following is a list of the more common health care occupations, however, it is not intended to represent all the possible health care occupations: Aboriginal and Torres Strait Islander Health Worker (ANZSCO code 411511) Acupuncturist (ANZSCO code 252211) Aged or disabled carer (ANZSCO code 423111) Ambulance officer (ANZSCO code 411111) Anaesthetist (ANZSCO code 253211) Audiologist (ANZSCO code 252711) Chiropractor (ANZSCO code 252111) Clinical psychologist (ANZSCO code 272311) Complementary Health Therapists nec (ANZSCO code 252299) Dental assistant (ANZSCO code 423211) Dental hygienist (ANZSCO code 411211) Dental specialist (ANZSCO code 252311) Dental technician (ANZSCO code 411213) Dental therapist (ANZSCO code 411214) Dentist (ANZSCO code 252312) Dermatologist(ANZSCO code 253911)

Dietician (ANZSCO code 251111)
Drug and Alcohol Counsellor (ANZSCO code 272112)
Enrolled nurse (ANZSCO code 411411)
General medical practitioner (ANZSCO code 253111)
Health professionals (ANZSCO code 25)
Hospital pharmacist (ANZSCO code 251511)
Intensive care ambulance paramedic (AUS) / ambulance paramedic (NZ) (ANZSCO code 411112)
Massage therapist (ANZSCO code 411611)
Medical diagnostic radiographer (ANZSCO code 251211)
Medical practitioners nec (ANZSCO code 253999)
Medical radiation therapist (ANZSCO code 251212)
Midwife (ANZSCO code 254111)
Naturopath (ANZSCO code 252213)
Nuclear medicine technologist (ANZSCO code 251213)
Nurse educator (ANZSCO code 254211)
Nurse manager (ANZSCO code 254311)
Nurse practitioner (ANZSCO code 254411)
Nurse researcher (ANZSCO code 254212)
Nursing assistant support worker (ANZSCO code 423312)
Occupational therapist (ANZSCO code 252411)
Ophthalmologist (ANZSCO code 253914)
Optometrist (ANZSCO code 251411)
Orthoptist (ANZSCO code 251412)
Orthotist or Prosthetist (ANZSCO code 251912)
Osteopath (ANZSCO code 252112)
Paediatrician (ANZSCO code 253321)
Pathologist (ANZSCO code 253915)
Physiotherapist (ANZSCO code 252511)
Podiatrist (ANZSCO code 252611)
Psychiatrist (ANZSCO code 253411)
Psychologists nec (ANZSCO code 272399)
Radiologist (ANZSCO code 253916)
Registered nurse (developmental disability)(ANZSCO code 254416)
Registered nurse (mental health)(ANZSCO code 254422)
Registered Nurses nec (ANZSCO code 254499)
Rehabilitation counsellor (ANZSCO code 272114)
Retail pharmacist (ANZSCO code 251513)
Social worker (ANZSCO code 272511)
Sonographer (ANZSCO code 251214)
Specialist physician(general medicine) (ANZSCO code 253311)
Speech pathologist (AUS) / speech language therapist (NZ) (ANZSCO code 252712)
Surgeon (general) (ANZSCO code 253511)
Therapy aide (ANZSCO code 423314)

Collection methods:

Data is collected at the time a health care provider identification record is created.

Multiple instances of health care occupation may be collected where the individual provides a significant amount of services in more than one category. For example, a dentist who is also a

medical practitioner may practice as both.
Record as many as apply.

Accurate data are best achieved using computer assisted coding. A computer assisted coding system is available from the ABS to assist in coding occupational data to ANZSCO codes.
Data coded at the 4-digit and 6-digit level will provide more detailed information than that collected at the higher levels and may be more useful. However, the level at which data are coded and reported will depend on the purpose of collecting this information.

Comments: ANZSCO defines 'occupation' as 'a set of jobs with similar sets of tasks'. Operationally this is defined as 'a collection of jobs which are sufficiently similar in their main tasks to be grouped together for purposes of the classification'. Job is defined as 'a set of tasks designed to be performed by one individual for a wage or salary'.

Source and reference attributes

Reference documents: In AS4846 this data element is referred to as 'Provider main field of practice'.

Relational attributes

Related metadata references: Supersedes Individual service provider—occupation (self-identified), code (ASCO 2nd edn) N[NNN]{-NN} Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 04/07/2007

Provider occupation end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation end date, DDMMYYYY
METeOR identifier:	289053
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an individual health care provider ceased practising in an identified occupation.
Data Element Concept:	Individual service provider—occupation end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:

This date must:

- be greater than or equal to the provider occupation start date;
- be a valid date;
- be collected for each provider occupation recorded.

If the date is estimated in some way, it is recommended that the metadata item *Date accuracy indicator* also be recorded at the time of record creation to flag the accuracy of the data.

For data integrity, data exchange, future data analysis and/or manipulation of data from diverse sources the *Date accuracy indicator* must be used in conjunction with the *provider occupation end date* in all instances to ensure accuracy.

Provider occupation start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation start date, DDMMYYYY
METeOR identifier:	289059
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an individual health care provider commenced practising in an identified occupation.
Data Element Concept:	Individual service provider—occupation start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:

This date must:

- be greater than or equal to the provider occupation start date;
- be a valid date;
- be collected for each provider occupation recorded.

If the date is estimated in some way, it is recommended that the metadata item *Date accuracy indicator* also be recorded at the time of record creation to flag the accuracy of the data.

For data integrity, data exchange, future data analysis and/or manipulation of data from diverse sources the *Date accuracy indicator* must be used in conjunction with the *provider occupation start date* in all instances to ensure accuracy.

Purchase of goods and services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—purchase of goods and services, total Australian currency NNNNN.N
METeOR identifier:	359935
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of purchases of goods and services, in Australian currency.
Data Element Concept:	Organisation—purchase of goods and services

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Expenses relating to purchases of goods and services are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- administrative expenses (excluding workers compensation premiums and payouts)
- domestic services
- drug supplies
- food supplies
- grants
- medical and surgical supplies
- patient transport
- payments to visiting medical officers
- repairs and maintenance
- social benefits
- subsidy expenses
- other expenses (includes contracted care services purchased

from private hospitals)

Collection methods:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Expenses relating to purchases of goods and services are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:

Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Quality accreditation/certification standard—Australian Council on Healthcare Standards EQuIP

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (Australian Council on Healthcare Standards EQuIP), code N
METeOR identifier:	302372
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the Australian Council on Healthcare Standards EQuIP standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Establishment—quality accreditation/certification standard status (Australian Council on Healthcare Standards EQuIP), code N Health, Superseded 14/09/2005

Quality accreditation/certification standard—Australian Quality Council

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (Australian Quality Council), code N
METeOR identifier:	302374
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the Australian Quality Council standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (Australian Quality Council), code N Health, Superseded 14/09/2005

Quality accreditation/certification standard—ISO 9000 quality family

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (International Organisation for Standardisation 9000 quality family), code N
METeOR identifier:	302377
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the International Organisation for Standardisation 9000 quality family standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (International Organisation for Standardisation 9000 quality family), code N Health, Superseded 14/09/2005

Quality accreditation/certification standard—Quality Improvement Council

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (Quality Improvement Council), code N
METeOR identifier:	302379
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the Quality Improvement Council standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (Quality Improvement Council), code N Health, Superseded 14/09/2005

Radiotherapy treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy treatment type, code N
METeOR identifier:	291438
Registration status:	Health, Standard 13/06/2004
Definition:	The type of radiation therapy used in initial treatment of the cancer, as represented by a code.
Data Element Concept:	Cancer treatment—radiotherapy treatment type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Permissible values:	Value	Meaning
	1	External radiotherapy treatment given
	2	Brachytherapy (radioactive implants)
	3	Unsealed radioisotopes
Supplementary values:	0	No radiotherapy treatment given
	9	Radiotherapy was administered but method was not stated

Data element attributes

Collection and usage attributes

Collection methods:

If codes 1,2,3 or 9 are used, the amount of radiation received should also be collected.

Most external beam radiotherapy is delivered on an outpatient basis.

CODE 2 Brachytherapy (radioactive implants)

This code is likely to be listed as a procedure for admitted patients.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons New South Wales Health Department
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:

See also Cancer treatment—radiation dose received, total Gray N[NNNN] Health, Standard 13/06/2004

Supersedes Radiotherapy treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.03 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This metadata item is collected for the analysis of outcome by treatment type.

Reason for cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—cessation reason, code N[N]
METeOR identifier:	270011
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—cessation reason

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Treatment completed
2	Change in main treatment type
3	Change in the delivery setting
4	Change in the principal drug of concern
5	Transferred to another service provider
6	Ceased to participate against advice
7	Ceased to participate without notice
8	Ceased to participate involuntary (non-compliance)
9	Ceased to participate at expiation
10	Ceased to participate by mutual agreement
11	Drug court and /or sanctioned by court diversion service
12	Imprisoned, other than drug court sanctioned
13	Died
98	Other

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use: To be collected on cessation of a treatment episode. Codes 1 to 12 listed above are set out as follows to enable a clearer picture of which codes are to be used for what purpose:

Treatment completed as planned:

CODE 1 Treatment completed

Client ceased to participate:

CODE 6 Ceased to participate against advice

CODE 7 Ceased to participate without notice

CODE 8 Ceased to participate involuntary (non-compliance)

CODE 9 Ceased to participate at expiation

Ceased to participate at expiation:

CODE 11 Drug court and /or sanctioned by court diversion service

CODE 12 Imprisoned, other than drug court sanctioned

Treatment not completed (other):

CODE 2 Change in main treatment type

CODE 3 Change in the delivery setting

CODE 4 Change in the principal drug of concern

CODE 5 Transferred to another service provider

Treatment ceased by mutual agreement:

CODE 10 Ceased to participate by mutual agreement

CODE 1 Treatment completed

This code is to be used when all of the immediate goals of the treatment have been completed as planned. Includes situations where the client, after completing this treatment, either does not commence any new treatment, commences a new treatment episode with a different main treatment or principal drug, or is referred to a different service provider for further treatment.

CODE 2 Change in main treatment type

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the main treatment type for alcohol and other drugs. See also Code 10.

CODE 3 Change in the delivery setting

A treatment episode may end if, prior to the completion of the existing treatment, there is a change in the treatment delivery setting for alcohol and other drugs. See also Code 10 and the Guide for use section in metadata item Episode of treatment for alcohol and other drugs.

CODE 4 Change in the principal drug of concern

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the principal drug of concern. See also Code 10.

CODE 5 Transferred to another service provider

This code includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital. Excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment (use Code 1).

CODE 6 Ceased to participate against advice

This code refers to situations where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest.

CODE 7 Ceased to participate without notice

This code refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.

CODE 8 Ceased to participate involuntary (non-compliance)

This code refers to situations where the client's participation has been ceased by the service provider due to non-compliance with the rules or conditions of the program.

CODE 9 Ceased to participate at expiation

This code refers to situations where the client has fulfilled their obligation to satisfy expiation requirements (e.g. participate in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment.

CODE 10 Ceased to participate by mutual agreement

This code refers to situations where the client ceases participation by mutual agreement with the service provider even though the treatment plan has not been completed. This may include situations where the client has moved out of the area. Only to be used when Code 2, 3 or 4 is not applicable.

CODE 11 Drug court and/or sanctioned by court diversion service

This code applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.

CODE 12 Imprisoned, other than drug court sanctioned

This code applies to clients who are imprisoned for reasons other than Code 11.

Data element attributes

Collection and usage attributes

Comments: Given the levels of attrition within alcohol and other drug treatment programs, it is important to identify the range of different reasons for ceasing treatment with a service.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Reason for cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.38 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008
Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009
Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Reason for readmission—acute coronary syndrome

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—reason for readmission following acute coronary syndrome episode, code N[N]
METeOR identifier:	285173
Registration status:	Health, Standard 04/06/2004
Definition:	The main reason for the **admission**, to any hospital, of a person within 28 days of discharge from an episode of admitted patient care for acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—reason for readmission following acute coronary syndrome episode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	ST elevation myocardial infarction
2	non-ST elevation ACS with high-risk features
3	non-ST elevation ACS with intermediate-risk features
4	non-ST elevation ACS with low-risk features
5	Planned Percutaneous Coronary Intervention (PCI)
6	Planned Coronary Artery Bypass Grafting (CABG)
7	Heart Failure (without MI)
8	Arrhythmia (without MI)
9	Conduction disturbance (without MI)
88	Non-cardiac cause

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 5 Planned Percutaneous Coronary Intervention (PCI)

This code is used when a readmission and PCI is planned, i.e. not precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1-4 should be coded.

CODE 6 Planned Coronary Artery Bypass Grafting (CABG)

This code is used coded when a readmission and CABG is planned, i.e, not precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1-4 should be

coded.

Data element attributes

Collection and usage attributes

Guide for use: The reason for readmission may be for cardiac or non-cardiac related causes.

Comments: This metadata item is designed to identify recurrent admissions following an initial presentation with acute coronary syndromes (ACS), not necessarily to the hospital responsible for the index admission.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Reason for readmission - Acute coronary syndrome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.16 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Reason for removal from elective surgery waiting list

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—reason for removal from a waiting list, code N
METeOR identifier:	269959
Registration status:	Health, Standard 01/03/2005
Definition:	The reason why a patient is removed from the elective surgery waiting list, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—reason for removal from a waiting list

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted as an elective patient for awaited procedure in this hospital or another hospital
2	Admitted as an emergency patient for awaited procedure in this hospital or another hospital
3	Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)
4	Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list
5	Surgery not required or declined
6	Transferred to another hospital's waiting list

Supplementary values:

Value	Meaning
9	Not known

Collection and usage attributes

Guide for use:

CODE 1 Admitted as an elective patient for awaited procedure in this hospital or another hospital

Patients undergoing the awaited procedure whilst admitted for another reason are to be coded this code.

CODE 2 Admitted as an emergency patient for awaited procedure in this hospital or another hospital

This code identifies patients who were admitted ahead of their normal position in the queue because the condition requiring treatment deteriorated whilst waiting. Admission as an emergency patient could also be due to other causes such as inappropriate urgency rating, delays in the system, or unpredicted biological variation.

CODES 3 - 5

CODE 3 Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)

CODE 4 Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list

CODE 5 Surgery not required or declined

These codes provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated other than as a patient of the hospital's waiting list. The awaited procedure may have been performed as an emergency or as an elective procedure.

CODE 6 Transferred to another hospital's waiting list

This code identifies patients who were transferred from one hospital's elective surgery waiting list to that of another hospital. The waiting time on the waiting lists at the initial hospital and subsequent hospitals should be combined for national reporting.

CODE 9 Not known

This code identifies patients removed from the waiting list for reasons unknown.

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Reason for removal from elective surgery waiting list, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.85 KB)

Implementation in Data Set Specifications: Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Received radiation dose

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiation dose received, total Gray N[NNNN]
METeOR identifier:	291472
Registration status:	Health, Standard 13/06/2004
Definition:	The received dose of radiation measured in Gray (Gy) - ICRU.
Data Element Concept:	Cancer treatment—radiation dose received

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5

Supplementary values:

Value	Meaning
00000	No radiation therapy was administered
99999	Radiation therapy was administered but the dose is unknown

Unit of measure:	Gray (Gy)

Data element attributes

Collection and usage attributes

Guide for use:

The International Commission on Radiation Units (ICRU) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on). The ICRU50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the centre of the planning target volume.

The ICRU58 should be recorded for brachytherapy.

For maximum consistency in this field the ICRU recommendations should be followed whenever possible.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

See also Cancer treatment—radiotherapy treatment type, code N Health, Standard 13/06/2004

Supersedes Received radiation dose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.56 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This item is collected for the analysis of outcome by treatment type.

Recurrent expenditure (indirect health care)— public health and monitoring services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (public health and monitoring services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270292
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure on indirect health care that is related to public health and monitoring services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Public or registered non-profit services and organisations with centralised, statewide or national public health or monitoring services. These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council. Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists. Record values up to hundreds of millions of dollars.
Comments:	Resources Working Party members were concerned about the

possibility of double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.13 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (indirect health care)—central administrations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (central administrations) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270294
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure measured in Australian dollars on indirect health care related to central administrations, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (e.g. the Department of Veterans' Affairs). Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.
Comments:	Resources Working Party members were concerned about the possibility of double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.13 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (indirect health care)—central and statewide support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (central and statewide support services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270293
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure measured in Australian dollars on indirect health care related to central and statewide support services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Public or registered services which provide central or statewide support services for residential establishments within the scope of the public hospital establishments national minimum data set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross. Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.
Comments:	Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.13 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (indirect health care)—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (other) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270295
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure in Australian dollars on health care that cannot be directly related to programs operated by a particular establishment and is not related to patient transport services, public health and monitoring services, central and statewide support services or central administrations, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Other: Any other indirect health care expenditure as defined above not catered for in the following categories: Patient transport services; Public health and monitoring services; Central and statewide support services; Central administrations. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information. Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.
Comments:	Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.13 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (indirect health care)—patient transport services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (patient transport services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270291
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure measured in Australian dollars on indirect health care related to patient transport services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Public or registered non-profit organisations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the scope of this data set. This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of their normal services. This category includes centralised and statewide patient transport services (for example, Queensland Ambulance Transport Brigade) which operate independently of individual inpatient establishments. Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.
Comments:	Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.13 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (mental health)—non-salary operating costs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]
Synonymous names:	Non-salary operating costs excluding depreciation
METeOR identifier:	287979
Registration status:	Health, Standard 08/12/2004
Definition:	Total expenditure by a mental health establishment relating to non-salary operating items.
Data Element Concept:	Establishment—recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Report all expenditure in thousands of dollars (i.e. $ 000's). Expenditure should include both the specific costs directly associated with the service and indirect costs, for example personnel services. Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service. Depreciation is to be excluded from the non-salary operating costs.
Collection methods:	Non-salary recurrent expenditure, excluding depreciation, is to be reported by service setting (admitted patient care, residential care, ambulatory care). For the admitted patient care setting non-salary recurrent expenditure, excluding depreciation, is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together. The sub-components of non-salary recurrent expenditure, and depreciation, are to be reported at the organisation level for the Mental health establishments NMDS. However, if the organisation is not reporting on an accrual basis then it does not need to report depreciation.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure (mental health)—salaries and wages

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296577
Registration status:	Health, Standard 08/12/2004
Definition:	Total salary and wage payments to all **staff** of a mental health establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:

Is formed using Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year),

total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding.

Total salary and wages is the sum of the above categories and is to be reported by service setting (admitted patient care, residential care, ambulatory care).

For the admitted patient setting the total for salary and wages is to be disaggregated by Specialised mental health service program type and Specialised mental health service target population, together.

Recurrent expenditure (salaries and wages)—administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270275
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **administrative and other clerical staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—carer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296531
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **carer consultants** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
Collection methods:	Note: This code is only to be reported for the Mental Health Establishments NMDS. For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288767
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **consultant psychiatrists** and **psychiatrists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.

Recurrent expenditure (salaries and wages)—consumer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296528
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **consumer consultants** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
Collection methods:	Note: This code is only to be reported for the Mental Health Establishments NMDS. For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005
	Implementation start date: 01/07/2005
	Mental health establishments NMDS 2005-2006 Health,

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure (salaries and wages)—diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270274
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **diagnostic and health professionals** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: Must be supplied if the sub-categories cannot be supplied. Can also be supplied if the sub-categories are supplied.

This data element should be derived from the salaries and wages paid to occupational therapists, social workers, psychologists and other diagnostic and health professionals.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—domestic and other staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270276
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **domestic and other staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—enrolled nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270270
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **enrolled nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—occupational therapists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (occupational therapists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288778
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **occupational therapists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.

Recurrent expenditure (salaries and wages)—other diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other diagnostic and health professionals) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288786
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **other diagnostic and health professionals** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.

This data element should be derived from the salaries and wages paid to Occupational therapists, social workers, psychologists and other diagnostic and health professionals.

Recurrent expenditure (salaries and wages)—other medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other medical officers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288776
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **other medical officers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Other medical officers are those who are neither registered as psychiatrists within the State or Territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.

Recurrent expenditure (salaries and wages)—other personal care staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270273
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **other personal care staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (psychiatry registrars and trainees)(financial year), total Australian currency N[N(8)]
METeOR identifier:	288774
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **psychiatry registrars and trainees** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.

Recurrent expenditure (salaries and wages)—psychologists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (psychologists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288784
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **psychologists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.

Recurrent expenditure (salaries and wages)—registered nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270269
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **registered nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—salaried medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270265
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **salaried medical officers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

This data element should be derived from the salaries and wages paid to consultant psychiatrists and psychiatrists, psychiatry registrars and trainees and other medical officers.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—social workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (social workers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288780
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **social workers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition 1: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Obligation condition 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.

Recurrent expenditure (salaries and wages)—student nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (student nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270271
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **student nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Student nurses are persons employed by the establishment currently studying in years one to three of a three year certificate course. This includes any person commencing or undertaking a three year course of training leading to registration as a nurse by the state or territory registration board. This includes full time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post basic training courses. Note: This code is not to be reported for the Mental health establishments National Minimum Data Set.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—total

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270470
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars for all employees of the establishment (including contract staff employed by an agency, provided staffing data is also available).
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Record as currency up to hundreds of millions of dollars.
Figures should be supplied for each of the staffing categories:
C1.1 Salaried medical officers
C1.2 Registered nurses
C1.3 Enrolled nurses
C1.4 Student nurses
C1.5 Trainee / pupil nurses
C1.6 Other personal care staff
C1.7 Diagnostic and health professionals
C1.8 Administrative and clerical staff
C1.9 Domestic and other staff

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB)

Implementation in Data Set Specifications: Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure (salaries and wages)—trainee/pupil nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (trainee/pupil nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270272
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **trainee/pupil nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.52 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Recurrent expenditure—Department of Veterans' Affairs funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)]
METeOR identifier:	287031
Registration status:	Health, Standard 08/12/2004
Definition:	Total recurrent expenditure funded by block grants provided by the Department of Veterans' Affairs (DVA) for provision of mental health services and payments made for mental health treatment and care of DVA clients.
Data Element Concept:	Establishment—recurrent expenditure (Department of Veterans' Affairs funded)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar.
Collection methods:	DVA-funded expenditure to be to be reported only once and for the specific statistical unit level at which the expenditure is available. Where DVA-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—National Mental Health Strategy funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)]
METeOR identifier:	289502
Registration status:	Health, Standard 08/12/2004
Definition:	Total recurrent expenditure funded by monies allocated by the Commonwealth to the state or territory to assist in implementation of the National Mental Health Strategy.
Data Element Concept:	Establishment—recurrent expenditure (National Mental Health Strategy payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to the nearest whole dollar.
Collection methods:	Report only the expenditure from those funds used to resource recurrent Expenditure on services within the scope of the NMDS—Mental Health Establishments. National Mental Health Strategy-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—State or Territory health authority funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)]
METeOR identifier:	288965
Registration status:	Health, Standard 08/12/2004
Definition:	The total recurrent expenditure from funds provided by the State or Territory health authority which were used to support the delivery and/or administration of mental health services reported by the organisation, region or central administration.
Data Element Concept:	Establishment—recurrent expenditure (state or territory health authority funded)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar. Includes specific mental health allocations as well as health funds appropriated for general or other specific purpose.
Collection methods:	State or Territory health authority-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where State or Territory health authority-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health,

Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—administrative expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270107
Registration status:	Health, Standard 01/03/2005
Definition:	The expenditure measured in Australian dollars incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation), for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (administrative expenses)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Rounded to the nearest whole dollar.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Administrative expenses, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—depreciation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (depreciation) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270279
Registration status:	Health, Standard 01/03/2005
Definition:	Depreciation charges measured in Australian dollars for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (depreciation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Depreciation is to be reported by service setting (admitted patient care, residential care, ambulatory care). For admitted patient care settings, depreciation is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together.
Comments:	With the long-term trend towards accrual accounting in the public sector, this metadata item will ultimately become significant for public sector establishments. Public sector establishments in some states have adopted modified accrual accounting identifying depreciation only, before reaching full accrual accounting. Depreciation is now reported for most public sector establishments and should be reported as a separate recurrent expenditure. Depreciation should be identified separately from other recurrent expenditure categories.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Depreciation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.07 KB)

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—domestic services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270283
Registration status:	Health, Standard 01/03/2005
Definition:	The costs measured in Australian dollars of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (domestic services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
Comments:	The possibility of separating fuel, light and power from domestic services which would bring the overall non-salary recurrent expenditure categories closer to the old Hospitals and Allied Services Advisory Council categories was briefly considered by the Resources Working Party but members did not hold strong views in this area.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Domestic services, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.58 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard

08/12/2004

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—drug supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270282
Registration status:	Health, Standard 01/03/2005
Definition:	The cost measured in Australian dollars of all drugs including the cost of containers, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (drug supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Drug supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—food supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270284
Registration status:	Health, Standard 01/03/2005
Definition:	The cost measured in Australian dollars of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (food supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Food supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.82 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—interest payments

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270186
Registration status:	Health, Standard 01/03/2005
Definition:	Payments in Australian dollars made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (interest payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.
Comments:	The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Interest payments, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.88 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental

health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—medical and surgical supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270358
Registration status:	Health, Standard 01/03/2005
Definition:	The cost in Australian dollars of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (medical and surgical supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
Collection methods:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Medical and surgical supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.94 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health,

Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—non-salary operating costs (excluding depreciation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270297
Registration status:	Health, Standard 01/03/2005
Definition:	Total expenditure relating to non-salary operating items, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Total is calculated from expenditure including:

- Payments to visiting medical officers
- Superannuation employer contributions (including funding basis)
- Drug supplies
- Medical and surgical supplies
- Food supplies
- Domestic services
- Repairs and maintenance
- Patient transport
- Administrative expenses
- Interest payments
- Depreciation
- Other recurrent expenditure.

Expenditure should include both the specific costs directly associated with the service and indirect costs for example personnel services.

Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate

service.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Non-salary operating costs, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.24 KB)

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (depreciation) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Recurrent expenditure—other Commonwealth Government funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288031
Registration status:	Health, Standard 08/12/2004
Definition:	Total recurrent expenditure by an organisation, region or central administration funded from other revenue paid directly by the Commonwealth Government and used to resource recurrent expenditure on services within the scope of the NMDS—Mental Health Establishments.
Data Element Concept:	Establishment—recurrent expenditure (other Commonwealth Government funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar. Includes expenditure where the funding is from nursing home and hostel subsidies for the care of patients in specialised mental health services, and any other special purpose grants including rural health support, education and training funds and incentive package funds made available under the Australian Health Care Agreements. Excludes expenditure funded by the Commonwealth under grants from the Department of Veterans' Affairs or from the National Mental Health Strategy.
Collection methods:	Other Commonwealth Government-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where other Commonwealth Government-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit

level possible only.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—other State or Territory funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288075
Registration status:	Health, Standard 08/12/2004
Definition:	The total recurrent expenditure from state or territory funding sources from government departments external to the health department portfolio which were used to support the delivery and/or administration of mental health services.
Data Element Concept:	Establishment—recurrent expenditure (other state or territory funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	State or territory-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred, e.g. at the state, regional or organisational level.
Collection methods:	Where state or territory-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only. Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set	Mental health establishments NMDS 2005-2006 Health,

Specifications:

Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—other patient revenue funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	290583
Registration status:	Health, Standard 08/12/2004
Definition:	Recurrent expenditure funded from other revenue paid directly by patients or third parties, such as private health insurers, on behalf of patients under care of the organisation, region or central administration mental health services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (other patient revenue funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to the nearest whole dollar.
Collection methods:	Other patient revenue funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level. Note: this excludes expenditure funded by Department of Veterans' Affairs payments in respect of specific patients, or funded by the Commonwealth nursing home or hostel subsidies which should be reported in Department of Veterans' Affairs funded expenditure or Commonwealth Government funded expenditure respectively. Where other patient revenue funded expenditure could be allocated to more than one level, it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:

See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—other recurrent expenditure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270126
Registration status:	Health, Standard 01/03/2005
Definition:	All other recurrent expenditure measured in Australian dollars not included elsewhere in any of the recurrent expenditure categories, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (other recurrent expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—other revenue funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288071
Registration status:	Health, Standard 08/12/2004
Definition:	The total recurrent expenditure funded from all other revenue that was received by the organisation, region and central administration and has not been reported elsewhere.
Data Element Concept:	Establishment—recurrent expenditure (other revenue funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar.
Collection methods:	Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level. Expenditure reported separately are listed below under the Relational attributes section.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment—recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—patient transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270048
Registration status:	Health, Standard 01/03/2005
Definition:	The direct cost in Australian dollars of transporting patients excluding salaries and wages of transport staff where payment is made by an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (patient transport cost)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Patient transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.68 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health,

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—payments to visiting medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270049
Registration status:	Health, Standard 01/03/2005
Definition:	All payments measured in Australian dollars made by an institutional health care establishment to **visiting medical officers** for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (visiting medical officer payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
Comments:	Although accepting the need to include visiting medical officer payments, the Resources Working Party decided not to include data on visiting medical officer services (whether hours or number of sessions or number of services provided) due to collection difficulties and the perception that use of visiting medical officers was purely a hospital management issue.

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Supersedes Payments to visiting medical officers, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.17 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard

08/12/2004

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—recoveries funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288685
Registration status:	Health, Standard 08/12/2004
Definition:	Recurrent expenditure funded from revenue that is in the nature of a recovery of expenditure incurred, including income from provision of meals and accommodation, use of facilities, etc. for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (recoveries funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar.
Collection methods:	Expenditure funded from recoveries to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where expenditure funded from recoveries could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, recoveries received through service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Recurrent expenditure—repairs and maintenance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269970
Registration status:	Health, Standard 01/03/2005
Definition:	The costs in Australian dollars incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (repairs and maintenance)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar. Expenditure of a capital nature should not be included here. Do not include salaries and wages of repair and maintenance staff. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Supersedes Repairs and maintenance, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.08 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health,

Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—superannuation employer contributions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270371
Registration status:	Health, Standard 01/03/2005
Definition:	Contributions paid in Australian dollars or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a state health authority, to a superannuation fund providing retirement and related benefits to establishment employees, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (superannuation employer contributions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
Comments:	The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments. In private enterprise some superannuation schemes are partially funded but this is considered too complex a distinction for national minimum data sets. It is noted that the emergence of salary sacrifice schemes allows employees to forego salary for higher superannuation contributions. If these become significant, national minimum data sets may have to take them into account at a future stage.

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Supersedes Superannuation employer contributions (including funding basis), version 1, DE, NHDD, NHIMG, Superseded

01/03/2005.pdf (16.41 KB)

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Recurrent expenditure—total

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)]
METeOR identifier:	288993
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure relating to salaries and wages, non-salary recurrent expenditure and depreciation for a financial year.
Data Element Concept:	Establishment—recurrent expenditure

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar. Total is calculated from expenditure including: salaries and wages; depreciation; and non-salary recurrent expenditure comprising: payments to visiting medical officers; superannuation employer contributions (including funding basis); drug supplies; medical and surgical supplies; food supplies; domestic services; repairs and maintenance; patient transport; administrative expenses; interest payments; and other recurrent expenditure.
Collection methods:	The total grant made to non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding. can be reported as the total recurrent expenditure if detailed expenditure data are not available.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure

	(National Mental Health Strategy funded), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)]] Health, Standard 08/12/2004 Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005 Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)]] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: Must be supplied if the sub-categories cannot be supplied. Can also be supplied if the sub-categories are supplied.

Referral destination to further care (from specialised mental health residential care)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—referral destination (mental health care), code N
METeOR identifier:	270130
Registration status:	Health, Standard 01/03/2005
Definition:	The type of health care the **resident** is referred to by the residential mental health care service for further care at the end of residential stay, as represented by a code.
Data Element Concept:	Episode of residential care—referral destination (mental health care)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Specialised mental health admitted patient care
2	Specialised mental health residential care
3	Specialised mental health ambulatory care
4	Private psychiatrist care
5	General practitioner care
6	Other care
7	Not referred
8	Not applicable (i.e. end of reference period)

Supplementary values:

9	Unknown/not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Where the **resident** is referred to two or more types of health care, the type of health care provided by the service primarily responsible for the care of the resident is to be reported.

Relational attributes

Related metadata references:	Supersedes Referral from specialised mental health residential care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.51 KB)
Implementation in Data Set Specifications:	Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Referral destination to further care (psychiatric patients)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (mental health care)—referral destination, code N
METeOR identifier:	269990
Registration status:	Health, Standard 01/03/2005
Definition:	The type of further health service care to which a person is referred from mental health, as represented by a code.
Data Element Concept:	Episode of admitted patient care—referral destination

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Not referred
2	Private psychiatrist
3	Other private medical practitioner
4	Mental health/alcohol and drug in-patient facility
5	Mental health/alcohol and drug non in-patient facility
6	Acute hospital
7	Other

Data element attributes

Source and reference attributes

Submitting organisation: National Minimum Data Set Working Parties

Relational attributes

Related metadata references: Supersedes Referral to further care (psychiatric patients), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Referred to ophthalmologist (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—referral to ophthalmologist indicator (last 12 months), code N
METeOR identifier:	302823
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the individual was referred to an **ophthalmologist** within the last 12 months, as represented by a code.
Data Element Concept:	Person—referral to ophthalmologist indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if the individual was referred to an ophthalmologist during the last 12 months.

CODE 2 No: Record if the individual was not referred to an ophthalmologist during the last 12 months.

Collection methods: Ask the individual if he/she was referred to an ophthalmologist during the last 12 months. Alternatively, obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary
Reference documents:	Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

Relational attributes

Related metadata references: Supersedes Health service event—referral to ophthalmologist

status (last 12 months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to detect abnormalities early and to avoid or postpone complications.

Region code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—region identifier, X[X]
METeOR identifier:	269940
Registration status:	Health, Standard 01/03/2005
Definition:	An alphanumeric identifier for the location of health services in a defined geographic or administrative area.
Data Element Concept:	Establishment—region identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[X]
Maximum character length:	2

Data element attributes

Collection and usage attributes

Guide for use:	Domain values are specified by individual states/territories. Regions may also be known as Areas or Districts. Any valid region code created by a jurisdiction is permitted.

Relational attributes

Related metadata references:	Supersedes Region code, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.33 KB) Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008 Community mental health care NMDS 2005-2006 Health,

Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Standard 04/05/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Region of first recurrence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—region of first recurrence of cancer, code N
METeOR identifier:	289136
Registration status:	Health, Standard 04/06/2004
Definition:	The region of first recurrence of primary cancer after a disease free intermission or remission, as represented by a code.
Data Element Concept:	Person with cancer—region of first recurrence of cancer

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Local
	2	Regional
	3	Both local and regional
	4	Distant
	5	Distant and either local or regional
	6	Local, regional and distant
Supplementary values:	0	None, patient is disease-free
	7	Patient was never disease-free
	8	Recurred but site unknown
	9	Unknown if recurred

Data element attributes

Collection and usage attributes

Guide for use:	The region of the first recurrence following the initial diagnosis should be recorded. The record should not be updated with subsequent recurrences. The cancer may recur in more than one site (e.g. both regional and distant metastases). Record the highest numbered applicable response.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Volume II Registry Operations and Data Standards (ROADS) (1998)

Relational attributes

Related metadata references:

Supersedes Region of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.03 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
This item is collected for the analysis of outcome by treatment type.

Regional lymph nodes examined

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of regional lymph nodes examined, total N[N]
METeOR identifier:	289177
Registration status:	Health, Standard 04/06/2004
Definition:	The total number of regional lymph nodes examined by the pathologist.
Data Element Concept:	Person with cancer—number of regional lymph nodes examined

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
0	No regional lymph nodes examined
90	Ninety or more regional lymph nodes examined
95	No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96	Regional lymph node removal documented as sampling but number unknown/not stated
97	Regional lymph nodes removal documented as dissection but number unknown/not stated
98	Regional lymph nodes removal but number unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate only

Collection and usage attributes

Guide for use:

CODE 95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed

No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed, is used for a lymph node aspiration when cytology or histology is positive for malignant cells.

CODE 99 Unknown; not stated; death certificate only

Unknown; not stated; death certificate only, is used if information about regional lymph nodes is unknown or if the field is not applicable for that site or histology.

Data element attributes

Source and reference attributes

Origin:	Australian Cancer Network Commission on Cancer American College of Surgeons
Reference documents:	Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001) Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	See also Person with cancer—number of positive regional lymph nodes, total N[N] Health, Standard 04/06/2004 Supersedes Regional lymph nodes examined, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.69 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Regional lymph nodes positive

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of positive regional lymph nodes, total N[N]
METeOR identifier:	289205
Registration status:	Health, Standard 04/06/2004
Definition:	The total number of regional lymph nodes examined by a pathologist and reported as containing tumour.
Data Element Concept:	Person with cancer—number of positive regional lymph nodes

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
0	All nodes examined negative
96	Ninety-six or more lymph nodes positive
97	Positive nodes but number not specified
98	No nodes examined
99	Unknown if nodes are positive or negative; not applicable

Collection and usage attributes

Guide for use:

CODE 97 Positive nodes but number not specified

Positive nodes but number not specified, is used when the cytology or histology from a lymph node aspiration is positive for malignant cells.

CODE 98 No nodes examined

Positive nodes but number not specified, is used when no nodes are removed or examined.

CODE 99 Unknown if nodes are positive or negative; not applicable

Unknown if nodes are positive or negative, is used if information about regional lymph nodes is unknown or if it is not applicable for that site or histology.

Data element attributes

Source and reference attributes

Origin:	Australian Cancer Network Commission on Cancer American College of Surgeons
Reference documents:	Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists

Second Edition Sydney (2001)
Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	See also Person with cancer—number of regional lymph nodes examined, total N[N] Health, Standard 04/06/2004 Supersedes Regional lymph nodes positive, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.03 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Removal date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting list removal date, DDMMYYYY
METeOR identifier:	270082
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a patient is removed from an elective surgery waiting list.
Data Element Concept:	Elective surgery waiting list episode—waiting list removal date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This date is recorded when a patient is removed from an elective surgery waiting list. Removal date will be the same as admission date for patients in Reason for removal from elective surgery waiting list categories 1 and 2.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Removal date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005 *Implementation start date:* 01/07/2006 *Information specific to this data set:* Right justified and zero filled Removal date ≥ date of birth Removal date ≤ listing date for care Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2002

Renal disease therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—renal disease therapy, code N
METeOR identifier:	270264
Registration status:	Health, Standard 01/03/2005
Definition:	The therapy the person is receiving for renal disease, as represented by a code.
Data Element Concept:	Person—renal disease therapy

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Drugs for modification of renal disease
2	Drugs for treatment of complications of renal disease
3	Peritoneal dialysis
4	Haemodialysis
5	Functioning renal transplant

Collection and usage attributes

Guide for use:

CODE 1 Drugs for modification of renal disease

This code is used to indicate drugs for modification of renal disease, includes drugs intended to slow progression of renal failure. Examples include antiproteinurics such as angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor antagonists (ATRA) and immunosuppressants.

CODE 2 Drugs for treatment of complications of renal disease

This code is used to indicate drugs for the treatment of the complications of renal disease. Examples include antihypertensive agents and drugs that are intended to correct biochemical imbalances caused by renal disease. (e.g. loop diuretics, ACEI, erythropoietin, calcitriol, etc).

CODE 3 Peritoneal dialysis

This code is used to indicate peritoneal dialysis, chronic peritoneal dialysis, delivered at home, at a dialysis satellite centre or in hospital.

CODE 4 Haemodialysis

This code is used to indicate haemodialysis, chronic haemodialysis delivered at home, at a dialysis satellite centre or in hospital.

CODE 5 Functioning renal transplant

This code is used to indicate functioning renal transplant, the

presence of a functioning renal transplant.

Data element attributes

Collection and usage attributes

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

Collection methods: To be collected on commencement of treatment and regularly reviewed.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Caring for Australians with Renal Impairment Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references: Supersedes Renal disease therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.52 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

Nephrotoxic agents (including radiocontrast) should be avoided where possible.
Drugs that impair auto-regulation of glomerular filtration rate (GFR) (NSAIDs, COX-2, ACEI, ATRA) should be used with caution in renal impairment, particularly when patients are acutely unwell for other reasons (sepsis, peri-operative etc).

Although combination ACEI and diuretic can be a very potent and efficacious means of reducing blood pressure (and thereby slowing progression), either drug should be introduced individually and carefully in a patient with underlying renal impairment. At the very least, diuretic therapy should be held or reduced when commencing an ACEI in a patient with renal impairment. Combination therapy with ACEI, diuretics and NSAIDs or COX-2 may be particularly harmful.

Drugs, which are primarily excreted by the kidney (e.g. metformin, sotalol, cisapride, etc.) need to be used with caution in patients with renal impairment. The calculated GFR needs to be determined and the dose reduced or the drug avoided as appropriate.

Renal disease—end-stage (diabetes complication)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—end-stage renal disease status (diabetes complication), code N
METeOR identifier:	270373
Registration status:	Health, Standard 01/03/2005
Definition:	Whether an individual has end-stage renal disease as a complication of diabetes, and has required dialysis or has undergone a kidney transplant, as represented by a code.
Data Element Concept:	Person—end-stage renal disease status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	End-stage renal disease - developed in the last 12 months
2	End-stage renal disease - developed prior to the last 12 months
3	No end-stage of renal disease

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	Ask the individual if he/she has required dialysis or has undergone a kidney (renal) transplant (due to diabetic nephropathy). Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Renal disease - end stage, diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

To determine chronic renal impairment: -

Glomerular filtration rate (GFR)
GFR > 90 ml/min normal
GFR > 60 - 90 ml/min: mild renal impairment
GFR > 30 - 60 ml/min: moderate renal impairment
GFR 0- 30 ml/min: severe renal impairment
For greater than 3 months.

In general, patients with GFR Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required.

Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (i.e. hypertensive, proteinuric (>1 g/24 hours), significant co-morbid illness) should be considered for referral to a nephrologist well before function declines to less than 30 ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation).
Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

End-stage renal disease is a recognised complication of Type 1 and Type 2 diabetes mellitus. Diabetes is the commonest cause for renal dialysis in Australia.

The term end-stage renal disease has become synonymous with the late stages of chronic renal failure. Diabetic nephropathy may be effectively prevented and treated by controlling glycemia and administering angiotensin-converting enzyme (ACE) inhibitors. *J Am Soc Nephrol 2002 Jun; 13(6): 1615-1625].*

Residential stay start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Residential stay—episode start date, DDMMYYYY
METeOR identifier:	269953
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a **resident** formally started a residential stay.
Data Element Concept:	Residential stay—episode start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references: Supersedes Residential stay start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.61 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Right justified and zero filled.

Residential stay start date ≤ episode of residential care end date.

Residential stay start date ≥ date of birth

Residual expenditure (mental health service)—academic positions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (academic positions), total Australian currency N[N(8)]
METeOR identifier:	290151
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Academic positions refer to grants from the organisation, region or state/territory administration to academic institutions for the establishment and maintenance of academic positions in psychiatry or related disciplines. This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.
Data Element Concept:	Specialised mental health service—residual expenditure (academic positions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants. This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region

or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

Report academic expenditure in this section only where the academic unit operates independently. Where the academic unit or position operates as an integral part of the service (e.g. an acute inpatient unit), the expenditure should be reported for the relevant organisation.

Where academic grants are paid directly by organisation, region or state/territory administration, these should be reported at that level.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—education and training

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (education and training), total Australian currency N[N(8)]
METeOR identifier:	290149
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Education and training refers to the cost of professional training and staff development activity within the mental health services managed by the organisation, region or state/territory administration that have not been included in expenditure reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (education and training)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants. Grants made to external agencies for the development of training-related resources materials or programs may also be reported under this category.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable. Where they do exist, expenditure on schools of nursing should

be reported at the organisation level.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—insurance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (insurance), total Australian currency N[N(8)]
METeOR identifier:	290164
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Insurance refers to public risk and other insurance amounts paid by the organisation, region or central administration in respect to its mental health services and not reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (insurance)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable. Note: insurance expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—mental health promotion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (mental health promotion), total Australian currency N[N(8)]
METeOR identifier:	290156
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the organisation, region or state/territory administration expenditure dedicated specifically to mental health promotion objectives. Mental health promotion is defined as activities designed to lead to improvement of the mental health functioning of persons through prevention, education and intervention activities and services.
Data Element Concept:	Specialised mental health service—residual expenditure (mental health promotion)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants. Reporting expenditure against this item is not intended to be based on costing of activities that retrospectively, entailed a significant mental health promotion component. Instead it should be confined to financial allocations that were clearly targeted towards mental health promotion objectives.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one

level.

Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—mental health research

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (mental health research), total Australian currency N[N(8)]
METeOR identifier:	290153
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditures by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to expenditure on basic or applied research in the mental health field funded by the organisation, region or state/territory administration.
Data Element Concept:	Specialised mental health service—residual expenditure (mental health research)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable: Report research expenditure for this category only where the research operated independently and where that expenditure is not reported elsewhere. Where the research activity occurs as an integral component of service delivery (e.g. in cases where research staff are also clinical staff within a hospital unit), the expenditure should be reported under the relevant service unit

(at the organisation-level).

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—other indirect expenditure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (other indirect expenditure), total Australian currency N[N(8)]
METeOR identifier:	290187
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Includes any other indirect expenditure (excluding grants to non-government organisations to provide mental health services other than residential services) that is incurred in the delivery of mental health services and is not reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (other indirect expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—patient transport services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (patient transport services), total Australian currency N[N(8)]
METeOR identifier:	290183
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to direct cost of transporting patients of mental health services.
Data Element Concept:	Specialised mental health service—residual expenditure (patient transport services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—program administration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (program administration), total Australian currency N[N(8)]
METeOR identifier:	290145
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to costs of administration and other support services (such as program management, admissions reception office, medical records etc.) at the mental health program-level (i.e. at state or territory, region or organisation level). Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program.
Data Element Concept:	Specialised mental health service—residual expenditure (program administration)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program. Excludes grants to non-government organisations for services that are to be reported separately. These include grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories,

where applicable:
Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—property leasing costs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (property leasing costs), total Australian currency N[N(8)]
METeOR identifier:	290185
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the costs of leasing premises used for the provision of mental health services (e.g. community clinics).
Data Element Concept:	Specialised mental health service—residual expenditure (property leasing costs)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—superannuation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (superannuation), total Australian currency N[N(8)]
METeOR identifier:	290158
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It includes superannuation employer contributions paid, or for an emerging cost scheme, that should be paid on behalf of the employee and that are not reported elsewhere. Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable, that is, there is no ongoing invested fund from which benefits are paid.
Data Element Concept:	Specialised mental health service—residual expenditure (superannuation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable. Note: Superannuation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (support services), total Australian currency N[N(8)]
METeOR identifier:	290147
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the cost of administration and other support services provided at the region-level. Such services include regional administration, information systems, personnel, finance and accounting functions. These services are usually provided from a central pool of resources managed at a regional level.
Data Element Concept:	Specialised mental health service—residual expenditure (support services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable: These services are usually provided from a central pool of resources managed at a regional level. Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residual expenditure (mental health service)—workers compensation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (workers compensation), total Australian currency N[N(8)]
METeOR identifier:	290160
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditures in Australian dollars specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to workers compensation premiums and payments made by the organisation, region or central administration on behalf of its employees and not reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (workers compensation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Note: Workers compensation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set	Mental health establishments NMDS 2005-2006 Health,

Specifications:

Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Resuscitation of baby—method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—baby resuscitation method, code N
METeOR identifier:	270116
Registration status:	Health, Standard 01/03/2005
Definition:	Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effect and to correct metabolic disturbances, as represented by a code.
Data Element Concept:	Birth event—baby resuscitation method

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	None
	2	Suction only
	3	Oxygen therapy only
	4	Intermittent positive pressure respiration (IPPR) through bag and mask
	5	Endotracheal intubation and IPPR
	6	External cardiac massage and ventilation
Supplementary values:	9	Not stated

Collection and usage attributes

Guide for use:	CODE 3 Oxygen therapy only If oxygen is given by bag and mask without IPPR, code as 'oxygen therapy'.

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item does not include drug therapy. Code the most severe measure used.
Comments:	Required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Resuscitation of baby, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.63 KB)

Revenue—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (other revenue) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364799
Registration status:	Health, Standard 05/12/2007
Definition:	All other revenue measured in Australian dollars received by the establishment for a financial year, that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments).
Data Element Concept:	Establishment—revenue (other revenue)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Relational attributes

Related metadata references:	Supersedes Establishment—revenue (other revenue) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Revenue—patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (patient) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364797
Registration status:	Health, Standard 05/12/2007
Definition:	All revenue measured in Australian dollars for a financial year, received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges.
Data Element Concept:	Establishment—revenue (patient)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Establishment—revenue (patient) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Revenue—recoveries

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (recoveries) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364805
Registration status:	Health, Standard 05/12/2007
Definition:	All revenue received in Australian dollars for a financial year, that is in the nature of a recovery of expenditure incurred.
Data Element Concept:	Establishment—revenue (recoveries)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar. This metadata item relates to all revenue received by establishments except for general revenue payments received from state or territory governments.
Comments:	The Resources Working Party had considered splitting recoveries into staff meals and accommodation, and use of hospital facilities (private practice) and other recoveries. Some states had felt that use of facilities was too sensitive as a separate identifiable item in a national minimum data set. Additionally, it was considered that total recoveries was an adequate category for health financing analysis purposes at the national level.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Establishment—revenue (recoveries) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Satisfaction with participation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of satisfaction with participation in a life area, code N
METeOR identifier:	320216
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree to which a person is satisfied with their involvement in a specified life area, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—level of satisfaction with participation in a life area

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	High satisfaction with participation
1	Moderate satisfaction with participation
2	Neither satisfied nor dissatisfied with participation
3	Moderate dissatisfaction with participation
4	Extreme dissatisfaction with participation
5	Complete restriction and dissatisfaction

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement in life situations.

This metadata item gives a rating of the person's degree of satisfaction with participation in a domain of life, in relation to their current life goals. Satisfaction with participation corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in which are embedded the concepts of choice, opportunity and importance.

CODE 0 High satisfaction with participation

Used if a person is involved in the specified life situation as he

or she wishes to fulfil his or her current life goals in terms of duration, frequency, manner and outcome.

CODE 1 Moderate satisfaction with participation

Used if the person is reasonably satisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome. This could occur if one of the criteria (duration, frequency, manner or outcome) is not fulfilled and that criterion is not critical to the person's goals. For example, the person does not participate in the specified life situation as frequently as wished, but the other criteria are met and the frequency is not so affected that it is critical to the person's satisfaction.

CODE 2 Neither satisfied nor dissatisfied with participation

Used if the person is neither satisfied nor dissatisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome.

CODE 3 Moderate dissatisfaction with participation

Used if two or three criteria (duration, frequency, manner or outcome) are not fulfilled, but are not so badly affected, in relation to the person's goals in that life area, that the person is extremely dissatisfied. For example, a person is able to participate in work, but is placed in supported employment rather than employment in the open labour market. This is not in line with the person's goals, so that the manner and outcome of the participation are not fulfilled.

CODE 4 Extreme dissatisfaction with participation

Used when all criteria (duration, frequency, manner and outcome) are not fulfilled for the specified life situation, or where any of the criteria are so badly affected in relation to the person's goals that they consider themselves to be extremely dissatisfied with this life area. An example of the latter would arise when a person is extremely dissatisfied with participation in interpersonal activities because his/her goal in terms of duration of social visits is never fulfilled, although other criteria (frequency and manner) may be fulfilled.

CODE 5 Complete restriction and dissatisfaction

Used when the person does not participate in this life situation in line with his or her own goals, i.e. in an area where they wish to participate and is completely dissatisfied with not participating in this life situation.

CODE 9 Not applicable

Used when participation in a life situation is not relevant, such as employment of an infant or where there is no participation and the person has no desire to participate in this area. For example, a personal preference not to participate in specific areas of community, social and civic life such as sport or hobbies. The area may not be applicable to the person's current life goals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

Satisfaction with participation should be coded from the perspective of the person. This data element should be coded in conjunction with the Person—activities and participation life area, code (ICF 2001) AN[NNN] data element. For example, a person's 'moderate satisfaction with participation in exchange of information'.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Activities and Participation cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Scheduled admission date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient care waiting list episode—scheduled admission date, DDMMYYYY
METeOR identifier:	269978
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.
Data Element Concept:	Admitted patient care waiting list episode—scheduled admission date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Comments:	If this metadata item were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list). This metadata item is required for the purposes of hospital management - allocation of beds, operating theatre time and other resources.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Scheduled admission date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.49 KB)

Separation date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation date, DDMMYYYY
METeOR identifier:	270025
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care—separation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Comments:

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Separation date, version 5, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.15 KB)

Is used in the formation of Establishment—number of separations (financial year), total N[NNNNN] Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies this field must:

- be ≤ last day of financial year
- be ≥ first day of financial year
- be ≥ Admission date

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies this field must:

- be ≤ last day of financial year
- be ≥ first day of financial year
- be ≥ Admission date

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies this field must:

- be ≤ last day of financial year
- be ≥ first day of financial year
- be ≥ Admission date

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies this field must:

- be ≤ last day of financial year
- be ≥ first day of financial year
- be ≥ Admission date

Separation time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation time, hhmm
METeOR identifier:	270026
Registration status:	Health, Standard 01/03/2005
Definition:	Time at which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care—separation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Comments:	Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.

Relational attributes

Related metadata references:	Supersedes Separation time, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.33 KB)

Separations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of separations (financial year), total N[NNNNN]
Synonymous names:	Discharge
METeOR identifier:	270407
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of **separations** occurring during the reference period. This includes both formal and statistical separations.
Data Element Concept:	Establishment—number of separations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Separation

Data element attributes

Collection and usage attributes

Guide for use:

May be calculated at:

- individual establishment level; or
- system (ie. state/territory) level i.e. the sum of the number of establishments.

The sum of the number of separations where the separation date has a value:

- >= the beginning of the reference period (typically a financial year); and
- <= the end of the reference period.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Separations, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.34 KB)

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Mental health establishments NMDS 2005-2006 Health,

Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set, separations are only to be reported for specialised mental health services provided by private hospitals that receive state or territory government funding. That is, separations from public hospitals need not be reported.

Service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service contact—service contact date, DDMMYYYY
METeOR identifier:	270122
Registration status:	Health, Standard 01/03/2005
Definition:	The date of service contact between a health service provider and patient/client.
Data Element Concept:	Service contact—service contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.
Collection methods:	For collection from community based (ambulatory and non-residential) agencies.

Relational attributes

Related metadata references:	Supersedes Service contact date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.14 KB) Is used in the formation of Person—number of service contact dates, total N[NN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007 Community mental health care 2004-2005 Health, Superseded 08/12/2004 *Implementation start date:* 01/07/2004 *Implementation end date:* 30/06/2005 Diabetes (clinical) DSS Health, Superseded 21/09/2005

Service mode (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—service mode, hospital code N{.N}
METeOR identifier:	270096
Registration status:	Health, Standard 01/03/2005
Definition:	Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—service mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:

Value	Meaning
1	Patient and provider in the same physical location
1.1	On the hospital campus of the provider
1.2	Not on the hospital campus of the provider
2	Patient and provider not in the same physical location, and communicating via:
2.1	Telephone
2.2	Telemedicine

Collection and usage attributes

Guide for use:

CODE 1.1 On the hospital campus of the provider

Patient and provider in the same physical location refers to face to face contacts. If this occurs at the hospital campus of the provider, use code 1.1.

CODE 1.2 Not on the hospital campus of the provider

If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2.

Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work).

Patient and provider not in the same physical location refers to service events delivered via a telephone call or video link (telemedicine). The provider may or may not be physically present on their hospital campus.

A service event delivered via a telephone call is included if

- it is a substitute for a face-to-face service event, and
- it is pre-arranged, and

- a record of the service event is included in the patient's medical record

A service event can be counted at each site participating via a video link.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Non-admitted patient service mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.76 KB)

Service type (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—service event type (clinical), code N[N]
METeOR identifier:	270090
Registration status:	Health, Standard 01/03/2005
Definition:	The type of clinical service provided to a non-admitted patient in a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—service event type (clinical)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Allied health and/or clinical nurse specialist
2	Dental
3	Imaging
4	Medical
5	Obstetrics and gynaecology
6	Paediatrics
7	Pathology
8	Pharmacy
9	Psychiatric
10	Surgical
11	Emergency department

Collection and usage attributes

Guide for use:

The following provides a guide to types of clinical services that are included in each of the categories in the data domain. Clinical services that are not specifically identified in this Guide for use should be classified as one of the groups in the data domain on the basis of the type of clinical professional staff involved in providing the service event.

In paediatric hospitals, the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgical should be reported as surgical.

Clinical service type	Clinical service examples
Allied health and/or clinical	Audiology

nurse specialist	Clinical pharmacy Diabetes education Neuropsychology Nutrition/dietetics Occupational therapy Optometry Orthoptics Orthotics Physiotherapy Podiatry Prosthetics Psychology Social work Speech pathology Stomal therapy Wound management
Dental	Dental
Imaging	Medical imaging
Medical	Aged care Alcohol and other drug Allergy Anti-coagulant Asthma Cardiology Clinical measurement Dermatology Dementia Developmental disabilities Diabetes Endocrine Epilepsy Falls Gastroenterology General internal medicine Genetic Haematology Hepatobiliary Hypertension Hyperbaric medicine Immunology Infectious diseases Medical oncology Metabolic bone Nephrology Neurology Occupational medicine Palliative care Pain management Pulmonary Radiation oncology Rehabilitation Respiratory Rheumatology Spinal Transplants

Obstetrics and gynaecology	Family planning Gynaecology Gynaecology oncology Obstetrics
Pathology	Pathology
Paediatrics	Adolescent health Neonatal Paediatric medicine Paediatric surgery
Pharmacy	Dispensing pharmacy
Psychiatric	Psychiatry
Surgical	Breast Burns Cardiac surgery Colorectal Craniofacial Ear, nose and throat Fracture General surgery Neurosurgery Ophthalmology Orthopaedics Plastic surgery Pre-admission Pre-anaesthesia Thoracic surgery Urology Vascular surgery
Emergency department	Emergency department

An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Data element attributes

Relational attributes

Related metadata references: Supersedes Non-admitted patient service type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.09 KB)

Sex

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—sex, code N
METeOR identifier:	287316
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The biological distinction between male and female, as represented by a code.
Data Element Concept:	Person—sex

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Male
	2	Female
	3	Intersex or indeterminate
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code. CODE 3 Intersex or indeterminate Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason. Intersex or indeterminate, should be confirmed if reported for people aged 90 days or greater.
Comments:	The definition for Intersex in Guide for use is sourced from the ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

Source and reference attributes

Origin:	Australian Capital Territory 2003. Legislation (Gay, Lesbian and Transgender) Amendment Act 2003
Reference documents:	Legislation (Gay, Lesbian and Transgender) Amendment Act 2003. See http://www.legislation.act.gov.au/a/2003-14/20030328-4969/pdf/2003-14.pdf.

Data element attributes

Collection and usage attributes

Collection methods:

Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.

When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, the person's sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

CODE 3 Intersex or indeterminate

Is normally used for babies for whom sex has not been determined for whatever reason.

Should not generally be used on data collection forms completed by the respondent.

Should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

CODE 9 Not stated/inadequately described

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin:

Australian Institute of Health and Welfare (AIHW) National Mortality Database 1997/98 AIHW 2001 National Diabetes Register, Statistical Profile, December 2000 (Diabetes Series No. 2.)

Reference documents:

Australian Bureau of Statistics

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Supersedes Person—sex, code N Health, Superseded 04/05/2005, Community services, Superseded 31/08/2005

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health,

Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For data collections using the Computer Assisted Telephone Interview demographic module DSS, only Codes 1 and 2 are collected.

For data collection using Computer Assisted Telephone Interviewing (CATI) it is recommended that sex be ascertained by the interviewer on the basis of information already collected or other cues such as voice or name. If the interviewer is unsure of the respondent's sex the following question may be used:

As this interview is being conducted over the phone, I need to ask are you male or female?

Male

Female

(Interviewer note: If respondent provides any response that can't be categorised to male or female, terminate interview.)

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Source of public and private revenue

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health industry relevant organisation—source of revenue, public and private code NNN
METeOR identifier:	352427
Registration status:	Health, Standard 05/12/2007
Definition:	The source of revenue received by a health industry relevant organisation, as represented by a code.
Data Element Concept:	Health industry relevant organisation—source of revenue

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
	Public sector
101	Australian Health Care Agreements
102	Other Special Purpose Payments
103	Medicare
104	Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme
105	National Health and Medical Research Council
106	Department of Veterans' Affairs
107	Other Australian government departments
108	State/Territory non-health departments
188	Other public sector revenue
	Private sector
201	Private health insurance
202	Workers compensation insurance
203	Motor vehicle third party insurance
204	Other compensation (e.g. Public liability, common law, medical negligence)
205	Private households (self-funded and out-of-pocket expenditure)
206	Non-profit institutions serving households
207	Corporations (other than health insurance)
288	Other private sector revenue
301	Overseas
999	Not further defined

Collection and usage attributes

Guide for use:

Public sector

CODE 101 Australian Health Care Agreements

This item is not currently required to be reported by state or territory health authorities.

Revenue received from the Australian Government Department of Health and Ageing under the Australian Health Care Agreements to assist in the cost of providing public patients with free access to public hospital services within a clinically appropriate time irrespective of where patients live.

CODE 102 Other Special Purpose Payments

This item is not currently required to be reported by state or territory health authorities.

Includes Specific Purpose Payments provided by the Australian Government to the states and territories such as:

- Public Health Outcomes Funding Agreement grants
- Highly Specialised Drugs grants
- National Radiotherapy grants
- National Mental Health Information Development grant
- Magnetic Resonance Imaging grants
- Postgraduate Medical Training grants
- Hepatitis C Education and Prevention grant
- Royal Flying Doctor Service grants

Excludes AHCA grants, Medicare or PBS/RPBS payments.

CODE 103 Medicare

This item is not currently required to be reported by state or territory health authorities.

Includes revenue received for services listed in the Medical Benefits Schedule that are provided by registered medical practitioners. Many medical services in Australia are provided on a fee-for-service basis and attract benefits or revenue from the Australian Government under Medicare.

Includes revenue received for medical services provided to private admitted patients in hospitals as well as some revenue that is not based on fee-for-service (i.e. alternative funding arrangements).

CODE 104 Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceuticals Benefits Scheme (RPBS)

Includes pharmaceuticals in the PBS and RPBS for which the Australian Government paid a benefit.

Excludes:

- revenue received for pharmaceuticals for which no PBS or RPBS benefit was paid;
- revenue received for other non-pharmaceutical medications;
- pharmaceuticals listed in the PBS or RPBS, the total costs of which are equal to, or less than, the statutory patient contribution for the class of patient concerned;
- medicines dispensed through private prescriptions that do not fulfil the criteria for payment under the PBS or RPBS; and
- over-the-counter medicines such as pharmacy-only medicines, aspirin, cough and cold medicines, vitamins and minerals, herbal and other complementary medicines, and a range of medical non-durables, such as bandages, band aids and condoms.

CODE 105 National Health and Medical Research Council

Includes health research funded by the National Health and Medical Research Council that is not reported elsewhere.

CODE 106 Department of Veterans' Affairs

Includes revenues received for health services provided to veterans, war widows and widowers with gold or white DVA cards. Types of services include public and private hospitals, local medical officers and specialists, residential aged care subsidy, allied health, rehabilitation appliances, dental services, community nursing, Veterans' Home Care and travel for treatment.

Excludes revenues received for pharmaceuticals provided to veterans, war widows and widowers with gold, white or orange DVA cards which are reported under code 104.

CODE 107 Other Australian Government Departments

Includes other revenues received for health services from, for example, the Department of Immigration and Citizenship and Department of Defence. Excludes Medicare payments from Medicare Australia (part of Department of Human Services) reported under code 103.

CODE 108 State/Territory non-health Departments

Includes correctional facilities, and departments that have contributed funding for the provision of a health service e.g. public health, emergency services, NSW Food Authority, NSW Health Care Complaints Commission, South Australia Ambulance Service, National Blood Authority, Red Cross, and prison health services such as WA Health services directorate and St Vincents Correctional Health Service Victoria.

CODE 188 Other public sector revenue

Includes all public sector revenue other than those reported under codes 101 to 108. May include revenue from Local governments.

Private sector

CODE 201 Private health insurance

Includes revenue from businesses mainly engaged in providing insurance cover for hospital, medical, dental or pharmaceutical expenses or costs.

Excludes:

1. accident and sickness insurance
2. liability insurance
3. life insurance
4. general insurance
5. other insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules
6. overseas visitors for whom travel insurance is the major funding source.

State and territory health authorities may report revenues for admitted patients, from private health insurance funds and private households, as a combined total if these revenues are not able to be reported separately.

CODE 202 Workers compensation insurance

Includes benefits paid under workers compensation insurance to the health industry relevant organisation for health care provided to workers, including trainees and apprentices, who have experienced a work-related injury. Type of benefits includes fees for medical or related treatment.

Excludes benefits paid under public liability, common law or

medical negligence.

CODE 203 Motor vehicle third party insurance

Includes personal injury claims arising from motor accidents and compensation for accident victims and their families for injuries or death. Excludes benefits paid under workers compensation insurance, public liability, common law or medical negligence.

CODE 204 Other compensation (e.g. Public liability, common law, medical negligence).

This item is not currently required to be reported by state or territory health authorities.

Includes revenues received from:

- public liability insurance for injury arising from an incident related to the organisation's normal activities;
- a court-ordered settlement for damages because of negligence under specific conditions a duty of care exists and was breached and material damage resulted as a consequence;
- health professionals employed by health authorities or otherwise covered by health authority professional indemnity arrangements; and
- a common law settlement cancels all other entitlements to workers compensation benefits. If a common law claim is not successful, the worker will continue to receive workers compensation under the statutory scheme.

Excludes benefits paid under motor vehicle third party insurance.

CODE 205 Private households (self-funded and out-of-pocket expenditure)

Includes payments received from the patient, the patient's family or friends, or other benefactors (i.e. patient revenue).

Includes cost-sharing and informal payments to health care providers. Cost-sharing is a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received. This is distinct from the payment of a health insurance premium, contribution or tax which is paid whether health care is received or not.

Cost-sharing can be in the form of co-payments, co-insurance or deductibles:

- co-payment: cost-sharing in the form of a fixed amount to be paid for a service;
- co-insurance: cost-sharing in the form of a set proportion of the cost of a service; and
- deductibles: cost-sharing in the form of a fixed amount which must be paid for a service before any payment of benefits can take place.

CODE 206 Non-profit institutions serving households

Non-profit institutions serving households (NPISHs) (i.e. non-profit NGOs) consist of non-profit institutions which provide goods or services to households free or at prices that are not economically significant. Such NPISHs may provide health care goods or services on a non-market basis to households in need, including households affected by natural disasters or war.

The revenues received from such NPISHs are provided mainly by donations in cash or in kind from the general public, corporations or governments. These include organisations such as the National Heart Foundation, Diabetes Australia or the Cancer Council etc. Excludes non-profit institutions that are market producers of goods

and services.

NOTE: This item is to be used for the reporting of revenues received from trusts or charities.

CODE 207 Corporations (other than health insurance)

This item is not currently required to be reported by state or territory health authorities.

Include revenues received from all corporations or quasi-corporations, whose principal activity is the production of market goods or services (other than health insurance). Included are all resident non-profit institutions that are market producers of goods or non-financial services. These include health or health-related organisations such as hospitals, pharmacies, medical and diagnostic laboratories, residential aged care facilities and providers of medical specialist services, and non-health organisations such as research organisations.

CODE 288 Other private sector revenue

Includes all private sector revenue other than those reported under codes 201 to 207.

CODE 301 Overseas

This item is not currently required to be reported by state or territory health authorities.

Includes funds provided from overseas countries for areas of health care such as research. Funds may be channelled through government or non-government organisations or private institutions. Also includes overseas visitors receiving health care for whom travel insurance is the major funding source.

CODE 999 Not further defined

Includes all revenue that could be a combination of categories 101 to 108, 188, 201 to 207 and 288 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Australian Institute of Health and Welfare 2007. Episode of care—principal source of funding, hospital code NN. Viewed 26 July 2007. <http://meteor.aihw.gov.au/content/index.phtml/itemId/339080>

Organisation for Economic Co-operation and Development A system of health accounts, Version 1. OECD 2000.

Australian Bureau of Statistics 2006, Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006, cat. no. 1292.0, ABS, Canberra

Standard Economic Sector Classifications of Australia (SESCA), 2002, cat. no. 1218.0, ABS, Canberra

Private Health Insurance Act 2007 No. 31, 2007 Chapter 4, Part 4–3 at http://www.comlaw.gov.au/

Data element attributes

Collection and usage attributes

Guide for use: If there is an expected source of revenue followed by a finalised actual source of revenue (for example, in relation to compensation claims), then the actual revenue source known at the end of the reporting period should be recorded.

The expected revenue source should be reported if the fee has not

been paid but is not to be waived.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Implementation in Data Set Specifications: Government health expenditure function revenue data cluster Health, Standard 05/12/2007

Government health expenditure organisation revenue data element cluster Health, Standard 05/12/2007

Source of referral to alcohol and other drug treatment service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—referral source, code NN
METeOR identifier:	269946
Registration status:	Health, Standard 01/03/2005
Definition:	The source from which the person was transferred or referred to the alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—referral source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Self
02	Family member/friend
03	Medical practitioner
04	Hospital
05	Mental health care service
06	Alcohol and other drug treatment service
07	Other community/health care service
08	Correctional service
09	Police diversion
10	Court diversion
98	Other

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 03 Medical practitioner

Includes medical specialists, vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.

CODE 04 Hospital

Includes public and private hospitals, hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care, satellite units managed and staffed by a hospital, emergency departments of hospitals, and mothercraft hospitals.

Excludes psychiatric hospitals, psychiatric units and drug and alcohol units located within or operating from hospitals, and outpatient clinics (see codes 05-07).

CODE 05 Mental health care service

Includes both residential and non-residential services. Includes psychiatric hospitals and psychiatric units within and outside of hospitals.

CODE 06 Alcohol and other drug treatment service

Includes both residential and non-residential services. Includes drug and alcohol units within and outside of hospitals.

CODE 07 Other community/health care service

Includes outpatient clinics and aged care facilities.

CODE 09 Police diversion

This code should be used when a person detained for a minor drug offence is formally referred to treatment by the police in order to divert the offender from the criminal justice pathway.

CODE 10 Court diversion

This code refers to the diversion of an offender into drug education, assessment and treatment at the discretion of a magistrate. This may occur at the point of bail or prior to sentencing.

CODE 98 Other

Includes persons referred under a legislative act (other than Drug *Diversion Act*) e.g. *Mental Health Act*.

Data element attributes

Collection and usage attributes

Comments: Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Source of referral to alcohol and other drug treatment service, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.19 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009
Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Source of referral to public psychiatric hospital

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—referral source, public psychiatric hospital code NN
METeOR identifier:	269947
Registration status:	Health, Standard 01/03/2005
Definition:	Source from which the person was transferred/referred to the public psychiatric hospital, as represented by a code.
Context:	To assist in analyses of intersectoral patient flow and health care planning.
Data Element Concept:	Episode of admitted patient care—referral source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

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

Supplementary values:

Value	Meaning
10	Unknown

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Source of referral to public psychiatric hospital, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded

23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised mental health service program type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—admitted patient care program type, code N
METeOR identifier:	288889
Registration status:	Health, Standard 08/12/2004
Definition:	Type of admitted patient care program provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—admitted patient care program type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Acute care
2	Other

Collection and usage attributes

Guide for use:

The categorisation of the admitted patient program is based on the principal purpose(s) of the program rather than the classification of the individual patients.

CODE 1 Acute care

Programs primarily providing specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder, that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms. This category applies only to services with a mental health service setting of overnight admitted patient care or residential care.

CODE 2 Other

Refers to all other programs primarily providing admitted patient care.

Includes programs providing rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery.

They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by

rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Also includes programs providing extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for admitted patient settings in mental health service units (see Specialised mental health service—service setting, code N data element).

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Specialised mental health service setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—service setting, code N
METeOR identifier:	288899
Registration status:	Health, Standard 08/12/2004
Definition:	The setting for care provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—service setting

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Admitted patient care setting
	2	Residential care setting
	3	Ambulatory care setting
Supplementary values:	9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Admitted patient care setting

The component of specialised mental health services that provides admitted patient care. These are specialised psychiatric hospitals and specialist psychiatric units located within hospitals that are not specialised psychiatric hospitals. Excludes hospital outpatient clinics.

CODE 2 Residential care setting

The component of specialised mental health services that provides residential care within **residential mental health services**. Excludes components that provide ambulatory care to patients or clients who are not residents.

CODE 3 Ambulatory care setting

The component of specialised mental health services that provides ambulatory care (service contacts). They include hospital outpatient clinics and non-hospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services.

Data element attributes

Collection and usage attributes

Guide for use: A single mental health service unit may provide care in more than one setting. This data element is intended to allow staffing,

resource and expenditure data related to these settings to be identified and reported separately.

Relational attributes

Related metadata references:

Supersedes Specialised mental health service – service delivery setting, code N Health, Superseded 08/12/2004

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised mental health service target population

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—target population group, code N
METeOR identifier:	288957
Registration status:	Health, Standard 08/12/2004
Definition:	The population group primarily targeted by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—specialised mental health service target population group

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Child and adolescent
2	Older person
3	Forensic
4	General

Collection and usage attributes

Guide for use:

CODE 1 Child and adolescent

These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 2 Older person

These services principally target people in the age group of 65 years and over. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 3 Forensic

Health services that provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.

CODE 4 General

These services principally target the general adult population (aged 18–64 years) but may also provide services to children,

adolescents or older people. These services are those services that cannot be described as specialist child and adolescent services or services for older people. It excludes forensic services.

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for admitted patient settings in mental health service units (see service setting data element).

The order of priority for coding is:

- where the forensic services are for children/adolescents or older persons these services should be coded to the category for that age group; and
- where the forensic services are for adults these services should be coded to forensic.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Specialised mental health service—hours staffed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of hours staffed, average hours NN
METeOR identifier:	288877
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of hours per day during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training.
Data Element Concept:	Specialised mental health service—number of hours staffed

Value domain attributes

Representational attributes

Representation class:	Average	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Unknown/not stated/inadequately described
Unit of measure:	Hour (h)	

Data element attributes

Collection and usage attributes

Guide for use:

Whole numbers of hours staffed (no decimals or fractions).

Valid numbers are 1 to 24.

The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data.

For residential mental health services, this refers to the number of hours per day during which appropriately trained staff (either with formal qualifications and/or on the job training) are employed on site, as their normal place of employment, within the service unit. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit.

Excludes ambulatory and admitted patient services.

Round to nearest whole hour.

Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised mental health service—supported public housing places

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of supported public housing places, total N[N(5)]
METeOR identifier:	288945
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of public housing places supported by specialised mental health services available at 30 June, targeted to people affected by mental illness or psychiatric disability. These are places provided by the public housing authority under a formal partnership agreement with the relevant State or Territory health authority. Such agreements commit the State or Territory health authority to assist people within their homes by providing ongoing clinical and disability support, including outreach services.
Data Element Concept:	Specialised mental health service—number of supported public housing places

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(5)]
Maximum character length:	6

Source and reference attributes

Steward:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—acquired immune deficiency syndrome unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acquired immune deficiency syndrome unit), yes/no code N
METeOR identifier:	270448
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of Acquired Immune Deficiency Syndrome (AIDS) patients is provided within an establishment as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—acute renal dialysis unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acute renal dialysis unit), yes/no code N
METeOR identifier:	270435
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to dialysis of renal failure patients requiring acute care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—acute spinal cord injury unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acute spinal cord injury unit), yes/no code N
METeOR identifier:	270432
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister's Advisory Council guidelines for service provision, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—alcohol and drug unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (alcohol and drug unit), yes/no code N
METeOR identifier:	270431
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility/service dedicated to the treatment of alcohol and drug dependence is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—bone marrow transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (bone marrow transplantation unit), yes/no code N
METeOR identifier:	308862
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for bone marrow transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—burns unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (burns unit (level III)), yes/no code N
METeOR identifier:	270438
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of the patient's body surface affected) is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Specialised service indicators—cardiac surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (cardiac surgery unit), yes/no code N
METeOR identifier:	270434
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to operative and peri-operative care of patients with cardiac disease is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—clinical genetics unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (clinical genetics unit), yes/no code N
METeOR identifier:	270444
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of, or anxious about genetic disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—comprehensive epilepsy centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (comprehensive epilepsy centre), yes/no code N
METeOR identifier:	270442
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—coronary care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (coronary care unit), yes/no code N
METeOR identifier:	270433
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to acute care services for patients with cardiac diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—diabetes unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (diabetes unit), yes/no code N
METeOR identifier:	270449
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of diabetics is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—domiciliary care service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (domiciliary care service), yes/no code N
METeOR identifier:	270430
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment is provided by the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Specialised service indicators—geriatric assessment unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (geriatric assessment unit), yes/no code N
METeOR identifier:	270429
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial **admission** to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—heart, lung transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (heart, lung transplantation unit), yes/no code N
METeOR identifier:	308866
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for heart including heart lung transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—hospice care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (hospice care unit), yes/no code N
METeOR identifier:	270427
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of palliative care to terminally ill patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—in-vitro fertilisation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (in-vitro fertilisation unit), yes/no code N
METeOR identifier:	270441
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—infectious diseases unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (infectious diseases unit), yes/no code N
METeOR identifier:	270447
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of infectious diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (intensive care unit (level III)), yes/no code N
METeOR identifier:	270426
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health,

Specialised service indicators—liver transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (liver transplantation unit), yes/no code N
METeOR identifier:	308868
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for liver transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—maintenance renal dialysis centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (maintenance renal dialysis centre), yes/no code N
METeOR identifier:	270437
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a specialised facility dedicated to maintenance dialysis of renal failure patients, as represented by a code. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—major plastic/reconstructive surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (major plastic/reconstructive surgery unit), yes/no code N
METeOR identifier:	270439
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Specialised service indicators—neonatal intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neonatal intensive care unit (level III)), yes/no code N
METeOR identifier:	270436
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of neonates requiring care and sophisticated technological support, is provided within an establishment, as represented by a code. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—neuro surgical unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neuro surgical unit), yes/no code N
METeOR identifier:	270446
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the surgical treatment of neurological conditions is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—nursing home care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (nursing home care unit), yes/no code N
METeOR identifier:	270428
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of nursing home care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—obstetric/maternity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (obstetric/maternity), yes/no code N
METeOR identifier:	270150
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of obstetric/maternity patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—oncology unit, cancer treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (oncology unit) (cancer treatment), yes/no code N
METeOR identifier:	270440
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients, is provided within an establishment, as represented by a code. Treatment services include surgery, chemotherapy and radiation.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—pancreas transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (pancreas transplantation unit), yes/no code N
METeOR identifier:	308870
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for pancreas transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—psychiatric unit/ward

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (psychiatric unit/ward), yes/no code N
METeOR identifier:	270425
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—rehabilitation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (rehabilitation unit), yes/no code N
METeOR identifier:	270450
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see metadata item Type of episode of care) are provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Specialised service indicators—renal transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (renal transplantation unit), yes/no code N
METeOR identifier:	308864
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for renal transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—sleep centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (sleep centre), yes/no code N
METeOR identifier:	270445
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Specialised service indicators—specialist paediatric

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (specialist paediatric), yes/no code N
METeOR identifier:	270424
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of children aged 14 or less is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (transplantation unit), yes/no code N
METeOR identifier:	270443
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient, is provided within an establishment. • bone marrow • renal • heart, including heart-lung • liver • pancreas.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—specialist private sector rehabilitation care indicator, code N
METeOR identifier:	270397
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the rehabilitation care that a patient receives from a private hospital meets the criteria for 'Specialist private sector rehabilitation care', as represented by a code.
Data Element Concept:	Episode of care—specialist private sector rehabilitation care indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is a qualifier of the three 'Rehabilitation' care types for admitted patients in private hospitals. When an admitted patient in a private hospital is receiving rehabilitation care (as defined in Hospital service—care type, code N[N].N), this metadata item should be recorded to denote whether or not that care meets the criteria for 'specialist rehabilitation'.

These are the criteria determined by The Commonwealth Department of Health and Ageing in respect of patients treated in the private sector, specialist rehabilitation is:

- Provided by a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing admitted patient and/or ambulatory care) meeting guidelines issued by the Commonwealth Department of Health and Ageing, and
- provided by a multi-disciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent, and
- provided for a person with limited functioning (impairments, activity limitations and participation restrictions) and for whom there is a reasonable expectation of functional gain, and
- for whom the primary treatment goal is improvement in functioning status which is evidenced in the medical record by:
  - an individualised and documented initial and periodic

assessment of functional ability, or

an individualised multi-disciplinary rehabilitation plan which includes agreed rehabilitation goals and indicative timeframes.

Comments: This metadata item has been developed by the Private Rehabilitation Working Group, and agreed by the private rehabilitation hospital sector, the private health insurance sector and the Commonwealth Department of Health and Ageing. Whilst most patients will be treated by a consultant in rehabilitation medicine (a Fellow of the Australasian Faculty of Rehabilitation Medicine) there are circumstances in which the treating doctor will not be a Fellow of the Faculty. These include, but are not limited to, care provided in geographic areas where there is a shortage of Fellows of the Australasian Faculty of Rehabilitation Medicine.

Source and reference attributes

Submitting organisation: Private Rehabilitation Working Group

Commonwealth Department of Health and Ageing

Staging basis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—staging basis of cancer, code A
METeOR identifier:	296981
Registration status:	Health, Standard 04/06/2004
Definition:	The timing and evidence for T, N and M cancer stage values, as represented by a code.
Data Element Concept:	Cancer staging—staging basis of cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
P	Pathological
C	Clinical

Collection and usage attributes

Guide for use:

CODE P Pathological

Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.

CODE C Clinical

Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.

Refer to the latest edition of the UICC reference manual TNM Classification of Malignant Tumours for coding rules.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Staging scheme source

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—cancer staging scheme source, code N
METeOR identifier:	296988
Registration status:	Health, Standard 04/06/2004
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis, as represented by a code.
Data Element Concept:	Cancer staging—cancer staging scheme source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	TNM Classification of Malignant Tumours (UICC)
2	Durie & Salmon for multiple myeloma staging
3	FAB for leukaemia classification
4	Australian Clinico-Pathological Staging (ACPS) System
8	Other

Supplementary values:

9	Unknown

Source and reference attributes

Reference documents:

Durie BGM, Salmon SE. *A clinical staging system for multiple myeloma correlation of measured myeloma cell mass with presenting clinical features, response to treatment and survival.* Cancer 36:842-54 (1975).

Bennett JM, Catovsky D, Daniel MT, Flandrin G, Galton DA, Gralnick HR, Sultan C. *Proposed revised criteria for the classification of acute myeloid leukemia: a report of the French-American-British Cooperative Group.* Ann Intern Med 103(4): 620-625 (1985).

Cheson BD, Cassileth PA, Head DR, Schiffer CA, Bennett JM, Bloomfield CD, Brunning R, gale RP, Grever MR, Keating MJ, et al. *Report of the National Cancer Institute-sponsored workshop on definitions of diagnosis and response in acute myeloid leukemia.* J Clin Oncol 8(5): 813-819 (1990).

Davis NC, Newland RC. *The reporting of colorectal cancer: the Australian Clinicopathological Staging system.* Aust NZ J Surg 52:395-397 (1982).

Public Health Division *NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1* Sydney NSW

Health Dept (2001).
NHMRC *Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* (1999)).

Data element attributes

Collection and usage attributes

Guide for use:

It is recommended that the TNM Manual of the UICC be used whenever it is applicable. The classifications published in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual are identical to the TNM classifications of the UICC.

TNM is not applicable to all tumour sites. Staging is of limited use in acute leukaemias, although a staging system is used for chronic lymphocytic leukaemia. Separate staging systems exist for lymphomas and myeloma. The *NHMRC Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* support the use of the Australian Clinico-Pathological Staging (ACPS) System. A table of correspondences between ACPS and TNM classifications is available.

The current edition of each staging scheme should be used.

Source and reference attributes

Origin:

International Union Against Cancer (UICC).
FAB (French-American-British) Group.
NSW Health Department.
National Health & Medical Research Council.
Clinical Oncological Society of Australia.
Australian Cancer Network.

Relational attributes

Related metadata references:

Supersedes Staging scheme source, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.82 KB)

See also Cancer staging—cancer staging scheme source edition number, code N[N] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Conditional obligation:
Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM) is used to stage the cancer, e.g. FAB for leukaemia classification is used.

Staging scheme source edition number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—cancer staging scheme source edition number, code N[N]
METeOR identifier:	297011
Registration status:	Health, Standard 04/06/2004
Definition:	The edition of the reference used for the purposes of staging the cancer, as represented by a code.
Data Element Concept:	Cancer staging—cancer staging scheme source edition number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
88	Not applicable (Cases that do not have a recommended staging scheme)
99	Unknown edition

Collection and usage attributes

Guide for use:	Record the edition number (i.e. 1 - 87).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:	See also Cancer staging—cancer staging scheme source, code N Health, Standard 04/06/2004 Supersedes Staging scheme source edition number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.74 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005 *Conditional obligation:* Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM) is used to stage the cancer, e.g. FAB for leukaemia classification is used.

Standards assessment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment indicator, yes/no code N
METeOR identifier:	356457
Registration status:	Health, Standard 05/12/2007
Definition:	Whether a service provider organisation routinely undertakes or undergoes formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Formal assessment against the relevant standards may occur via self-assessment or external assessment methods. A 'formal' self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available. A 'formal' assessment also includes a formal in-depth review against the relevant standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation or the organisation of which the service provider organisation is a sub-unit.

CODE 1 Yes
The service provider organisation routinely undertakes or undergoes formal assessment against the specified healthcare standards.

CODE 2 No
The service provider organisation does not routinely undertake or undergo formal assessment against the specified healthcare standards.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Information specific to this data set:
This information is required for the calculation of the national palliative care performance indicator number 2: 'The proportion of palliative care agencies, within their setting of care, that routinely undertake or undergo formal assessment against the Palliative Care Australia standards'.

Standards assessment level

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment level, code N
METeOR identifier:	359019
Registration status:	Health, Standard 05/12/2007
Definition:	The level of assessment undertaken or undergone by a service provider organisation against relevant industry standards as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formally assessed
2	Accredited

Collection and usage attributes

Guide for use:

CODE 1 Formally assessed

Formal assessment may entail self-assessment and/or assessment by an independent external reviewer. This assessment may take place in the context of an accreditation process for the organisation.

A formal assessment, whether self-assessed or externally reviewed, should involve a number of aspects, including the planning and development of a clear structure for the assessment process, the use of an accepted evaluation method such as a peer review, and the use of validated tools where these are available.

CODE 2 Accredited

This code should only be recorded where accreditation has been granted to the organisation and is current.

Data element attributes

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:	Palliative care performance indicators DSS Health, Standard 05/12/2007
	Conditional obligation:

Recorded when the data element Service provider organisation—standards assessment indicator, yes/no code N value is 'yes' (code 1).

Standards assessment method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment method, code N
METeOR identifier:	287762
Registration status:	Health, Standard 05/12/2007
Definition:	The method used by a service provider organisation to undertake or undergo formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment method

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formal self-assessment
2	In-depth external review

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Formal self-assessment

The service provider organisation undertakes formal self-assessment, on a routine basis, against the agreed criteria outlined in the defined industry standards.

A formal self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available.

CODE 2 In-depth external review

The service provider organisation routinely undergoes an in-depth review against the defined industry standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Palliative care performance indicators DSS Health, Standard

Specifications: 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation—standards assessment indicator, yes/no code N* value is 'yes' (code 1).

Information specific to this data set:
The acceptable industry-agreed standards for the purposes of this data element are the most recent standards developed and published by Palliative Care Australia.

State/Territory of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—state/territory of birth, code N
METeOR identifier:	270151
Registration status:	Health, Standard 01/03/2005
Definition:	The state/territory in which the baby was delivered, as represented by a code.
Data Element Concept:	Birth event—state/territory of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use:	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents:	Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 30/09/2005

Data element attributes

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes State/Territory of birth, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.18 KB)

Implementation in Data Set Specifications:

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Standard 04/05/2005

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Status of the baby

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth status, code N
METeOR identifier:	269949
Registration status:	Health, Standard 01/03/2005
Definition:	The status of the baby at birth as represented by a code.
Data Element Concept:	Birth—birth status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Live birth
	2	Stillbirth (fetal death)
Supplementary values:	9	Not stated

Collection and usage attributes

Guide for use:

Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (WHO, 1992 definition).

Stillbirth is a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more **birthweight**; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Source and reference attributes

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

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Status of the baby, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.95 KB)

Implementation in Data Set Specifications:

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Essential to analyse outcome of pregnancy.

Street name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street name, text [A(30)]
METeOR identifier:	270019
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The concatenation of a person's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Person (address)—street name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:	To be used in conjunction with street type. To be used in conjunction with street suffix.
Comments:	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0) , the Street name metadata item in conjunction with street type, house/property identifier and street suffix should also be used.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Street name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.12 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard
04/07/2007

Street name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street name, text [A(30)]
METeOR identifier:	290218
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The concatenation of an organisation's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Service provider organisation (address)—street name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:	To be used in conjunction with street type. To be used in conjunction with street suffix.
Comments:	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0) , the Street name metadata item in conjunction with street type, house/property identifier and street suffix should also be used.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Street suffix code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street suffix, code A[A]
METeOR identifier:	270022
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The abbreviated suffix that identifies the type of street where a person resides, as represented by a code.
Data Element Concept:	Person (address)—street suffix

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods:	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Street suffix code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.91 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Street suffix code (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street suffix, code A[A]
METeOR identifier:	290170
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The abbreviated suffix that identifies the type of street where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—street suffix

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods:	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Street type code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street type, code A[AAA]
METeOR identifier:	270020
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of public thoroughfare where a person resides, as represented by a code.
Data Element Concept:	Person (address)—street type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr
Highway	Hwy
Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge
Road	Rd

Square	Sq
Street	St
Terrace	Tce

Data element attributes

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Supersedes Street type code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.75 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 04/05/2005

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Street type code (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street type, code A[AAA]
METeOR identifier:	290193
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of public thoroughfare where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—street type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr
Highway	Hwy
Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge

Road	Rd
Square	Sq
Street	St
Terrace	Tce

Data element attributes

Collection and usage attributes

Collection methods: To be collected in conjunction with street name. To be collected in conjunction with street suffix.

Source and reference attributes

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications: Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Suburb/town/locality name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—suburb/town/locality name, text [A(50)]
METeOR identifier:	287326
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	The full name of the locality contained within the specific address of a person, as represented by text.
Data Element Concept:	Person (address)—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(50)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. This metadata item may be used to describe the location of person. It can be a component of a street or postal address. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names.
Collection methods:	Enter 'Unknown' when the locality name or geographic area for a person or event is not known. Enter 'No fixed address' when a person has no fixed address or is **homeless**.

Source and reference attributes

Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia Australia Post 2005. Australia Postcode File. Viewed 12 April, www.auspost.com.au/postcodes

Relational attributes

Related metadata references:	Supersedes Person (address)—suburb/town/locality name, text [A(50)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Person (address) — postal delivery point identifier, {N(8)} Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Is used in the formation of Dwelling — geographic location, remoteness structure code (ASGC 2004) N[N] Housing assistance, Retired 10/02/2006

Implementation in Data Set Specifications:

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI), the suggested question is:

What is your suburb, town or community?

(Single response)

Enter town/suburb/community.

Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:
This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory
Health Authorities for Postcode files.

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory
Health Authorities for Postcode files.

Suburb/town/locality name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—suburb/town/locality name, text [A(50)]
METeOR identifier:	290059
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	The full name of the general locality containing the specific address of an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address)—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(50)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of an organisation. It can be a component of a street or postal address.
Collection methods:	Enter 'Unknown' when the locality name or geographic area for an organisation is not known.

Source and reference attributes

Origin:	National Health Data Committee National Community Services Data Committee Australia Post 2005. Australia Postcode File. Viewed 12 April www.auspost.com.au/postcodes
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is used in the formation of Service provider organisation (address)—postal delivery point identifier, {N(8)} Health, Standard 04/05/2005, Community services, Standard 31/08/2005

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Standard 04/07/2007

Information specific to this data set:
This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory Health Authorities for Postcode files.

Surgical specialty

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor), code NN
METeOR identifier:	270146
Registration status:	Health, Standard 01/03/2005
Definition:	The area of clinical expertise held by the doctor who will perform the elective surgery, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Cardio-thoracic surgery
02	Ear, nose and throat surgery
03	General surgery
04	Gynaecology
05	Neurosurgery
06	Ophthalmology
07	Orthopaedic surgery
08	Plastic surgery
09	Urology
10	Vascular surgery
11	Other

Collection and usage attributes

Comments: The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties - ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Surgical specialty, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (15.68 KB)

Implementation in Data Set Specifications: Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Surgical treatment procedure for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 6th edn) NNNNN-NN
METeOR identifier:	364304
Registration status:	Health, Standard 05/02/2008
Definition:	The surgical procedure used in the primary treatment of the cancer, as represented by a code.
Data Element Concept:	Cancer treatment—surgical procedure for cancer

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 6th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	Each surgical treatment procedure used in the initial treatment of the cancer should be recorded. Surgical procedures performed for palliative purposes only should not be included. For surgical procedures involved in the administration of another modality (e.g. implantation of infusion pump, isolated limb perfusion/infusion, intra-operative radiotherapy) record both the surgery and the other modality. Any systemic treatment which can be coded as a procedure through ACHI should be so coded (e.g. stem cell or bone marrow infusion).

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	National Centre for Classification in Health New South Wales Department of Health, Public Health Division
Reference documents:	NSW Department of Health NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 (2001).

Relational attributes

Related metadata references:	Supersedes Cancer treatment—surgical procedure for cancer, procedure code (ACHI 5th edn) NNNNN-NN Health, Superseded 05/02/2008

Systemic therapy agent name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy agent name (primary cancer), antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)]
METeOR identifier:	288446
Registration status:	Health, Standard 04/06/2004
Definition:	The chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer, as represented by a code.
Data Element Concept:	Cancer treatment—systemic therapy agent name (primary cancer)

Value domain attributes

Representational attributes

Classification scheme:	Self-Instructional Manual for Tumour Registrars Book 8 Antineoplastic Drugs, 3rd edition
Representation class:	Code
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The purpose of collecting specific treatment information is to account for all treatment types, which may assist in evaluation of effectiveness of different treatment patterns. The actual agents used will sometimes be of interest. Systemic therapy often involves treatment with a combination of agents. These may be known by acronyms but since details of drugs and acronyms may vary it is recommended that each agent be recorded separately. Oral chemotherapy normally given on an outpatient basis should also be included. New codes and names will need to be added as new agents become available for clinical use. Hormone therapy agents and immunotherapy agents should be recorded under this data element.
Collection methods:	The full name of the agent(s) should be recorded if the coding manual is not available.
Comments:	Collecting dates for systemic therapy will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Source and reference attributes

Origin:	National Cancer Institute Surveillance, Epidemiology and End

Results (SEER) Program

Reference documents: Surveillance, Epidemiology and End Results (SEER) Program Self-instructional manual for tumour registrars: Book 8 - Antineoplastic drugs 3rd Edition National Cancer Institute.

Relational attributes

Related metadata references: Supersedes Systemic therapy agent name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This item is collected for the analysis of outcome by treatment type.

Teaching status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—teaching status (university affiliation), code N
METeOR identifier:	270148
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator to identify the non-direct patient care activity of teaching for a particular establishment, as represented by a code.
Data Element Concept:	Establishment—teaching status (university affiliation)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Unknown

Data element attributes

Collection and usage attributes

Guide for use:

In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant state health authority.

Comments:

The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:

- teaching
- research
- group or community contacts
- public health activities
- mobile centre and/or part-time service.

However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant

state health authority. If a teaching hospital is identified by a Yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Teaching status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Telephone number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—telephone number, text [X(40)]
METeOR identifier:	270266
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The person's contact telephone number, as represented by text.
Data Element Concept:	Person—telephone number

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	More than one phone number may be recorded as required. Each phone number should have an appropriate telephone number type code assigned. Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).
Collection methods:	Prefix plus telephone number: Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix. For example, 08 8226 6000 or 0417 123456. Punctuation: Do not record punctuation. For example, (08) 8226 6000 or 08-8226 6000 would not be correct. Unknown: Leave the field blank.
Comments:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee

National Community Services Data Committee
Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Telephone number, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.42 KB)

Implementation in Data Set Specifications: Health care client identification Health, Superseded 04/05/2005

Telephone number type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (telephone)—telephone number type, code A
METeOR identifier:	270299
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The type of telephone number recorded for a person, as represented by a code.
Data Element Concept:	Person (telephone)—telephone number type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
B	Business or work
H	Home
M	Personal mobile
N	Contact number (not own)
O	Business or work mobile
T	Temporary

Data element attributes

Collection and usage attributes

Guide for use:	Where more than one telephone number has been recorded, then each telephone number should have the appropriate telephone number type code assigned.
Comments:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Telephone number type, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.45 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005

Time creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme measured time, hhmm
METeOR identifier:	285179
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which the person's creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	Record the time in 24-hour clock format.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Time creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.23 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Time of first angioplasty balloon inflation or stenting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—first angioplasty balloon inflation or stenting time, hhmm
METeOR identifier:	285191
Registration status:	Health, Standard 04/06/2004
Definition:	The time of the first angioplasty balloon inflation or stent placement.
Data Element Concept:	Person—first angioplasty balloon inflation or stenting time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Time of first angioplasty balloon inflation or stenting, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.55 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005
	Information specific to this data set:
	For Acute coronary syndrome (ACS) reporting, refers to coronary arteries.
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Time of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy time, hhmm
METeOR identifier:	285201
Registration status:	Health, Standard 04/06/2004
Definition:	The time intravenous (IV) fibrinolytic therapy was first administered to a person.
Data Element Concept:	Person—intravenous fibrinolytic therapy time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be reported.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Time of intravenous fibrinolytic therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* For Acute coronary syndrome (ACS) reporting, refers to coronary arteries. Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Time of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage time, hhmm
METeOR identifier:	313817
Registration status:	Health, Standard 07/12/2005
Definition:	The time at which the patient is **triaged**.
Context:	Emergency Department care.
Data Element Concept:	Non-admitted patient emergency department service episode—triage time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode—**triage** date.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Triage—triage time, hhmm Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Non-admitted patient emergency department care NMDS 2007-

2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Time patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—presentation time, hhmm
METeOR identifier:	270080
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which the patient presents for the delivery of a service.
Data Element Concept:	Health service event—presentation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:

For community health care, outreach services and services provided via telephone or telehealth, this may be the time at which the service provider presents to the patient or the telephone/telehealth session commences.

The time of patient presentation at the **emergency department** is the earliest occasion of being registered clerically or triaged.

The time that the patient presents is not necessarily:

- the listing time for care (see listing date for care for an analogous concept), nor
- the time at which care is scheduled to be provided, nor
- the time at which commencement of care actually occurs (for admitted patients see admission time, for hospital non-admitted patient care and community health care see service commencement time).

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Time patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.17 KB) Is used in the formation of Non-admitted patient emergency

department service episode—waiting time (to service delivery), total minutes NNNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Time troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured time, hhmm
METeOR identifier:	285211
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which the troponin (T or I) was measured.
Data Element Concept:	Person—troponin level measured time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Time troponin measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.53 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Tobacco smoking status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking status, code N
METeOR identifier:	270311
Registration status:	Health, Standard 01/03/2005
Definition:	A person's current and past smoking behaviour, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Daily smoker
2	Weekly smoker
3	Irregular smoker
4	Ex-smoker
5	Never smoked

Collection and usage attributes

Guide for use:

CODE 1 Daily smoker

A person who smokes daily

CODE 2 Weekly smoker

A person who smokes at least weekly but not daily

CODE 3 Irregular smoker

A person who smokes less than weekly

CODE 4 Ex-smoker

A person who does not smoke at all now, but has smoked at least 100 cigarettes or a similar amount of other tobacco products in his/her lifetime.

CODE 5 Never-smoker

A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.

Source and reference attributes

Reference documents:	Standard Questions on the Use of Tobacco Among Adults (1998)

Data element attributes

Collection and usage attributes

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18 years and over.

Comments:

There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smoker is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of 'occasional' smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers.
  Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

Smoker type is used to define subpopulations of adults (age 18+ years) based on their smoking behaviour.

Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity.

This data element can be used to estimate smoking prevalence. Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.55 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
Smoker type is used to define sub-populations of adults (age 18+ years) based on their smoking behaviour. Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity. This metadata item can be used to estimate smoking prevalence.

Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)

- To monitor health risk factors and progress towards National Health Goals and Targets

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Tobacco smoking status (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—regular tobacco smoking indicator (last 3 months), code N
METeOR identifier:	302467
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has been a regular smoker (daily or weekly) of any tobacco material over the previous 3 months, as represented by a code.
Data Element Concept:	Person—regular tobacco smoking indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the person has smoked daily or weekly over the previous 3 months. CODE 2 No: Record if the person has not smoked daily or weekly over the previous 3 months or has been an irregular smoker.
Collection methods:	Ask the individual if he/she has regularly smoked (daily or weekly) any tobacco material over the past 3 months.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—tobacco smoking status (previous three months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:
For people with diabetes smoking is one of the most powerful treatable risk factors. Associated with hypertension, diabetes and hypercholesterolemia, smoking is a definite health hazard for coronary heart disease.

Tobacco smoking—consumption/quantity (cigarettes)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—number of cigarettes smoked (per day), total N[N]
METeOR identifier:	270332
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of cigarettes (manufactured or roll-your-own) smoked per day by a person.
Context:	Public health and health care
Data Element Concept:	Person—number of cigarettes smoked

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is relevant only for persons who currently smoke cigarettes daily or at least weekly. Daily consumption should be reported, rather than weekly consumption. Weekly consumption is converted to daily consumption by dividing by 7 and rounding to the nearest whole number.

Quantities greater than 98 (extremely rare) should be recorded as 98.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions.

The questions cover persons aged 18 and over.

Comments:

The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual.

Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products.

From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs
  (assessment of interventions)

- monitor health risk factors and progress towards National Health
  Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person's exposure to tobacco smoke.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - consumption/quantity (cigarettes), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual. Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products. From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions)
- monitor health risk factors and progress towards National Health Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person's exposure to tobacco smoke.

Tobacco smoking—duration (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking duration (daily smoking), total years N[N]
METeOR identifier:	270330
Registration status:	Health, Standard 01/03/2005
Definition:	The total duration in years, of daily smoking for a person who is now a daily smoker or has been a daily smoker in the past.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking duration

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	In order to estimate duration of smoking the person's date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person's current age. If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age. Record duration of less than one year as 0.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1, 5, 6, 7) and self-administered (Question 1, 3, 3a, 4) versions. The questions cover persons aged 18 years and over.
Comments:	Duration of daily smoking is an indicator of exposure to increased risk to health. In this data element, duration is measured as the years elapsed from the time the person first started smoking daily and when they most recently quit smoking daily (or the present for those persons who still smoke daily). There may have been intervening periods when the person did not smoke daily. However, as the negative health effects of smoking accumulate over time, the information on duration of daily smoking, as measured in this data element, remains useful, despite any intervening periods of non-daily smoking.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - duration (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.68 KB)

Is formed using Person—tobacco smoking start age (daily smoking), total years NN Health, Standard 01/03/2005

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Tobacco smoking—ever daily use

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking daily use status, code N
METeOR identifier:	270329
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a person has ever smoked tobacco in any form on a daily basis in their lifetime, as represented by a code.
Data Element Concept:	Person—tobacco smoking daily use status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ever-daily
2	Never-daily

Collection and usage attributes

Guide for use:

CODE 1 Ever-daily

If a person reports that they now smoke cigarettes, cigars, pipes or any other tobacco products daily OR if they report that in the past they have been a daily smoker, they are coded to 1 (ever-daily).

CODE 2 Never-daily

If a person reports that they have never smoked cigarettes, cigars, pipes or any other tobacco products daily AND they have never in the past been a daily smoker then they are coded to 2 (never-daily).

Data element attributes

Collection and usage attributes

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18 years and over.

Comments:

Whether a person has ever smoked on a daily basis can be used to assess an individual's health risk from smoking and to monitor population trends in smoking behaviour.

It can also be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions);

- monitor health risk factors;
- ascertain determinants and consequences of smoking.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - ever daily use, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.97 KB)

Tobacco smoking—frequency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking frequency, code N
METeOR identifier:	270328
Registration status:	Health, Standard 01/03/2005
Definition:	How often a person now smokes a tobacco product, as represented by a code.
Data Element Concept:	Person—tobacco smoking frequency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Smokes daily
2	Smokes at least weekly, but not daily
3	Smokes less often than weekly
4	Does not smoke at all

Data element attributes

Collection and usage attributes

Guide for use:	To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1) and self-administered (Question 1) versions. The questions relate to smoking of manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products and are designed to cover persons aged 18 years and over.
Comments:	The frequency of smoking helps to assess a person's exposure to tobacco smoke which is a known risk factor for cardiovascular disease and cancer. From a public health point of view, the level of consumption of tobacco as measured by frequency of smoking tobacco products is only relevant for regular smokers (persons who smoke daily or at least weekly). Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - frequency, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.71 KB)

Tobacco smoking—product

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco product smoked, code N
METeOR identifier:	270327
Registration status:	Health, Standard 01/03/2005
Definition:	The type of tobacco product smoked by a person, as represented by a code.
Data Element Concept:	Person—tobacco product smoked

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cigarettes - manufactured
2	Cigarettes - roll-your-own
3	Cigars
4	Pipes
5	Other tobacco product
6	None

Data element attributes

Collection and usage attributes

Guide for use:	To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.
Collection methods:	The recommended standard for collecting information about smoking the above tobacco products is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer or self-administered versions.
Comments:	Tobacco smoking is a known risk factor for cardiovascular disease and cancer. The type of tobacco product smoked by a person in conjunction with information about the frequency of smoking assists with establishing a profile of smoking behaviour at the individual or population level and with monitoring shifts from cigarette smoking to other types of tobacco products and vice versa. It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including

pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - product, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.09 KB)

Tobacco smoking—quit age (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking quit age (daily smoking), total years NN
METeOR identifier:	270323
Registration status:	Health, Standard 01/03/2005
Definition:	The age in years at which a person who has smoked daily in the past and is no longer a daily smoker most recently stopped smoking daily.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking quit age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	In order to estimate quit-age, the person's date of birth or current age should also be collected. Quit-age may be directly reported, or derived from the date the person quit smoking or the length of time since quitting, once the person's date of birth (or current age) is known. Quit-age is relevant only to persons who have been daily smokers in the past and are not current daily smokers.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Question 6) and self-administered (Question 3a) versions. The questions cover persons aged 18 years and over. The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this metadata item refers to when the person most recently stopped smoking daily. However, in order to provide information on when the person most recently stopped smoking daily, the most appropriate question to ask at the time of collecting the information is when the person finally stopped smoking daily.
Comments:	Quit-age and start-age provide information on the duration of

daily smoking and exposure to increased risk to health.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - quit age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.76 KB)

Is used in the formation of Person—time since quitting tobacco smoking (daily smoking), code NN Health, Standard 01/03/2005

Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Tobacco smoking—start age (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking start age (daily smoking), total years NN
METeOR identifier:	270324
Registration status:	Health, Standard 01/03/2005
Definition:	The age in years at which a person who has ever been a daily smoker, first started to smoke daily.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking start age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	Record age in completed years. This information is relevant only if a person currently smokes daily or has smoked daily in the past.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18 years and over.
Comments:	Start-age may be used to derive duration of smoking, which is a much stronger predictor of the risks associated with smoking than is the total amount of tobacco smoked over time. Where the information is collected by survey and the sample permits, population estimates should be presented by sex and age groups. The recommended age groups are: It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:	Supersedes Tobacco smoking - start age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.65 KB) Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Tobacco smoking—time since quitting (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—time since quitting tobacco smoking (daily smoking), code NN
METeOR identifier:	270356
Registration status:	Health, Standard 01/03/2005
Definition:	The time since a person most recently quit daily smoking, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—time since quitting tobacco smoking

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	12 months (1 year)
02	2 years etc. to 78
79	79+ years
80	Less than 1 month
81	1 month
82	2 months
83	3 months
84	4 months
85	5 months
86	6 months
87	7 months
88	8 months
89	9 months
90	10 months
91	11 months
92	months, not specified
93	years, not specified

Supplementary values:

Value	Meaning
99	not stated

Data element attributes

Collection and usage attributes

Guide for use:	In order to estimate time since quitting for all respondents, the person's date of birth or current age should also be collected.

For optimal flexibility of use, the time since quitting is coded as months or years. However, people may report the time that they quit smoking in various ways (e.g. age, a date, or a number of days or weeks ago). When the information is reported in weeks and is less than 4, or in days and is less than 28, then code 80.

When the person reports the time since quitting as weeks ago, convert into months by dividing by 4 (rounded down to the nearest month).

If days reported are between 28 and 59, then code 81.

Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 6) and self-administered (Question 3) versions.

Comments:

Time since quitting daily smoking may give an indication of improvement in the health risk profile of a person. It is also useful in evaluating health promotion campaigns.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - time since quitting (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.98 KB)

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Total contract patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—number of patient days (of contracted care), total N[NN]
METeOR identifier:	270301
Registration status:	Health, Standard 01/03/2005
Definition:	Sum of the number of contract patient days for all periods within the hospital stay.
Data Element Concept:	Admitted patient hospital stay—number of patient days (of contracted care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Count number of days.

A day is measured from midnight to 2359 hours.

Contract patient days are included in the total count of patient days. If necessary, contract patient days can be distinguished from other patient days by using the following rules:

- The day the contract commences is counted as a contract patient day.
- If the patient is on contract from midnight to 2359 count as a contract patient day.
- The day a contract is completed is not counted as a contract patient day.
- If the patient is admitted and commences a contract on the same day, this is not counted as a contract patient day.
- If a contract is completed and the patient is separated on the same day, the day should not be counted as a contract or other patient day.

Relational attributes

Related metadata references:

Supersedes Total contract patient days, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.87 KB)

Total hours worked by a medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical practitioner—hours worked, total NNN
METeOR identifier:	270136
Registration status:	Health, Standard 01/03/2005
Definition:	The total hours worked in a week in a job by a medical practitioner, including any on-call hours actually worked (includes patient care and administration).
Context:	Health labour force
Data Element Concept:	Medical practitioner—hours worked

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item relates to each position (job) held by a medical practitioner, not the aggregate of hours worked in all.
Collection methods:	There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
Comments:	It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Source and reference attributes

Submitting organisation:	National Health Labour Force Data Working Group

Relational attributes

Related metadata references:

Supersedes Total hours worked by a medical practitioner, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.95 KB)

Implementation in Data Set Specifications:

Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

Value must be less than 169 (except for 999).

Used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Total leave days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of leave days, total N[NN]
METeOR identifier:	270251
Registration status:	Health, Standard 01/03/2005
Definition:	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
Data Element Concept:	Episode of admitted patient care—number of leave days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to midnight.

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

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

Comments:

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Total leave days, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.62 KB)

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies:

(Episode of admitted patient care—separation date, DDMMYYYY minus Episode of admitted patient care—admission date, DDMMYYYY) minus Admitted patient hospital stay—number of leave days, total N[NN] must be ≥ 0 days.

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies:

(Episode of admitted patient care—separation date, DDMMYYYY minus Episode of admitted patient care—admission date, DDMMYYYY) minus Admitted patient hospital stay—number of leave days, total N[NN] must be ≥ 0 days.

Total psychiatric care days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—number of psychiatric care days, total N[NNNN]
METeOR identifier:	270300
Registration status:	Health, Standard 01/03/2005
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.
Data Element Concept:	Episode of care—number of psychiatric care days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

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

Public acute care hospitals:

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

Private acute care hospitals:

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

Psychiatric hospitals:

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

Psychiatric hospitals are establishments devoted primarily to

the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

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

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

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

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

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type).

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

Collection methods:

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

- Ideally, the new data field should be collected locally by

hospitals and added to the unit record data provided to the relevant state/territory health authority.

- Acute care hospitals in most states and territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

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

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Reference documents: Health Insurance Act 1973 (Commonwealth)

Relational attributes

Related metadata references:

Supersedes Total psychiatric care days, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.85 KB)

Is formed using Establishment—establishment type, sector and services provided code AN.N{.N} Health, Standard 01/03/2005

Is formed using Hospital service—care type, code N[N].N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Total days in psychiatric care must be: ≥ zero; and ≤ length of stay.

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Total days in psychiatric care must be ≥ zero;
Total days in psychiatric care must be ≤ length of stay.

Treatment delivery setting for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—service delivery setting, code N
METeOR identifier:	270068
Registration status:	Health, Standard 01/03/2005
Definition:	The main physical setting in which the type of treatment that is the principal focus of a client's alcohol and other drug treatment episode is actually delivered irrespective of whether or not this is the same as the usual location of the service provider, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Non-residential treatment facility
2	Residential treatment facility
3	Home
4	Outreach setting
8	Other

Collection and usage attributes

Guide for use:

Only one code to be selected at the end of the alcohol and other drug treatment episode. Agencies should report the setting in which most of the main type of treatment was received by the client during the treatment episode.

CODE 1 Non-residential treatment facility

This code refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.

CODE 2 Residential treatment facility

This code refers to community-based settings in which clients reside either temporarily or long-term in a facility that is not their home or usual place of residence to receive alcohol and other drug treatment. This does not include ambulatory situations, but does include therapeutic community settings.

CODE 3 Home

This code refers to the client's own home or usual place of residence.

CODE 4 Outreach setting

This code refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by Codes 1-3. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Data element attributes

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Treatment delivery setting for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Triage category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage category, code N
METeOR identifier:	270078
Registration status:	Health, Standard 01/03/2005
Definition:	The urgency of the patient's need for medical and nursing care, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—triage category

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Resuscitation: immediate (within seconds)
2	Emergency: within 10 minutes
3	Urgent: within 30 minutes
4	Semi-urgent: within 60 minutes
5	Non-urgent: within 120 minutes

Data element attributes

Collection and usage attributes

Collection methods:

This triage classification is to be used in the emergency departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur's response to the question: 'This patient should wait for medical care no longer than ...?'.

The triage category is allocated by an experienced **registered nurse** or medical practitioner. If the triage category changes, record the more urgent category.

Source and reference attributes

Origin:	National Triage Scale, Australasian College for Emergency Medicine

Relational attributes

Related metadata references:	Supersedes Triage category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.26 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded

07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Triglyceride level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—triglyceride level (measured), total millimoles per litre N[N].N
METeOR identifier:	270229
Registration status:	Health, Standard 01/03/2005
Definition:	A person's triglyceride level measured in millimoles per litre.
Data Element Concept:	Person—triglyceride level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the absolute result of the total triglyceride measurement.

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

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Note that to calculate the low-density lipoprotein - cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al, 1972):

- a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein - cholesterol (HDL-C) is required,
- the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L, and
- that while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 6 weeks after an event.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references:

Supersedes Triglycerides - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.12 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Candidate 04/03/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

A relationship between triglyceride and High-density Lipoprotein Cholesterol (HDL-C) and chronic heart disease (CHD) event rates has been shown. This view is supported by the observation that the remnants of triglyceride-rich lipoproteins are the particles that occur in dysbetalipoproteinaemia, a condition associated with a very high risk of premature atherosclerotic vascular disease. There have been two comprehensive reviews of the relationship between plasma triglyceride and CHD (see Criqui et al. 1993 and Austin et al. 1991). Criqui concludes that triglyceride is not an independent predictor of CHD and is probably not causally related to the disease, while Austin provides a compelling case for a causal role of (at least) some triglyceride rich lipoproteins. Conclusions drawn from population studies of the relationship between plasma triglyceride and the risk of CHD include the following:

- an elevated concentration of plasma triglyceride (> 2.0 mmol/L) is predictive of CHD when associated with either an increased concentration of LDL-C or a decreased concentration of HDL-C.
- the relationship between CHD risk and plasma triglyceride is not continuous, with evidence that the risk is greatest in people with triglyceride levels between 2 and 6 mmol/L (Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88. National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand).

It is likely that the positive relationship between plasma triglyceride and CHD, as observed in many population studies, is because an elevated level of plasma triglyceride in some people is a reflection of an accumulation of the atherogenic remnants of chylomicrons and very Low-density Lipoprotein (LDL). These particles are rich in both triglyceride and cholesterol and appear to be at least as atherogenic as LDL.

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

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

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

Alterations in fat transport, often resulting in hyper-triglyceridaemia, are well-recognised concomitants of diabetes mellitus.

Elevated plasma triglyceride levels are present in about one third of diabetic patients. It seems that triglycerides are related to the critical role of insulin in the production and removal from plasma of triglyceride-rich lipoproteins.

Lifestyle modifications, including weight loss and reduction of excess alcohol intake, are particularly effective for reducing triglyceride and increasing HDL-C.

Troponin assay type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin assay type, code N
METeOR identifier:	285225
Registration status:	Health, Standard 04/06/2004
Definition:	The type of troponin assay (I or T) used to assess the person's troponin levels, as represented by a code.
Data Element Concept:	Person—troponin assay type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cardiac troponin T (cTnT)
2	Cardiac troponin I (cTnI)
3	Not taken

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Troponin assay type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.06 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, record the type of troponin assay (I or T) used to assess troponin levels during this presentation.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Troponin assay—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN]
METeOR identifier:	285326
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of `troponin T' or `troponin I' measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range of troponin assay

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

See also Person—troponin level (measured), total micrograms per litre NN.NN Health, Standard 04/06/2004

Supersedes Troponin assay - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.88 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Troponin level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level (measured), total micrograms per litre NN.NN
METeOR identifier:	285253
Registration status:	Health, Standard 04/06/2004
Definition:	A person's troponin measured in micrograms per litre.
Data Element Concept:	Person—troponin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN.NN
Maximum character length:	4

Supplementary values:

Value	Meaning
88.88	Not measured
99.99	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Collection and usage attributes

Guide for use: CODE 88.88 Not measured

This code is used if test for troponin (T or I) was not done.

Data element attributes

Collection and usage attributes

Guide for use: Measured in different assays dependent upon laboratory methodology.

When only one troponin level is recorded, this should be the peak level during the admission.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Standard 04/06/2004

Supersedes Troponin measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.14 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Tumour size at diagnosis (solid tumours)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—solid tumour size (at diagnosis), total millimetres NNN
METeOR identifier:	270184
Registration status:	Health, Standard 01/03/2005
Definition:	The largest dimension of a solid tumour, measured in millimetres.
Data Element Concept:	Person with cancer—solid tumour size

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Unknown

Unit of measure: Millimetre (mm)

Collection and usage attributes

Guide for use: Size in millimetres with valid values 001 to 997.

Data element attributes

Collection and usage attributes

Guide for use: The reporting standard for the size of solid tumours is:
Breast cancer or other solid neoplasms - the largest tumour dimension, measured to a precision of 1mm.

Relational attributes

Related metadata references: Supersedes Tumour size at diagnosis - solid tumours, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.37 KB)

Implementation in Data Set Specifications:
Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
This is used to measure the diameter of the largest dimension of breast cancers and other solid neoplasms for patient management, population cancer statistics and research.

Tumour thickness at diagnosis (melanoma)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—melanoma thickness (at diagnosis), total millimetres NNN.NN
METeOR identifier:	270185
Registration status:	Health, Standard 01/03/2005
Definition:	The measured thickness of a melanoma in millimetres.
Data Element Concept:	Person with cancer—melanoma thickness

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN.NN
Maximum character length:	5
Supplementary values:	Value: 999.99 — Meaning: Unknown
Unit of measure:	Millimetre (mm)

Data element attributes

Collection and usage attributes

Guide for use:	The reporting standard for the thickness of melanoma is: Primary cutaneous melanoma - the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01mm. Size in millimetres - valid values are: 000.01 to 997.99

Relational attributes

Related metadata references:	Supersedes Tumour thickness at diagnosis - melanoma, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Type and sector of employment establishment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—establishment type (employment), industry code NN
METeOR identifier:	269954
Registration status:	Health, Standard 01/03/2005
Definition:	The sector of employment and main type of work/speciality area of the health professional, as represented by a code.
Data Element Concept:	Health professional—establishment type (employment)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Private medical practitioner rooms/surgery (including 24-hour medical clinics)
02	Other public non-residential health care facility (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
03	Other private non-residential health care (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
04	Hospital - acute care (including psychiatric or specialist hospital) hospital (public)
05	Hospital - acute care (including psychiatric or specialist hospital) hospital (private)
06	Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (public)
07	Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (private)
08	Tertiary education institution (public)
09	Tertiary education institution (private)
10	Defence forces
11	Government department or agency (e.g. laboratory, research organisation etc.)
12	Private industry/private enterprise (e.g. insurance, pathology, bank)
13	Other (specified) public

	14	Other (specified) private
Supplementary values:	99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

Establishments are coded into self reporting groupings in the public and private sectors. This can be seen in the code list for medical practitioners.

Minor variations in ordering of sequence and disaggregation of the principal categories will be profession-specific as appropriate; where a more detailed set of codes is used, the essential criterion is that there should not be an overlap of the detailed codes across the Australian and New Zealand Standard Industrial Classification category definitions.

Note:

Public psychiatric hospitals are non-acute care facilities, whereas private psychiatric hospitals are acute care facilities. To minimise the possibility of respondent confusion and mis-reporting, public psychiatric hospitals are included in the grouping for acute care public hospitals.

Source and reference attributes

Origin:

Australian Bureau of Statistics 1993. Australian and New Zealand Standard Industrial Classification (ANZSIC). Cat. No. 1292.0. Canberra: ABS

Data element attributes

Collection and usage attributes

Comments:

Day surgery centres, outpatient clinics and medical centres approved as hospitals under the Health Insurance Act 1973 (Commonwealth) have emerged as a new category for investigation. These will be included in a review of the National Health Labour Force Collection questions and coding frames.

Source and reference attributes

Submitting organisation:

National Health Labour Force Data Working Group

Reference documents:

Australian Bureau of Statistics 1993. Australian and New Zealand Standard Industrial Classification (ANZSIC). Cat. No. 1292.0. Canberra: ABS

Relational attributes

Related metadata references:

Supersedes Type and sector of employment establishment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.83 KB)

Implementation in Data Set Specifications:

Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

To analyse distribution of service providers by setting (defined by industry of employer and sector), cross-classified with main type of work and/or specialty area.

Type of accommodation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—accommodation type (usual), code N[N]
METeOR identifier:	270088
Registration status:	Health, Standard 01/03/2005
Definition:	The type of accommodation setting in which a person usually lives/lived, as represented by a code.
Context:	Admitted patient mental health care: Permits analysis of the usual residential accommodation type of people prior to admission to institutional health care. The setting in which the person usually lives can have a bearing on the types of treatment and support required by the person and the outcomes that result from their treatment.
Data Element Concept:	Person—accommodation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes
2	Psychiatric hospital
3	Residential aged care service
4	Specialised alcohol/other drug treatment residence
5	Specialised mental health community-based residential support service
6	Domestic-scale supported living facility (e.g. group home for people with disability)
7	Boarding/rooming house/hostel or hostel type accommodation, not including aged persons' hostel
8	Homeless persons' shelter
9	Shelter/refuge (not including homeless persons' shelter)
10	Other supported accommodation
11	Prison/remand centre/youth training centre
12	Public place (homeless)
13	Other accommodation, not elsewhere classified

Supplementary values:	14	Unknown/unable to determine

Collection and usage attributes

Guide for use:

CODE 3 Residential aged care service

Includes nursing home beds in acute care hospitals.

CODE 4 Specialised alcohol/other drug treatment residence

Includes alcohol/other drug treatment units in psychiatric hospitals.

CODE 5 Specialised mental health community-based residential support service

Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

CODE 6 Domestic-scale supported living facility (e.g. group home for people with disability)

Domestic-scale supported living facilities include group homes for people with disability, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

CODE 10 Other supported accommodation

Includes other supported accommodation facilities such as hostels for people with disability and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Data element attributes

Collection and usage attributes

Guide for use:

'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer to questioning about a person's usual accommodation setting may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

Comments:

The changes made to this metadata item are in accordance with the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. Home and Community Care Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).

Relational attributes

Related metadata references:

Supersedes Type of accommodation, version 2, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (19.41 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Type of augmentation of labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour augmentation type, code N
METeOR identifier:	270036
Registration status:	Health, Standard 01/03/2005
Definition:	Methods used to assist progress of labour, as represented by a code.
Data Element Concept:	Birth event—labour augmentation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Supplementary values:

5	Not stated

Collection and usage attributes

Comments: Prostaglandin is listed as a method of augmentation in the data domain. Advice from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.

Data element attributes

Collection and usage attributes

Guide for use: More than one method of augmentation can be recorded, except where 0=none applies.

Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.

Comments: Type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Type of augmentation of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.39 KB)

Type of health or health related function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—type of health or health related function, code NNN
METeOR identifier:	352187
Registration status:	Health, Standard 05/12/2007
Definition:	Describes the type of activities or programs with a health or health-related function provided by an organisation, as represented by a code.
Data Element Concept:	Organisation—type of health or health related function

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
101	Admitted patient care – Mental health program
102	Admitted patient care – Non-Mental health program
199	Admitted patient care – Not further defined
201	Residential care – Mental health program
202	Residential care – Non-Mental health program
299	Residential care – Not further defined
301	Ambulatory care – Mental health program
302	Ambulatory care – Emergency department
303	Ambulatory care – General practitioner
304	Ambulatory care – Medical specialist
305	Ambulatory care – Imaging/pathology
306	Ambulatory care – Dental service
307	Ambulatory care – Optometry service
308	Ambulatory care – Allied health service
309	Ambulatory care – Community health service
388	Ambulatory care – Other
399	Ambulatory care – Not further defined
401	Public health – Communicable disease control
402	Public health – Selected health promotion
403	Public health – Organised immunisation
404	Public health – Environmental health
405	Public health – Food standards and hygiene
406	Public health – Breast cancer screening

407	Public health – Cervical screening
408	Public health – Bowel cancer screening
409	Public health – Prevention of hazardous and harmful drug use
410	Public health – Public health research
488	Public health – Other public health
499	Public health – Not further defined
501	Health related care – Patient transport
502	Health related care – Patient transport subsidies
503	Health related care – Medications
504	Health related care – Aids and appliances
505	Health related care – Health administration
506	Health related care – Health research
588	Health related care – Other
599	Health related care – Not further defined
601	Other function – Home and Community Care
602	Other function – Aged care
603	Other function – Other welfare
688	Other function – Other
699	Other function – Not further defined

Collection and usage attributes

Guide for use:

CODE 101 Admitted patient care – Mental health program

An **admission** to a mental health program includes:

The component of the mental health program that provides admitted patient care. These services are delivered through specialised psychiatric hospitals and designated psychiatric units located within hospitals that are not specialised psychiatric hospitals.

NOTE: This is the admitted patient component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential care mental health programs, **ambulatory care** mental health programs which are provided as **outpatient** and **emergency department** care to non-admitted patients, and community-based (non-hospital) mental health programs.

CODE 102 Admitted patient care – Non-mental health program

An admitted patient non-mental health program includes:

All services, excluding mental health services, provided to admitted patients, including acute care, rehabilitative care, palliative care, geriatric evaluation and management, psychogeriatric care, maintenance care, newborn care and any other admitted patient care e.g. organ procurement – posthumous. Also includes admitted patient services where service delivery is contracted to private hospitals or treatment facilities and **hospital in the home** services.

Excludes emergency department and outpatient care provided to non-admitted patients, and community-based (non hospital) care.

CODE 199 Admitted patient care – Not further defined

Comprises admitted patient care services that could be a combination of categories 101 and 102 but which could not be further disaggregated.

State and territory health authorities are only to report admitted patient care under codes 101 or 102.

CODE 201 Residential care – Mental health program

A residential mental health care program includes:

The component of the specialised mental health program that provides residential care. A **resident** in one **residential mental health service** cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Comprises the residential component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential aged care services, residential disability, alcohol and other drug treatment health care services and residential type care provided to admitted patients in hospitals. Also excludes mental health programs provided to admitted patients, emergency and outpatient care patients, and community health (non-hospital) and other ambulatory care patients.

CODE 202 Residential care – Non-mental health program

A residential non-mental health care program includes alcohol and other drug treatment health care services.

Excludes residential mental health care program services, residential aged care services, residential disability services and residential type care provided to admitted patients in hospitals. Also excludes services provided to admitted patients and patients receiving ambulatory care.

CODE 299 Residential care – Not further defined

Comprises residential care services that could be a combination of categories 201 and 202 but which could not be further disaggregated.

State and territory health authorities are only to report residential care under codes 201 or 202.

CODE 301 Ambulatory care – Mental health program

The component of a specialised mental health program supplied by a specialised mental health service that provides **ambulatory health care**.

Comprises the ambulatory component of the mental health care program reported to the Mental Health Establishments NMDS, i.e. specialised mental health program services provided by emergency departments, outpatient clinics and community-based (non-hospital) services.

Excludes specialised mental health care provided to admitted and residential patients.

CODE 302 Ambulatory care – Emergency department

Comprises emergency department services provided in an **emergency department**.

Excludes specialised mental health services provided by emergency departments, outpatient clinics and community-based (non-hospital) services. Also excludes residential and admitted patient services.

CODE 303 Ambulatory care – General practitioner

This item is not currently required to be reported by state and territory health authorities.

The definition relates to the broad type of non-referred general practitioner services as specified on the Medicare Benefits Schedule website. These services comprise general practitioner attendances, including General Practitioner, Vocationally Registered General Practitioner (GP/VRGP) and other non-referred attendances, to non-admitted patients, and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.

This category is not limited to services funded by Medicare Australia. It also includes services funded from other sources such as Motor Vehicle Third Party Insurance and Workers Compensation Insurance, among others. Therefore, general or nurse practitioner services such as vaccinations for overseas travel are included regardless of their funding source.These non-referred general practitioner services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 304 Ambulatory care – Medical specialist

This item is not currently required to be reported by state and territory health authorities.

Specialist attendances, obstetrics, anaesthetics, radiotherapy, operations and assistance at operations care. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Includes salaried medical officers.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 305 Ambulatory care – Imaging/pathology service.

This item is not currently required to be reported by state and territory health authorities.

Pathology and diagnostic imaging services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes services provided to admitted or residential care patients and non-admitted patients in an emergency department.

CODE 306 Ambulatory care – Dental service

Includes any non-admitted patient and community dental services, including dental assessments, preventative services and treatments, regardless of funding source. Oral and maxillofacial services and cleft lip and palate services, as

defined in the current Medicare Benefits Schedule, are also included in this category.

Includes dental services funded from a range of sources such as Medicare Benefits Scheme, Motor Vehicle Third Party Insurance and dental services funded by vouchers for dental care.

These dental services are provided in private or group practices in dental clinics, community health care centres or hospital outpatient clinics.

Excludes dental care provided to admitted patients in hospitals (same day or overnight) or to non-admitted patients in an emergency department.

CODE 307 Ambulatory care – Optometry service

This item is not currently required to be reported by state and territory health authorities.

Optometry services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are mainly provided in private or group practices, but may be provided in hospital outpatient centres.

Excludes optometry services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 308 Ambulatory care – Allied health service

Includes services provided by the following allied health items. Aboriginal health worker, diabetes educator, audiologists, exercise physiologist, dietician, mental health worker, occupational therapist, physiotherapist, podiatrist or chiropodist, chiropractor, osteopath, psychologist and speech pathologist. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments.

Excludes allied health services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 309 Ambulatory care – Community health services

Includes community health services such as family, maternal, child and youth health (including well baby clinics) as well as Aboriginal and Torres Strait Islander and migrant health services. Also includes health care for people with acute, post-acute, chronic and end of life illnesses, alcohol and drug treatment services, child psychology services, community midwifery, community nursing, school and district nursing, community rehabilitation, continence services, telehealth, dietetics, family planning and correctional health services.

Excludes mental health services reported under code 301 and services provided to admitted and residential care patients and non-admitted patients in an emergency department. Also excludes services already reported under codes 303 to 308.

CODE 388 Ambulatory care – Other

Comprises ambulatory care services other than those reported under codes 301 to 309.

CODE 399 Ambulatory care – Not further defined

Comprises ambulatory care services that could be a combination of categories 301 to 309 and 388, but which could not be further disaggregated, such as public outpatient services.

CODE 401 Public health – Communicable disease control

This category includes all activities associated with the development and implementation of programs to prevent the spread of communicable diseases.

Communicable disease control is recorded using three sub-categories:

HIV/AIDS, hepatitis C and sexually transmitted infections

Needle and syringe programs

Other communicable disease control.

The **public health** component of the HIV/AIDS, hepatitis C and STI strategies includes all activities associated with the development and implementation of prevention and education programs to prevent the spread of HIV/AIDS, hepatitis C and sexually transmitted infections.

CODE 402 Public health – Selected health promotion

This category includes those activities fostering healthy lifestyle and a healthy social environment overall, and health promotion activities targeted at health risk factors which lead to injuries, skin cancer and cardiovascular disease (for example diet, inactivity) that are delivered on a population-wide basis. The underlying criterion for the inclusion of health promotion programs within this category was that they are population health programs promoting health and wellbeing.

The Selected health promotion programs are:

Healthy settings (for example municipal health planning)

Public health nutrition

Exercise and physical activity

Personal hygiene

Mental health awareness promotion

Sun exposure and protection

Injury prevention including suicide prevention and female genital mutilation.

CODE 403 Public health – Organised immunisation

This category includes immunisation clinics, school immunisation programs, immunisation education, public awareness, immunisation databases and information systems.

Organised immunisation is recorded using three sub-categories:

Organised childhood immunisation (as defined by the National Health and Medical Research Council Schedule/Australian Standard Vaccination Schedule)

Organised pneumococcal and influenza immunisation—the target groups for pneumococcal immunisation are Indigenous people over 50 years and high-risk Indigenous younger people aged 15–49 years. Influenza vaccine is available free to all Australians 65 years of age and over, Indigenous people over 50 years and high-risk Indigenous younger people aged 15–19 years.

All other organised immunisation (for example tetanus)—as opposed to ad hoc or opportunistic immunisation.

CODE 404 Public health – Environmental health

This category relates to health protection education (for example safe chemical storage, water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example radiation safety, and pharmaceutical regulation and safety).

CODE 405 Public health – Food standards and hygiene

This category includes the development, review and implementation of food standards, regulations and legislation as well as the testing of food by the regulatory agency.

CODE 406 Public health – Breast cancer screening

This category relates to Breast cancer screening and includes the complete breast cancer screening pathway through organised programs.

The breast cancer screening pathway includes such activities as recruitment, screen taking, screen reading, assessment (this includes fine needle biopsy), core biopsy, open biopsy, service management and program management.

CODE 407 Public health – Cervical screening

This category relates to organised cervical screening programs such as the state cervical screening programs and rural access programs, including coordination, provision of screens and assessment services.

Cervical screening, funded through Medicare, for both screening and diagnostic services is also included. The methodology used in deriving the estimates is set out in the Jurisdictions' technical notes (section 11.2 of NPHER 2004-05).

CODE 408 Public health – Bowel screening

This category relates to organised bowel screening programs, such as the National Bowel Cancer Screening Program (NBCSP) and the Bowel Cancer Screening Pilot program. The screening pathway includes self administered home based tests by persons turning 55 years or 65 years of age across Australia who mail results in for analysis, the assessment/diagnostic service and program management.

CODE 409 Public health – Prevention of hazardous and harmful drug use

This category includes activities targeted at the general population with the aim of reducing the overuse or abuse of alcohol, tobacco, illicit and other drugs of dependence, and mixed drugs. The Australian Standard Classification of Drugs of Concern includes analgesics, sedatives and hypnotics, stimulants and hallucinogens, anabolic agents and selected hormones, antidepressants and anti-psychotics, and also miscellaneous drugs of concern.

Report for each sub-category as below, the aggregate of which will be total expenditure on Prevention of hazardous and harmful drug use:

Alcohol

Tobacco

Illicit and other drugs of dependence

Mixed.

CODE 410 Public health – Public health research

The basic criterion for distinguishing public health research and development from other public health activities is the presence in research and development of an appreciable element of novelty and resolution of scientific and/or technical uncertainty.

Includes mainly new or one-off research in the 8 core public health functions listed under codes 401 to 409.

General research and development work relating to the running of ongoing public health programs is included under the other relevant public health activities in codes 401 to 409.

CODE 488 Public health – Other public health

Comprises public health functions not reported to the National Public Health Expenditure Project.

CODE 499 Public health – Not further defined

Comprises public health services that could be a combination of categories 401 to 410 but which could not be further disaggregated.

State and territory health authorities are only to report public health services under codes 401 to 409.

CODE 501 Health related care – Patient transport

This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care.

Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine).

Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location.

The provider of this service could be a public or private hospital or an ambulance service.

CODE 502 Health related care – Patient transport subsidies

Government subsidies to private ambulance services e.g. patient transport vouchers, support programs to assist isolated patients with travel to obtain specialised health care.

It also includes transportation in conventional vehicles, such as taxi, when the latter is authorised and the costs are reimbursed to the patient (e.g. for patients undergoing renal dialysis or chemotherapy).

CODE 503 Health related care – Medications

This item is not currently required to be reported by state and territory health authorities.

Includes pharmaceuticals and other medical non-durables, prescribed medicines and over-the-counter pharmaceuticals. Included within these categories are: medicinal preparations, branded and generic medicines, drugs, patent medicines, serums and vaccines, vitamins and minerals and oral contraceptives, prescribed medicines exclusively sold to customers with a medical voucher, irrespective of whether it is covered by public or private funding. Includes branded and

generic products, private households' non-prescription medicines and a wide range of medical non-durables such as bandages, condoms and other mechanical contraceptive devices, elastic stockings, incontinence articles and toothbrushes, toothpastes and therapeutic mouth washes.

CODE 504 Health related care – Aids and appliances

This item is not currently required to be reported by state and territory health authorities.

This item comprises glasses and other vision products, orthopaedic appliances & other prosthetics, hearing aids, medico-technical devices including wheelchairs and all other miscellaneous medical durables not elsewhere classified such as blood pressure instruments.

CODE 505 Health related care – Health administration

Administrative services which cannot be allocated to a specific health good and service. Those unallocatable services might include, for example, maintaining an office of the Chief Medical Officer; a Departmental liaison officer in the office of the Minister; or a number of other agency-wide items for which it is not possible to derive appropriate or meaningful allocations to particular health programs.

CODE 506 Health related care – Health research

Includes all research on health topics that is not included in public health research (code 409). That is, it includes all research classified under ABS Australian Standard Research Classification code 320000, excluding code 321200.

Excludes public health research and non-health related research.

CODE 588 Health related care – Other

Includes for example, services provided by health and health-related call centres and e-health information services.

Excludes health related care reported under codes 501 to 506 and health assessments provided under the Aged Care Assessment Program which are reported under code 602.

CODE 599 Health related care – Not further defined

Comprises health related care that could be a combination of categories 501 to 506 but which could not be further disaggregated.

State and territory health authorities are only to report health related care under codes 501 to 506.

CODE 601 Other function – Home and community care

This item is not currently required to be reported by state and territory health authorities.

Comprises Home and Community Care services reported under the HACC NMDS.

Information on these service categories is available in the following report:

National classifications of community services. Version 2.0. AIHW Cat. No. HWI 40. Canberra: Australian Institute of Health and Welfare, 2003.

Excludes services reported under codes 602 to 604.

CODE 602 Other function – Aged care

This item is not currently required to be reported by state and territory health authorities.

Includes residential care aged care programs, aged care

assessment programs and other non-health aged care programs, such as respite care and day care activities.

Excludes services provided under the HACC program.

CODE 603 Other function – Other welfare

This item is not currently required to be reported by state and territory health authorities.

Includes services delivered to clients, or groups of clients with special needs such as the young or the disabled. Excludes aged care services reported under code 602.

CODE 688 Other function – Other

This item is not currently required to be reported by state and territory health authorities. Includes for example, car parking, accommodation for staff or for patients' relatives, or non-health related research.

CODE 699 Other function – Not further defined

This item is not currently required to be reported by state and territory health authorities.

Comprises other functions that could be a combination of categories 601 to 603 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents:

Australian Bureau of Statistics 1998. Australian Standard Research Classification. Cat. no. 1297.0. Canberra: ABS.

Australian Government Department of Health and Ageing Medicare Benefits Schedule Book, 1 November 2006 available from http://www.health.gov.au/mbsonline

Australian Institute of Health and Welfare 2003. National classifications of community services. Version 2.0. AIHW cat. no. HWI 40. Canberra: AIHW.

Australian Institute of Health and Welfare 2007. National public health expenditure report 2004–05. Health and welfare series expenditure series no. 29. cat. no. HWE 36. Canberra: AIHW.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Government health expenditure function revenue data cluster Health, Standard 05/12/2007

Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Type of labour induction

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour induction type, code N
METeOR identifier:	270037
Registration status:	Health, Standard 01/03/2005
Definition:	Method used to induce labour, as represented by a code.
Data Element Concept:	Birth event—labour induction type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Data element attributes

Collection and usage attributes

Guide for use:	More than one method of induction can be recorded, except where 0=none applies.
Comments:	Type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Type of labour induction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.89 KB)

Type of usual accommodation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—accommodation type (prior to admission), code N
METeOR identifier:	270079
Registration status:	Health, Standard 01/03/2005
Definition:	The type of physical accommodation the person lived in prior to **admission**.
Context:	Admitted patient mental health care: Permits analysis of the prior residential accommodation type of people admitted to residential aged care services or other institutional care.
Data Element Concept:	Person—accommodation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	House or flat
2	Independent unit as part of retirement village or similar
3	Hostel or hostel type accommodation
4	Psychiatric hospital
5	Acute hospital
6	Other accommodation
7	No usual residence

Collection and usage attributes

Collection methods:	The above classifications have been based on Question 16 of Form NH5. The Australian Government Department of Health and Aged Care has introduced a new Aged Care Application and Approval form which replaces the NH5.

Data element attributes

Collection and usage attributes

Collection methods:	This metadata item is not available for New South Wales State nursing homes. As this item includes only details of physical accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate metadata item (see metadata item Admission mode).

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of usual accommodation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Type of visit to emergency department

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—type of visit to emergency department, code N
METeOR identifier:	270362
Registration status:	Health, Standard 01/03/2005
Definition:	The reason the patient presents to an emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—type of visit to emergency department

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.
2	Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.
3	Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.
4	Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.
5	Dead on arrival: a patient who is dead on arrival at the emergency department.

Data element attributes

Collection and usage attributes

Comments:	Required for analysis of emergency department services.

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Type of visit to emergency department, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.64 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Urgency of admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission urgency status, code N
METeOR identifier:	269986
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the **admission** has an urgency status assigned and, if so, whether **admission** occurred on an emergency basis, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission urgency status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Urgency status assigned - emergency
	2	Urgency status assigned - elective
	3	Urgency status not assigned
Supplementary values:	9	Not known/not reported

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Urgency status assigned - emergency

Emergency admission:

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

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

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or
- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdoes, toxic substance or toxin effect; or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

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

CODE 2 Urgency status assigned - Elective

Elective admissions:

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

Scheduled admissions:

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

Admissions from elective surgery waiting lists:

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

- Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see code 1 in metadata item Reason for removal from an elective surgery waiting list code N) will be assigned an Admission urgency status code N code of 2. In that case, their clinical urgency category could be regarded as further detail on how urgent their admission was.
- Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see code 2 in metadata item Reason for removal from an elective surgery waiting list code N), will be assigned an Admission urgency status code N code of 1.

CODE 3 Urgency status not assigned

Admissions for which an urgency status is usually not assigned:

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

listed above and be admitted on an emergency basis.

CODE 9 Not known/not reported

This code is used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

Source and reference attributes

Submitting organisation: Emergency definition working party

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Urgency of admission, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.39 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Vascular history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular condition status (history), code NN
METeOR identifier:	269958
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the person has had a history of vascular conditions, as represented by a code.
Context:	The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s). It may be used to map vascular conditions, assist in risk stratification and link to best practice management.
Data Element Concept:	Person—vascular condition status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Myocardial infarction
02	Unstable angina pectoris
03	Angina
04	Heart failure
05	Atrial fibrillation
06	Other dysrhythmia or conductive disorder
07	Rheumatic heart disease
08	Non-rheumatic valvular heart disease
09	Left ventricular hypertrophy
10	Stroke
11	Transient ischaemic attack
12	Hypertension
13	Peripheral vascular disease (includes abdominal aortic aneurism)
14	Deep vein thrombosis
15	Other atherosclerotic disease
16	Carotid stenosis
17	Vascular renal disease
18	Vascular retinopathy (hypertensive)
19	Vascular retinopathy (diabetic)
97	Other vascular

	98	No vascular history
Supplementary values:	99	Unknown/not stated /not specified

Collection and usage attributes

Comments: Can be mapped to the current version of ICD-10-AM.

Source and reference attributes

Origin: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2000), National Centre for Classification in Health, Sydney

Data element attributes

Collection and usage attributes

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

Collection methods: Ideally, vascular history information is derived from and substantiated by clinical documentation.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Centre for Classification in Health
National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Vascular history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.83 KB)

Implementation in Data Set Specifications:
Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005
Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Vascular procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular procedures (history), code NN
METeOR identifier:	269962
Registration status:	Health, Standard 01/03/2005
Definition:	The vascular procedures the person has undergone, as represented by a code.
Data Element Concept:	Person—vascular procedure

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Amputation for arterial vascular insufficiency
02	Carotid endarterectomy
03	Carotid angioplasty/stenting
04	Coronary angioplasty/stenting
05	Coronary artery bypass grafting
06	Renal artery angioplasty/stenting
07	Heart transplant
08	Heart valve surgery
09	Abdominal aortic aneurism repair/bypass graft/stenting
10	Cerebral circulation angioplasty/stenting
11	Femoral/popliteal bypass/graft/stenting
12	Congenital heart and blood vessel defect surgery
13	Permanent pacemaker implantation
14	Implantable cardiac defibrillator
98	Other

Supplementary values:

Value	Meaning
99	Unknown/not recorded

Data element attributes

Collection and usage attributes

Collection methods:	Ideally, Vascular procedure information is derived from and substantiated by clinical documentation.
Comments:	In settings where the monitoring of a person's health is ongoing and where a history can change over time (such as general practice), the Service contact—service contact date,

DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases - Australian facts 2001. AIHW Cat. No. CVD 13. Canberra: AIHW, National Heart foundation of Australia, National Stroke Foundation of Australia (CVD Series No. 14)

Relational attributes

Related metadata references:	Supersedes Vascular procedures, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.54 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Visual acuity (left eye)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—visual acuity (left eye), code NN
METeOR identifier:	269963
Registration status:	Health, Standard 01/03/2005
Definition:	A person's left eye visual acuity, as represented by a code.
Data Element Concept:	Person—visual acuity

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	6/5
02	6/6
03	6/9
04	6/12
05	6/18
06	6/24
07	6/36
08	6/60
09	CF (count fingers)
10	HM (hand movement)
11	PL (perceive light)
12	BL (blind)
13	6/7.5

Supplementary values:

99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.

- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents: Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

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

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references: Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

See also Person—visual acuity (right eye), code NN Health, Standard 01/03/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Patients with diabetes have an increased risk of developing several eye complications including retinopathy, cataract and glaucoma that can lead to loss of vision. Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications. Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye
- if at subsequent examinations declining visual acuity is detected
- if any retinal abnormality is detected
- if clear view of retina is not obtained.

Visual acuity (right eye)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—visual acuity (right eye), code NN
METeOR identifier:	270381
Registration status:	Health, Standard 01/03/2005
Definition:	A person's right eye visual acuity, as represented by a code.
Data Element Concept:	Person—visual acuity

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	6/5
02	6/6
03	6/9
04	6/12
05	6/18
06	6/24
07	6/36
08	6/60
09	CF (count fingers)
10	HM (hand movement)
11	PL (perceive light)
12	BL (blind)
13	6/7.5

Supplementary values:

99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.

- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents: Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

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

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references: See also Person—visual acuity (left eye), code NN Health, Standard 01/03/2005

Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Patients with diabetes have an increased risk of developing several eye complications including retinopathy, cataract and glaucoma that can lead to loss of vision. Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications. Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye
- if at subsequent examinations declining visual acuity is detected
- if any retinal abnormality is detected
- if clear view of retina is not obtained.

Waist circumference (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—waist circumference (measured), total centimetres NN[N].N
METeOR identifier:	270129
Registration status:	Health, Standard 01/03/2005
Definition:	A person's waist circumference measured in centimetres.
Data Element Concept:	Person—waist circumference

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not measured
Unit of measure:	Centimetre (cm)

Data element attributes

Collection and usage attributes

Collection methods:

The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity, and without drawing attention to an individual's weight.

The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995) which was adapted from Lohman et al. (1988) and the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996).

In order to ensure consistency in measurement, the following measurement protocol should be used.

Measurement protocol:

The measurement of waist circumference requires a narrow (7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.

The subject should remove any belts and heavy outer clothing. Measurement of waist circumference should be taken over at most one layer of light clothing. Ideally the measure is made directly over the skin.

The subject stands comfortably with weight evenly distributed on both feet, and the feet separated about 25-30 cm. The arms

should hang loosely at the sides. Posture can affect waist circumference. The measurement is taken midway between the inferior margin of the last rib and the crest of the ilium, in the mid-axillary plane. Each landmark should be palpated and marked, and the midpoint determined with a tape measure and marked.

The circumference is measured with an inelastic tape maintained in a horizontal plane, at the end of normal expiration. The tape is snug, but does not compress underlying soft tissues. The measurer is positioned by the side of the subject to read the tape. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body.

The measurement is recorded at the end of a normal expiration to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured waist circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over-reporting (Armitage & Berry 1994). For example, a mean value of 72.25 cm would be rounded to 72.2 cm, while a mean value of 72.35 cm would be rounded to 72.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1 metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured waist circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last-digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments: This metadata item is recommended for use in population

surveys and health care settings.

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

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

For reporting purposes, it may be desirable to present waist circumference in categories. It is recommended that 5-cm groupings are used for this purpose. Waist circumference should not be rounded before categorisation. The following categories may be appropriate for describing the waist circumferences of Australian men, women children and adolescents, although the range will depend on the population.

Waist

35 cm = Waist

40 cm = Waist

... in 5 cm categories

105 cm = Waist

Waist => 110 cm

Source and reference attributes

Submitting organisation: World Health Organization International Society for the Advancement of Kinanthropometry

Relational attributes

Related metadata references: Supersedes Waist circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.95 KB)

Is used in the formation of Adult—waist-to-hip ratio, N.NN Health, Standard 01/03/2005

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Waist circumference risk indicator - adults

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—waist circumference risk indicator, Caucasian adult code N
METeOR identifier:	270205
Registration status:	Health, Standard 01/03/2005
Definition:	The sex specific category of risk of metabolic complications associated with excess abdominal adiposity in adult Caucasians, as represented by a code.
Data Element Concept:	Adult—waist circumference risk indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Not at risk (male waist circumference less than 94 cm, female waist circumference less than 80 cm)
	2	Increased (male waist circumference ≥ 94 cm, female waist circumference ≥ 80 cm)
	3	Substantially increased (male waist circumference ≥ 102 cm, female waist circumference ≥ 88 cm)
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item cannot be determined if waist circumference measured has not been collected (i.e. is coded to 999.9) and/or sex is not stated (i.e. coded to 9). This metadata item applies to persons aged 18 years or older.
Collection methods:	This metadata item should be derived after the data entry of waist circumference measured. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Comments:	This metadata item is recommended for use in population surveys and health care settings. Recent evidence suggests that waist circumference may provide a more practical correlate of abdominal fat distribution and associated ill health. The identification of risk using waist circumference is population-specific and will depend on levels of obesity and

other risk factors for cardiovascular disease and non-insulin dependent diabetes mellitus.

Populations differ in the level of risk associated with a particular waist circumference, so that globally applicable cut-off points cannot be developed. For example, complications associated with abdominal fat in black women and those of South Asian descent are markedly higher for a given level of BMI than in Europeans. Also, although women have almost the same absolute risk of coronary heart disease as men at the same WHR, they show increases in relative risk of coronary heart disease at lower waist circumferences than men. Thus, there is a need to develop sex-specific waist circumference cut-off points appropriate for different populations. Hence, the cut-off points used for this metadata item are associated with obesity in Caucasians. This issue is being investigated further.

Cut-off points for children and adolescents are also being developed. Research shows that a high childhood BMI and high trunk skin fold values are predictive of abdominal obesity as an adult and waist circumference measures in childhood track well into adulthood.

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

National health metadata item currently exist for sex, date of birth, country of birth and Indigenous status and smoking. Metadata items are being developed for physical activity.

Source and reference attributes

Origin: World Health Organization

Reference documents: Obesity: Preventing and Managing the Global Epidemic: Report of a World Health Organization (WHO) Expert Committee. Geneva: WHO, 2000 as described by Han TS et al (1995)

Relational attributes

Related metadata references: Supersedes Waist circumference risk indicator - adults, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.53 KB)

Waist-to-hip ratio

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—waist-to-hip ratio, N.NN
METeOR identifier:	270207
Registration status:	Health, Standard 01/03/2005
Definition:	A ratio calculated by dividing the waist circumference of an adult person by the hip circumference of that same person.
Data Element Concept:	Adult—waist-to-hip ratio

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N.NN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	Formula: WHR = waist circumference (cm) divided by hip circumference (cm). Adult WHR is a continuous variable. Adult WHR cannot be calculated if either component necessary for its calculation (i.e. abdominal circumference or hip circumference) has not been collected (i.e. is coded to 999.9).
Collection methods:	As there are no cut-off points for waist to hip ratio for children and adolescents, it is not necessary to calculate this item for those aged under 18 years. Waist-to-hip ratio (WHR) should be derived after the data entry of waist circumference and hip circumference. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Comments:	Adult cut-off points for WHR, that may define increased risk of cardiovascular disease and all cause mortality, range from 0.9 to 1.0 for men and 0.8 to 0.9 for women (Croft et al. 1995, Bray 1987, Bjorntorp 1985). These values are based primarily on evidence of increased risk of death in European populations, and may not be appropriate for all age and ethnic groups. In Australia and New Zealand, the cutoffs of >0.9 for males and >0.8 for females were used in the Australian Bureau of Statistics' 1995 National Nutrition Survey. This metadata item applies to persons aged 18 years or older as no cut off points have been developed for children and adolescents. It is recommended for use in population surveys and health care settings. More recently it has emerged that waist circumference alone, or

in combination with other metabolic measures, is a better indicator of risk and reduces the errors in WHR measurements. WHR is therefore no longer a commonly used measure.

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

Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure.

Waist- to-hip ratio (WHR) can be used:

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

Presentation of data:

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

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

Source and reference attributes

Origin:

National Health Data Committee

National Centre for Monitoring Cardiovascular Disease

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Waist-to-hip ratio, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.96 KB)

Is formed using Person—waist circumference (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—hip circumference (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Waiting list category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—elective care type, code N
METeOR identifier:	335048
Registration status:	Health, Standard 07/12/2005
Definition:	The type of elective hospital care that a patient requires, as represented by a code.
Data Element Concept:	Elective care waiting list episode—elective care type

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 5th edition
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Elective surgery
2	Other

Collection and usage attributes

Guide for use:

Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

CODE 1 Elective surgery

All elective surgery, that is excluding procedures listed in exclusion list for Code 2, should be included in this code.

CODE 2 Other

Patients awaiting the following procedures should be classified as Code 2 - other:

- organ or tissue transplant procedures
- procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
- cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
- biopsy of:
  - kidney (needle only)
  - lung (needle only)
  - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- peritoneal renal dialysis;

- haemodialysis
- colonoscopy
- endoscopic retrograde cholangio-pancreatography (ERCP)
- endoscopy of:
  - biliary tract
  - oesophagus
  - small intestine
  - stomach
- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the Australian Classification of Health Interventions (ACHI) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

Comments:

The table of Australian Classification of Health Interventions (ACHI) (5th edition) procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians. A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use to facilitate more readily the identification of the exclusions when the list of codes is not used.

ACHI CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant:
90172-00 [555] 90172-01 [555] 90204-00 [659] 90204-01 [659] 90205-00 [660] 90205-01 [660] 13700-00 [801] 13706-08 [802] 13706-00 [802] 13706-06 [802] 13706-07 [802] 13706-09 [802] 13706-10 [802] 30375-21 [817] 90317-00 [954] 90324-00 [981] 36503-00 [1058] 36503-01 [1058] 14203-01 [1906]

Procedures associated with obstetrics: 16511-00 [1274] Obstetric Blocks [1330] to [1345] and [1347]
90463-01 [1330] 90488-00 [1330]

Biopsy (needle) of:
• kidney: 36561-00 [1047]
• lung: 38412-00 [550]
• liver and gall bladder: 30409-00 [953] 30412-00 [953] 90319-01 [951] 30094-04 [964]

Bronchoscopy:
41889-00 [543] 41892-00 [544] 41904-00 [546] 41764-02 [416] 41895-00 [544] 41764-04 [532] 41892-01 [545] 41901-00 [545] 41898-00 [543] 41898-01 [544] 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Peritoneal renal dialysis:
13100-06 [1061] 13100-07 [1061] 13100-08 [1061] 13100-00 [1060]

Endoscopy of biliary tract:
30484-00 [957] 30484-01 [957] 30484-02 [974] 30494-00 [971] 30452-00 [971] 30491-00 [958] 30491-01 [958] 30485-00 [963] 30485-01 [963] 30452-01 [958] 30450-00 [959] 30452-02 [959] 90349-00 [975]

Endoscopy of oesophagus:
30473-03 [850] 30473-04 [861] 41822-00 [861] 30478-11 [856] 41819-00 [862] 30478-10 [852] 30478-13 [861] 41816-00 [850] 41822-00 [861] 41825-00 [852] 30478-12 [856] 41831-00 [862] 30478-12 [856] 30490-00 [853] 30479-00 [856]

Panendoscopy:
30476-03 [874] 32095-00 [891] 30568-00 [893] 30569-00 [894] 30473-05 [1005] 30473-00 [1005] 30473-02 [1005] 30478-00 [1006] 30478-14 [1006] 30478-01 [1007] 30478-02 [1007] 30478-03 [1007] 30478-15 [1007] 30478-16 [1007] 30478-17 [1007] 30478-20 [1007] 30478-21 [1007] 30473-01 [1008] 30478-04 [1008] 30473-06 [1008] 30478-18 [1008]

Endoscopy of large intestine, rectum and anus:
32075-00 [904] 32090-00 [905] 32084-00 [905] 30479-02 [908] 90308-00 [908] 32075-01 [910] 32078-00 [910] 32081-00 [910] 32090-01 [911] 32093-00 [911] 32084-01 [911] 32087-00 [911] 30479-01 [931] 90315-00 [933]

Miscellaneous cardiac:
38603-00 [642] 38600-00 [642] 38256-00 [647] 38256-01 [647] 38256-02 [647] 38278-00 [648] 38278-01 [648] 38284-00 [648] 90202-00 [649] 38470-00 [649] 38473-00 [649] 38281-01 [650] 38281-02 [650] 38281-03 [650] 38281-04 [650] 38281-05 [650] 38281-06 [650] 38281-07 [651] 38281-07 [651] 38281-08 [651] 38281-09 [651] 38281-10 [651] 38281-00 [652] 38278-02 [654] 38456-07 [654] 90203-00 [654] 38284-01 [654] 90219-00 [663] 38281-11 [655] 38281-12 [655] 38212-00 [665] 38209-00 [665] 38200-00 [667] 38203-00 [667] 38206-00 [667] 35324-00 [740] 35315-00 [758] 35315-01 [758] 90214-00 [648] 90202-01 [649] 38281-13 [652] 38278-03 [654] 38284-02 [654] 90214-01 [654] 90214-02 [654] 90203-01 [654] 38456-08 [654] 38281-14 [655] 38212-01 [665] 38213-00 [665]

Endovascular interventional:
35304-01 [670] 35305-00 [670] 35304-00 [670] 35305-01 [670] 35310-00 [671] 35310-01 [671] 35310-03 [671] 35310-04 [671] 35310-02 [671] 35310-05 [671] 34524-00 [694] 13303-00 [694] 34521-01 [694] 32500-01 [722] 32500-00 [722] 13300-01 [738] 13300-02 [738] 13319-00 [738] 13300-00 [738] 13815-00 [738] 13815-01 [738] 34521-02 [738] 34530-04 [738] 90220-00 [738]

Urethroscopy:
36800-00 [1090] 36800-01 [1090] 37011-00 [1093] 37008-01 [1093] 37008-00 [1093] 37315-00 [1112] 37318-01 [1116] 36815-01 [1116] 37854-00 [1116] 35527-00 [1116] 37318-04 [1117] 36800-03 [1090] 37318-02 [1116] 37318-03 [1116]

Dental:
Blocks [450] to [490]
97022-00 [451] 97025-00 [451] 97113-00 [453] 97121-01 [454] 97123-01 [454] 97165-01 [455] 97221-00 [456] 97222-00 [456] 97231-00 [456] 97232-00 [456] 97233-00 [456] 97234-00 [456] 97384-00 [461] 97386-01 [461] 97415-00 [462] 97417-00 [462] 97431-00 [463] 97433-00 [463] 97434-00 [463] 97437-00 [463]

97445-00 [464] 97455-00 [464] 97511-01 [465] 97512-01 [465] 97513-01 [465] 97514-02 [465] 97515-02 [465] 97541-01 [465] 97542-01 [465] 97543-01 [465] 97544-00 [465] 97545-00 [465] 97521-01 [466] 97522-01 [466] 97523-01 [466] 97524-00 [466] 97525-00 [466] 97531-00 [466] 97532-00 [466] 97533-00 [466] 97534-00 [466] 97535-00 [466] 97551-01 [466] 97552-01 [466] 97553-01 [466] 97554-01 [466] 97555-01 [466] 97572-01 [469] 97574-01 [469] 97575-00 [469] 97578-00 [469] 97582-01 [469] 97583-01 [469] 97631-00 [470] 97632-00 [471] 97649-00 [471] 97671-00 [473] 97672-00 [473] 97673-00 [473] 97732-00 [474] 97733-00 [474] 97739-00 [474] 97741-00 [475] 97762-00 [476] 97765-00 [476] 97768-00 [476] 97825-00 [479]

Other diagnostic and non-surgical:
90347-01 [983] 30406-00 [983] 90347-02 [983] 30408-00 [983]

Blocks [1820] to [1939], [1940] to [2016]

11003-00 [1825] 11018-00 [1826] 11018-01 [1826] 11614-00 [1851] 11602-00 [1852] 11604-00 [1852] 11605-00 [1852] 11610-00 [1852] 11611-00 [1852] 11612-00 [1852] 11709-00 [1853] 11917-00 [1860] 11919-00 [1860] 96207-00 [1921] 96207-01 [1921] 96207-02 [1921] 96207-03 [1921] 96207-04 [1921] 96207-05 [1921] 96207-06 [1921] 96207-07 [1921] 96207-08 [1921] 96207-09 [1921] 96208-00 [1921] 96208-01 [1921] 96208-02 [1921] 96208-03 [1921] 96208-04 [1921] 96208-05 [1921] 96208-06 [1921] 96208-07 [1921] 96208-08 [1921] 96208-09 [1921] 55084-00 [1943] 55600-00 [1943] 60000-01 [1992] 60048-00 [1996] 60060-00 [1997] 60060-01 [1997] 61442-00 [2012] 96196-00 [1920] 96196-01 [1920] 96196-02 [1920] 96196-03 [1920] 96196-04 [1920] 96196-05 [1920] 96196-06 [1920] 96196-07 [1920] 96196-08 [1920] 96196-09 [1920] 96197-00 [1920] 96197-01 [1920] 96197-02 [1920] 96197-03 [1920] 96197-04 [1920] 96197-05 [1920] 96197-06 [1920] 96197-07 [1920] 96197-08 [1920] 96197-09 [1920] 96198-00 [1920] 96198-01 [1920] 96198-02 [1920] 96198-03 [1920] 96198-04 [1920] 96198-05 [1920] 96198-06 [1920] 96198-07 [1920] 96198-08 [1920] 96198-09 [1920] 96199-00 [1920] 96199-01 [1920] 96199-02 [1920] 96199-03 [1920] 96199-04 [1920] 96199-05 [1920] 96199-06 [1920] 96199-07 [1920] 96199-08 [1920] 96199-09 [1920] 96200-00 [1920] 96200-01 [1920] 96200-02 [1920] 96200-03 [1920] 96200-04 [1920] 96200-05 [1920] 96200-06 [1920] 96200-07 [1920] 96200-08 [1920] 96200-09 [1920] 96201-00 [1920] 96201-01 [1920] 96201-02 [1920] 96201-03 [1920] 96201-04 [1920] 96201-05 [1920] 96201-06 [1920] 96201-07 [1920] 96201-08 [1920] 96201-09 [1920] 96202-00 [1920] 96202-01 [1920] 96202-02 [1920] 96202-03 [1920] 96202-04 [1920] 96202-05 [1920] 96202-06 [1920] 96202-07 [1920] 96202-08 [1920] 96202-09 [1920] 96203-00 [1920] 96203-01 [1920] 96203-02 [1920] 96203-03 [1920] 96203-04 [1920] 96203-05 [1920] 96203-06 [1920] 96203-07 [1920] 96203-08 [1920] 96203-09 [1920] 96204-00 [1920] 96204-01 [1920] 96204-02 [1920] 96204-03 [1920] 96204-04 [1920] 96204-05 [1920] 96204-06 [1920] 96204-07 [1920] 96204-08 [1920] 96204-09 [1920] 96205-00 [1920] 96205-01 [1920] 96205-02 [1920] 96205-03 [1920] 96205-04 [1920] 96205-05 [1920] 96205-06 [1920] 96205-07 [1920] 96205-08 [1920] 96205-09 [1920] 96206-00 [1920] 96206-01 [1920] 96206-02 [1920] 96206-03 [1920] 96206-04 [1920] 96206-05 [1920] 96206-06 [1920] 96206-07 [1920] 96206-08 [1920] 96206-09 [1920]

Source and reference attributes

Reference documents: National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth

Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Elective care waiting list episode—elective care type, code N Health, Superseded 07/12/2005

Waiting time at a census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN]
METeOR identifier:	269961
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list to a designated census date.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The number of days is calculated by subtracting the Elective care waiting list episode—listing date for care, DDMMYYYY from the Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at the census date.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at the census date, then the number of days waited at the less urgent Elective surgery waiting list episode—clinical urgency, code N category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at census date) the number of days at the less urgent clinical urgency category should be calculated by subtracting the Elective care waiting list episode—listing date for care, DDMMYYYY from the Elective care waiting list episode—category reassignment date, DDMMYYYY. If the patient's clinical urgency was reclassified more than once, days spent in

each period of less urgent clinical urgency than the one applying at the census date should be calculated by subtracting one Elective care waiting list episode—category reassignment date, DDMMYYYY from the subsequent Elective care waiting list episode—category reassignment date, DDMMYYYY, and then adding the days together.

When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore at the census date the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at a designated census date whereas the metadata item Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] measures waiting times at removal.

The calculation of waiting times for patients who are transferred from an elective surgery waiting list managed by one public acute hospital to another will be investigated in the future. In this case, the amount of time waited on previous lists should follow the patient to the next. Therefore at the census date, their waiting time includes the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients are overdue, or had extended waits at a census date. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Elective surgery waiting list episode—patient listing status, readiness for care code N Health, Standard 01/03/2005

Is formed using Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—listing date for care, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Waiting time at a census date, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.69 KB)

Is used in the formation of Elective surgery waiting list episode—overdue patient status, code N Health, Standard

	01/03/2005 Is used in the formation of Elective surgery waiting list episode—extended wait patient indicator, code N Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005 *Implementation start date:* 30/09/2006 Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005 *Implementation start date:* 30/09/2002 *Implementation end date:* 30/06/2006

Waiting time at removal from elective surgery waiting list

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at removal), total days N[NNN]
METeOR identifier:	269960
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	The number of days is calculated by subtracting the listing date for care from the removal date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal. Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'. If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited. In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the listing date for care from the category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category

reassignment date, and then adding the days together.

When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.

Therefore at the removal date, the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at removal whereas the metadata item waiting time at a census date measures waiting times at a designated census date.

The calculation of waiting times for patients, who are transferred from an elective surgery waiting list managed by one public acute hospital to another, will be investigated in the future. In this case, the amount of time waited on previous lists would follow the patient to the next. Therefore when the patient is removed from the waiting list (for admission or other reason), their waiting time would include the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients were overdue, or had extended waits when they were removed from the waiting list. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Waiting time at removal from elective surgery waiting list, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.97 KB)

Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting list removal date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—listing date for care, DDMMYYYY Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—overdue patient status, code N Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—extended wait patient indicator, code N Health, Standard 01/03/2005

Implementation in Data Set

Elective surgery waiting times (removals data) NMDS Health,

Specifications:

Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Weight (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (self-reported), total kilograms NN[N]
METeOR identifier:	302365
Registration status:	Health, Standard 14/07/2005
Definition:	A person's self-reported weight (body mass).
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
888	Unknown
999	Not stated

Unit of measure: Kilogram (Kg)

Collection and usage attributes

Guide for use:

CODE 888 Unknown

Use this code if self-reported body mass (weight) is unknown.

CODE 999 Not stated

Use this code if self-reported body mass (weight) is not responded to.

Data element attributes

Collection and usage attributes

Collection methods:

The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their weight is. For example, the ABS National Health Survey 1989-90 included the question 'How much do you weigh without clothes and shoes?'. The data collection form should allow for both metric (to the nearest 1 kg) and imperial (to the nearest 1 lb) units to be recorded.

If practical, it is preferable to enter the raw data into the data base before conversion of measures in imperial units to metric. However, if this is not possible, weight reported in imperial units can be converted to metric prior to data entry using a conversion factor of 0.454 kg to the lb.

Rounding to the nearest 1 kg will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than

the nearest 1 kg. The following rounding conventions are desirable to reduce systematic over reporting (Armitage and Berry 1994):

nnn.x where x

nnn.x where x > 5 - round up, e.g. 72.7 kg would be rounded to 73 kg.

nnn.x where x = 5 - round to the nearest even number, e.g. 72.5 kg would be rounded to 72 kg, while 73.5 kg would be rounded to 74 kg.

Comments:

This metadata item is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure weight.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables. Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

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

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

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men and women, although the range will depend on the population. The World Health Organization's range for weight is 30-140 kg.

Weight

30 kg = Weight

35 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

On average, body mass (weight) tends to be underestimated when self-reported by respondents. Data for men and women aged 20-69 years in 1989 indicated that men underestimated by an average of 0.2 kg (sem of 0.05 kg) and women by an average of 0.4 kg (sem of 0.04 kg) (Waters 1993). The extent of underestimation varied with age.

Source and reference attributes

Origin:

National Centre for Monitoring Cardiovascular Disease

Australian Institute of Health and Welfare

National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Weight - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.45 KB) Supersedes Adult—weight (self-reported), total kilograms NN[N] Health, Superseded 14/07/2005 Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005 Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Weight in grams (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total grams NNNN
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	310245
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in grams.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Gram (g)

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005 Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008 *Information specific to this data set:*

For the provision of state and territory hospital data to Commonwealth agencies this metadata item must be consistent with diagnoses and procedure codes for valid grouping.
Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Weight in kilograms (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total kilograms N[NN].N
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	270208
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in kilograms.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value Meaning 999.9 Not collected
Unit of measure:	Kilogram (Kg)

Collection and usage attributes

Guide for use:	A continuous variable measured to the nearest 0.1 kg. CODE 999.9 Not collected Use this code if measured weight is not collected.

Data element attributes

Collection and usage attributes

Guide for use:	In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.
Collection methods:	The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity and without drawing attention to an individual's weight. The measurement protocol described below is that recommended by the WHO Expert Committee (1995). Measurement protocol: Equipment used should be described and reported. Scales should have a resolution of at least 0.1kg and should have the capacity to weigh up to at least 200 kg. Measurement intervals and labels should be clearly readable under all conditions of use of the instrument. Scales should be capable of being calibrated across the entire range of measurements. Precision error should be no more than 0.1kg. Scales should be calibrated on each day of use. Manufacturers' guidelines should be followed with regard to the transportation of the scales.

Adults and children who can stand:

The subject stands over the centre of the weighing instrument, with the body weight evenly distributed between both feet.

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater. Any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form. Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

If the subject has had one or more limbs amputated, record this on the data collection form and weigh them as they are. If they are wearing an artificial limb, record this on the data collection form but do not ask them to remove it. Similarly, if they are not wearing the limb, record this but do not ask them to put it on.

The measurement is recorded to the nearest 0.1 kg. If the scales do not have a digital readout, take a repeat measurement. If the two measurements disagree by more than 0.5 kg, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured weight is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 kg. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage and Berry 1994). For example, a mean value of 72.25 kg would be rounded to 72.2 kg, while a mean value of 72.35 kg would be rounded to 72.4 kg.

Infants:

Birth weight and gender should be recorded with gestational age. During infancy a levelled pan scale with a bean and movable weights or digital scales capable of measuring to two decimal places of a kilogram are acceptable. Birth weight should be determined within 12 hours of birth. The infant, with or without a nappy or diaper is placed on the scales so that the weight is distributed equally about the centre of the pan. When the infant is lying or suspended quietly, weight is recorded to the nearest 10 grams. If the nappy or diaper is worn, its weight is subtracted from the observed weight i.e. reference data for infants are based on nude weights.

Validation and quality control measures:

If practical, equipment should be checked daily using one or more objects of known weight in the range to be measured. It is recommended that the scale be calibrated at the extremes and in the mid range of the expected weight of the population being studied.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement of weight, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement) between

observers should not exceed 0.5 kg and be less than 0.5 kg within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

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

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men, women, children and adolescents, although the range will depend on the population.

Weight

10 kg = Weight

15 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

Source and reference attributes

Submitting organisation:

World Health Organization The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing

Reference documents:

Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults (US National Heart, Lung and Blood Institute (NHLBI) in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases).
Chronic Diseases and Associated Risk Factors in Australia 2001 (AIHW).

Relational attributes

Related metadata references:

Supersedes Weight - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (29.31 KB)

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, body mass index (BMI) should be below 27 kg/m 2 for men and women. For adults who suffer from diabetes, the recommendation is to measure weight and calculate BMI on the initial visit and then measure weight every 3 months. If the patient is on a weight reduction program, weight is to be measured more frequently.

Strong evidence exists that weight loss reduces blood pressure in both overweight hypertensive and non-hypertensive individuals; reduces serum triglycerides and increases high-density lipoprotein (HDL)-cholesterol; and generally produces some reduction in total serum cholesterol and low-density lipoprotein (LDL)-cholesterol.

The risk of developing diabetes rises continuously with increasing obesity (DHAC & AIHW 1999:13). An increased central distribution of body fat (when fatness is concentrated in the abdomen) also appears to be associated more often with Type 2 diabetes (Bishop et al. 1998:430-1).

Weight loss reduces blood glucose levels in overweight and obese persons with and without diabetes; and weight loss also reduces blood glucose levels and HbA1c in some patients with type 2 diabetes. Although there have been no prospective trials to show changes in mortality with weight loss in obese patients, reductions in risk factors

would suggest that development of type 2 diabetes and CVD would be reduced with weight loss.

Weight is an overall measure of body size that does not distinguish between fat and muscle. Weight is an indicator of nutritional and health status. Low pre-pregnancy weight is an indicator of poorer gestational outcome in women (Kramer 1988). Low weight is also associated with osteoporosis. In general, change in weight in adults is of interest because it is an indicator of changing health status, and in children as it indicates changing health status and growth and development. Self-reported or parentally-reported weight for children and adolescents should be used cautiously if at all. It enables the calculation of body mass index (BMI) which requires the measurement of height and weight for adults as well as sex and date of birth for children and adolescents.

Working partnership indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—working partnership indicator, yes/no code N
METeOR identifier:	290696
Registration status:	Health, Standard 05/12/2007
Definition:	Whether a service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s), as represented by a code.
Data Element Concept:	Service provider organisation—working partnership indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A formal working partnership involves arrangements between a service provider organisation and another service provider or organisation, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

CODE 1 Yes
The service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s) in place.

CODE 2 No
The service provider organisation has no formal working

partnership(s) with other service provider(s) or organisation(s) in place.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Information specific to this data set:
This information is required for the calculation of palliative care performance indicator number 4: 'The proportion of palliative care agencies, within their setting of care, that have formal working partnerships with other service provider(s) and organisation(s)'.

Year insulin started

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—insulin start date, YYYY
METeOR identifier:	269928
Registration status:	Health, Standard 01/03/2005
Definition:	The year the patient started insulin injections.
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—insulin start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that insulin injections were started. This data element has to be completed for all patients who use insulin. It is used to cross check diabetes type assignment.
Collection methods:	Ask the individual the year when he/ she started to use insulin. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year insulin started, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.15 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

This data element provides information about the duration of diabetes in individual patients.

Insulin is a regulating hormone secreted into the blood in response to a rise in concentration of blood glucose or amino acids. It is a double-chain protein hormone formed from proinsulin in the beta cells of the pancreatic islets of Langerhans. Insulin promotes the storage of glucose and the uptake of amino acids, increases protein and lipid

synthesis, and inhibits lipolysis and gluconeogenesis. Commercially prepared insulin is available in various types, which differ in the speed they act and in the duration of their effectiveness.

Year of arrival in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (overseas born)—year of first arrival in Australia, date YYYY
METeOR identifier:	269929
Registration status:	Health, Standard 04/05/2005 Community services, Standard 01/03/2005
Definition:	The year a person (born outside of Australia) first arrived in Australia, from another country, with the intention of staying in Australia for one year or more.
Data Element Concept:	Person (overseas born)—year of first arrival in Australia

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Data element attributes

Collection and usage attributes

Collection methods:

Actual year of arrival in Australia.

Recommended question:

In what year did you/the person first arrive in Australia to live here for one year or more?

(Write in the calendar year of arrival or mark the box if here less than one year)

Calendar year of arrival

Will be here less than one year

It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. To deal with these cases in self-enumerated collections, an instruction such as 'Please indicate the year of first arrival only' should be included with the question.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Source and reference attributes

Origin: The Australian Bureau of Statistics Standard for Year of Arrival in Australia. (last viewed 05/12/2006)

Reference documents: The ABS standard for Year of arrival in Australia appears on the ABS website select Other ABS Statistical Standards/Standards for Social, Labour and Demographic Variables/Cultural Diversity Variable.

Relational attributes

Related metadata references: Supersedes Year of arrival in Australia, version 2, DE, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.52 KB)

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Year of diagnosis of diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (diabetes mellitus), YYYY
METeOR identifier:	269930
Registration status:	Health, Standard 01/03/2005
Definition:	The year a patient was first diagnosed as having diabetes
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that the patient was first diagnosed as having diabetes.
Collection methods:	Ask the individual the year when he/ she was diagnosed with diabetes. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year of diagnosis of diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.06 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:
Long-term complications of diabetes mellitus affect the eyes, kidneys, nerves, and blood vessels.

National Minimum Data Sets

A National minimum data set (NMDS) is a minimum set of data elements agreed for mandatory collection and reporting at a national level. It may include data elements that are also included in other National minimum data sets. An NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

Admitted patient care NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	361679
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	The purpose of this National Minimum Data Set is to collect information about care provided to admitted patients in Australian hospitals. The scope is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. Hospital boarders and still births are not included as they are not admitted to hospital. Posthumous organ procurement episodes are also not included.

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients
Collection methods:	Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (e.g. monthly). *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2008
Comments:	*Scope links with other NMDS* Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: • Admitted patient mental health care NMDS. Episodes of care for admitted patients where care type is palliative care: • Admitted patient palliative care NMDS. *Glossary items* Some previous Knowledgebase data element concepts are available in the METeOR glossary. Glossary items are available online through links in the relevant metadata items. In addition links to the glossary terms that are relevant to this National minimum data set are listed below. **Admission** **Diagnosis** **Episode of acute care**

Hospital boarder
Hospital-in-the-home care
Live birth
Neonate
Newborn qualification status
Organ procurement - posthumous
Same-day patient
Separation

Relational attributes

Related metadata references: Supersedes Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activity when injured	Mandatory	50
-	Additional diagnosis	Mandatory	50
-	Admission date	Mandatory	1
-	Admitted patient election status	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Care type	Mandatory	1
-	Condition onset flag	Mandatory	50
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Diagnosis related group	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	External cause (admitted patient)	Mandatory	50
-	Funding source for hospital patient	Mandatory	1
-	Hospital insurance status	Mandatory	1
-	Indigenous status	Mandatory	1
-	Intended length of hospital stay	Mandatory	1
-	Inter-hospital contracted patient	Mandatory	1
-	Major diagnostic category	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mode of admission	Mandatory	1
-	Mode of separation	Mandatory	1
-	Number of days of hospital-in-the-home care	Mandatory	1
-	Number of qualified days for newborns	Conditional	1
-	Person identifier	Mandatory	1
-	Place of occurrence of external cause of injury (ICD-10-AM)	Mandatory	50
-	Principal diagnosis	Mandatory	1
-	Procedure	Mandatory	50
-	Region code	Mandatory	1
-	Separation date	Mandatory	1

-	Sex	Mandatory	1
-	Source of referral to public psychiatric hospital	Conditional	1
-	Total leave days	Mandatory	1
-	Total psychiatric care days	Mandatory	1
-	Urgency of admission	Mandatory	1
-	Weight in grams (measured)	Conditional	1

Admitted patient mental health care NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	362305
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this minimum data set is restricted to 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 who are not in psychiatric units.

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients
Collection methods:	Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (for example, monthly). *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2008
Comments:	Number of days of hospital in the home care data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date. *Scope links with other NMDS* Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: • Admitted patient care NMDS • Admitted patient palliative care NMDS *Glossary items* Some previous Knowledgebase data element concepts are available in the METeOR glossary. Currently the metadata search in METeOR does not cover glossary items however these items are available through links in the relevant metadata items. In addition links to the glossary terms that are relevant to this National minimum data set are included here. **Resident** **Residential mental health care service** **Same-day patients** **Separation**

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: Supersedes Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Mandatory	1
-	Admission date	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Conditional	1
-	Date of birth	Mandatory	1
-	Diagnosis related group	Mandatory	1
-	Employment status (admitted patient)	Mandatory	1
-	Employment status—public psychiatric hospital admissions	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Major diagnostic category	Mandatory	1
-	Marital status	Conditional	1
-	Mental health legal status	Mandatory	1
-	Mode of separation	Mandatory	1
-	Person identifier	Mandatory	1
-	Previous specialised treatment	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Referral destination to further care (psychiatric patients)	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1
-	Source of referral to public psychiatric hospital	Mandatory	1
-	Total leave days	Mandatory	1
-	Total psychiatric care days	Mandatory	1
-	Type of accommodation	Mandatory	1
-	Type of usual accommodation	Mandatory	1

Admitted patient palliative care NMDS 2008-09

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	361960
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this data set is admitted patients receiving palliative care in all public and private acute hospitals, and free standing day hospital facilities. Hospitals operated by the Australian Defence Force, correctional authorities and Australia's external territories are not currently included. Palliative care patients are identified by the data element *Hospital service—care type, code N[N].N*.

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients.
Collection methods:	*National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data collected and collated nationally* Financial years ending 30 June each year.
Implementation start date:	01/07/2008
Comments:	*Scope links with other NMDSs* Episodes of care for admitted patients receiving palliative care in all public and private acute hospitals and free standing day hospital facilities: • Admitted patient care NMDS. • Admitted patient mental health care NMDS.

Source and reference attributes

Submitting organisation:	National Health Information Group

Relational attributes

Related metadata references:	Supersedes Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Conditional	1
-	Establishment identifier	Mandatory	1
-	Funding source for hospital patient	Mandatory	1
-	Indigenous status	Mandatory	1
-	Mode of separation	Mandatory	1

-	Number of days of hospital-in-the-home care	Mandatory	1
-	Person identifier	Conditional	1
-	Previous specialised treatment	Mandatory	1
-	Principal diagnosis	Conditional	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1
-	Admission date	Mandatory	1
-	Mode of admission	Mandatory	1

Alcohol and other drug treatment services NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	362318
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	This metadata set is nationally mandated for collection and reporting. Publicly funded government and non-government agencies providing alcohol and/or drug treatment services. Including community-based ambulatory services and outpatient services. The following services are currently not included in the coverage: • services based in prisons and other correctional institutions; • agencies that provide primarily accommodation or overnight stays such as 'sobering-up shelters' and 'half-way houses'; • agencies that provide services concerned primarily with health promotion; • needle and syringe programs; • agencies whose sole function is to provide prescribing and/or dosing of methadone; and • acute care and psychiatric hospitals, or alcohol and drug treatment units that report to the admitted patient care National Minimum Data Set and do not provide treatment to non-admitted patients. Clients who are on a methadone maintenance program may be included in the collection where they also receive other types of treatment.

Collection and usage attributes

Statistical unit:	Completed treatment episodes for clients who participate in a treatment type as specified in the data element Episode of treatment for alcohol and other drugs—treatment type (main), code N.
Collection methods:	Data to be reported in each agency on completed treatment episode and then forwarded to state/territory authorities for collation. *National reporting requirements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2008

Source and reference attributes

Submitting organisation:	National Health Information Group

Relational attributes

Related metadata references: Supersedes Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Client type (alcohol and other drug treatment services)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of cessation of treatment episode for alcohol and other drugs	Mandatory	1
-	Date of commencement of treatment episode for alcohol and other drugs	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Geographical location of service delivery outlet	Mandatory	1
-	Indigenous status	Mandatory	1
-	Injecting drug use status	Conditional	1
-	Main treatment type for alcohol and other drugs	Mandatory	1
-	Method of use for principal drug of concern	Conditional	1
-	Other drug of concern	Conditional	4
-	Other treatment type for alcohol and other drugs	Mandatory	4
-	Person identifier	Mandatory	1
-	Preferred language	Mandatory	1
-	Principal drug of concern	Conditional	1
-	Reason for cessation of treatment episode for alcohol and other drugs	Mandatory	1
-	Sex	Mandatory	1
-	Source of referral to alcohol and other drug treatment service	Mandatory	1
-	Treatment delivery setting for alcohol and other drugs	Mandatory	1

Community mental health care NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	362308
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	This NMDS includes data about service contacts provided by specialised mental health services for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services.

Collection and usage attributes

Statistical unit:	Mental health service contact
Implementation start date:	01/07/2008

Relational attributes

Related metadata references:	Supersedes Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Country of birth	Conditional	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Indigenous status	Mandatory	1
-	Marital status	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mental health service contact date	Mandatory	1
-	Mental health service contact duration	Mandatory	1
-	Mental health service contact—patient/client participation indicator	Mandatory	1
-	Mental health service contact—session type	Mandatory	1
-	Person identifier	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Region code	Mandatory	1
-	Sex	Mandatory	1

Elective surgery waiting times (census data) NMDS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	335002
Registration status:	Health, Standard 07/12/2005
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this minimum data set is patients on waiting lists for elective surgery (as defined in the Waiting list category data element) which are managed by public acute hospitals. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals. Hospitals may also collect information for other care (as defined in the Waiting list category data element), but this is not part of the National Minimum Data Set (NMDS) for Elective surgery waiting times. Patients on waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Census data: Data are collected for patients on elective surgery waiting lists who are yet to be admitted to hospital or removed for another reason. The scope is patients on elective surgery waiting lists on a census date who are 'ready for care' as defined in the Elective surgery waiting list episode—patient listing status, readiness for care code N data element.

Collection and usage attributes

Statistical unit:	Patients on waiting lists on census dates.
Collection methods:	Elective care waiting list episode—category reassignment date, DDMMYYYY is not required for reporting to the NMDS, but is necessary for the derivation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN]. Elective care waiting list episode—elective care type, code N and Elective surgery waiting list episode—patient listing status, readiness for care code N are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to state and territory health authorities as required. *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Census dates are 30 September, 31 December, 31 March and 30 June.
Implementation start date:	30/09/2006
Comments:	There are two different types of data collected for this national minimum data set (census data and removals data) and the scope and list of data elements associated with each is different. For the purposes of this NMDS, public hospitals include hospitals which are set up to provide services for public

patients (as public hospitals do), but which are managed privately.

The inclusion of public patients removed from elective surgery waiting lists managed by private hospitals will be investigated in the future.

Source and reference attributes

Submitting organisation: National Health Information Management Group

Relational attributes

Related metadata references: Supersedes Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Census date	Mandatory	1
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Extended wait patient	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at a census date	Mandatory	1

Elective surgery waiting times (removals data) NMDS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	335007
Registration status:	Health, Standard 07/12/2005
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this minimum data set is patients removed from waiting lists for elective surgery (as defined in the Waiting list category data element) which are managed by public acute hospitals. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals. Hospitals may also collect information for other care (as defined in the Waiting list category data element), but this is not part of the National Minimum Data Set (NMDS) for elective surgery waiting times. Patients removed from waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Removals data: Data are collected for patients who have been removed from an elective surgery waiting list (for admission or another reason). Patients who were 'ready for care' and patients who were 'not ready for care' at the time of removal are included.

Collection and usage attributes

Statistical unit:	Patients removed from waiting lists (for admission or other reason) during each financial year.
Collection methods:	Elective care waiting list episode—category reassignment date, DDMMYYYY is not required for reporting to the NMDS, but is necessary for the derivation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN]. Elective care waiting list episode—elective care type, code N and Elective surgery waiting list episode—patient listing status, readiness for care code N are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to state and territory health authorities as required. *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year for removals data.
Implementation start date:	01/07/2006
Comments:	There are two different types of data collected for this national minimum data set (census data and removals data) and the scope and list of data elements associated with each is different. For the purposes of this NMDS, public hospitals include hospitals which are set up to provide services for public

patients (as public hospitals do), but which are managed privately.

The inclusion of public patients removed from elective surgery waiting lists managed by private hospitals will be investigated in the future.

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: Supersedes Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Indicator procedure	Mandatory	1
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Extended wait patient	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Conditional	1
-	Reason for removal from elective surgery waiting list	Mandatory	1
-	Removal date	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at removal from elective surgery waiting list	Mandatory	1

Government health expenditure NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	352482
Registration status:	Health, Standard 05/12/2007
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this dataset is direct government and government-funded expenditure on health and health–related goods and services.

Collection and usage attributes

Statistical unit:	Providers of health or health related goods and services or non-health services that support the health services industry; health or health related functions; and the sources of funds for these providers or functions.
Guide for use:	The GHE NMDS consists of 2 mandatory data clusters and 1 conditional data cluster. The first two data elements named in each data cluster form one of the two axes of a matrix that combine to provide all data in Australian dollars. Data are to be reported in Australian dollars except when reporting the State/Territory identifier of the Jurisdiction.
Collection methods:	Data are collected by a number of providers from their administrative systems and forwarded to the relevant state or territory health authority on a regular basis (for example, monthly). Hospitals forward data obtained from patient administrative and clinical record systems to the relevant state or territory health authority on a regular basis (for example, monthly). Other data is obtained either directly from annual reports or through surveys. National reporting arrangements State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. Periods for which data are collected and nationally collated: Financial years ending 30 June each year.
Implementation start date:	01/07/2008
Comments:	Scope links with other NMDSs • National Public Hospital Establishments NMDS • Mental Health Establishments NMDS

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Government health expenditure organisation revenue data element cluster	Mandatory	1
2	Government health expenditure organisation expenditure data cluster	Mandatory	1

3	Government health expenditure function revenue data cluster	Conditional	1
4	Australian State/Territory identifier (jurisdiction)	Mandatory	1

Health labour force NMDS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	273041
Registration status:	Health, Standard 01/03/2005
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this set of data elements is all health occupations. National collections using this data set have been undertaken for the professions of medicine, nursing, dentistry, pharmacy, physiotherapy and podiatry, using labour force questionnaires in the annual renewal of registration to practice.

Collection and usage attributes

Statistical unit:	A health professional's labour force data
Collection methods:	*National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2005

Source and reference attributes

Submitting organisation:	National Health Information Group

Relational attributes

Related metadata references:	Supersedes Health labour force, NMDS, NHIMG, Superseded 01/03/2005.pdf (113.44 KB)

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Classification of health labour force job	Mandatory	1
-	Date of birth	Mandatory	1
-	Hours on-call (not worked) by medical practitioner	Mandatory	1
-	Hours worked by health professional	Mandatory	1
-	Hours worked by medical practitioner in direct patient care	Mandatory	1
-	Principal area of clinical practice	Mandatory	1
-	Principal role of health professional	Mandatory	1
-	Profession labour force status of health professional	Mandatory	1
-	Total hours worked by a medical practitioner	Mandatory	1
-	Type and sector of employment establishment	Mandatory	1

Mental health establishments NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	362299
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	All specialised mental health services managed or funded by State or Territory health authorities. The statistical units are specialised mental health services. These are the specialised mental health components of the State and Territory health authorities, and of regions within states and territories; specialised mental health service organisations; service units within those organisations; and private hospital and non-government residential service units funded by specialised mental health services. Non-government residential mental health services and specialised mental health services provided by private hospitals that receive State or Territory government funding are included as service units for this NMDS. In addition, information on funding of non-government organisations by non-health departments for the provision of mental health services is collected through a specific data element. Ambulatory services managed by non-government organisations are not defined as statistical units for this NMDS. The data elements relevant to each of these types of statistical unit differ, as detailed below. States and Territories determine the organisational units that will report as 'regions', 'organisations', and 'service units' for this NMDS. However, as a minimum, each hospital reported to the Public Hospital Establishments NMDS should be defined as a service unit for the purposes of this NMDS and should use the same establishment identifiers in this NMDS as are used in the National Public Hospital Establishments NMDS. In addition, as a minimum, 24 hour staffed residential services and non-24 hour staffed residential services should be defined as separate service units.

Collection and usage attributes

Statistical unit:	Specialised mental health services.
Collection methods:	*National reporting arrangements* State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2008
Comments:	*Private hospitals and non-government organisation residential services* Only the following data elements are mandatory for non-government organisation residential mental health services and

specialised mental health services provided by private hospitals that receive State or Territory government funding: Accrued mental health care days, Co-location status of mental health service, Geographical location of establishment, Establishment identifier, Number of available beds for admitted patients, Number of episodes of residential care, Separations, Specialised mental health services—hours staffed and Total recurrent expenditure.

For these services it is not mandatory to disaggregate data elements by Specialised mental health services program type or Specialised mental health services target population where specified.

Non-residential non-government organisation mental health services

Information on the total expenditure ($) on non-residential non-government organisation mental health services (i.e. the 'grants to non-government organisations' data elements) by service type (e.g. accommodation services) is to be reported where available, but is also not mandatory.

Glossary items

Some previous Knowledgebase data element concepts are available in the METeOR glossary. Currently the metadata search in METeOR does not cover glossary items however these items are available through links in the relevant metadata items. In addition links to the glossary terms that are relevant to this National minimum data set are included here.

Episode of residential care end

Episode of residential care start

Mental health-funded non-government organisation

Residential mental health care service

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: Supersedes Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Accrued mental health care days	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Carer participation arrangements—carer consultants employed	Mandatory	1
-	Carer participation arrangements—carer satisfaction surveys	Conditional	1
-	Carer participation arrangements—formal complaints mechanism	Conditional	1
-	Carer participation arrangements—formal participation policy	Conditional	1
-	Carer participation arrangements—regular discussion groups	Conditional	1
-	Co-location status of mental health service	Conditional	1
-	Consumer committee representation arrangements	Mandatory	1
-	Consumer participation arrangements—consumer consultants employed	Conditional	1

-	Consumer participation arrangements—consumer satisfaction surveys	Conditional	1
-	Consumer participation arrangements—formal complaints mechanism	Conditional	1
-	Consumer participation arrangements—formal participation policy	Conditional	1
-	Consumer participation arrangements—regular discussion groups	Conditional	1
-	Establishment identifier	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Full-time equivalent staff (mental health)—all staff	Conditional	1
-	Full-time equivalent staff—administrative and clerical staff	Mandatory	1
-	Full-time equivalent staff—carer consultants	Mandatory	1
-	Full-time equivalent staff—consultant psychiatrists and psychiatrists	Mandatory	1
-	Full-time equivalent staff—consumer consultants	Mandatory	1
-	Full-time equivalent staff—diagnostic and health professionals	Mandatory	1
-	Full-time equivalent staff—domestic and other staff	Mandatory	1
-	Full-time equivalent staff—enrolled nurses	Mandatory	1
-	Full-time equivalent staff—occupational therapists	Mandatory	1
-	Full-time equivalent staff—other diagnostic and health professionals	Mandatory	1
-	Full-time equivalent staff—other medical officers	Mandatory	1
-	Full-time equivalent staff—other personal care staff	Mandatory	1
-	Full-time equivalent staff—psychiatry registrars and trainees	Mandatory	1
-	Full-time equivalent staff—psychologists	Mandatory	1
-	Full-time equivalent staff—registered nurses	Mandatory	1
-	Full-time equivalent staff—salaried medical officers	Optional	1
-	Full-time equivalent staff—social workers	Mandatory	1
-	Geographical location of establishment	Mandatory	1
-	Grants to non-government organisations—accommodation services	Mandatory	1
-	Grants to non-government organisations—advocacy services	Conditional	1
-	Grants to non-government organisations—community awareness/health promotion services	Conditional	1
-	Grants to non-government organisations—counselling services	Conditional	1
-	Grants to non-government organisations—independent living skills support services	Mandatory	1
-	Grants to non-government organisations—other and unspecified mental health services	Mandatory	1
-	Grants to non-government organisations—pre-vocational training services	Mandatory	1
-	Grants to non-government organisations—psychosocial support services	Conditional	1
-	Grants to non-government organisations—recreation services	Mandatory	1
-	Grants to non-government organisations—respite services	Mandatory	1

-	Grants to non-government organisations—self-help support group services	Mandatory	1
-	Mental health services grants to non-government organisations by non-health departments	Mandatory	1
-	National standards for mental health services review status	Mandatory	1
-	Number of available beds for admitted patients	Conditional	1
-	Number of episodes of residential care	Mandatory	1
-	Recurrent expenditure (mental health)—non-salary operating costs	Conditional	1
-	Recurrent expenditure (mental health)—salaries and wages	Optional	1
-	Recurrent expenditure (salaries and wages)—administrative and clerical staff	Conditional	1
-	Recurrent expenditure (salaries and wages)—carer consultants	Conditional	1
-	Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists	Conditional	1
-	Recurrent expenditure (salaries and wages)—consumer consultants	Conditional	1
-	Recurrent expenditure (salaries and wages)—diagnostic and health professionals	Conditional	1
-	Recurrent expenditure (salaries and wages)—domestic and other staff	Conditional	1
-	Recurrent expenditure (salaries and wages)—enrolled nurses	Conditional	1
-	Recurrent expenditure (salaries and wages)—occupational therapists	Conditional	1
-	Recurrent expenditure (salaries and wages)—other diagnostic and health professionals	Conditional	1
-	Recurrent expenditure (salaries and wages)—other medical officers	Conditional	1
-	Recurrent expenditure (salaries and wages)—other personal care staff	Conditional	1
-	Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees	Conditional	1
-	Recurrent expenditure (salaries and wages)—psychologists	Conditional	1
-	Recurrent expenditure (salaries and wages)—registered nurses	Conditional	1
-	Recurrent expenditure (salaries and wages)—salaried medical officers	Conditional	1
-	Recurrent expenditure (salaries and wages)—social workers	Conditional	1
-	Recurrent expenditure—administrative expenses	Conditional	1
-	Recurrent expenditure—Department of Veterans' Affairs funded	Mandatory	1
-	Recurrent expenditure—depreciation	Conditional	1
-	Recurrent expenditure—domestic services	Conditional	1
-	Recurrent expenditure—drug supplies	Conditional	1
-	Recurrent expenditure—food supplies	Conditional	1
-	Recurrent expenditure—interest payments	Conditional	1
-	Recurrent expenditure—medical and surgical supplies	Conditional	1
-	Recurrent expenditure—National Mental Health Strategy funded	Conditional	1

-	Recurrent expenditure—other Commonwealth Government funded	Conditional	1
-	Recurrent expenditure—other patient revenue funded	Conditional	1
-	Recurrent expenditure—other recurrent expenditure	Conditional	1
-	Recurrent expenditure—other revenue funded	Conditional	1
-	Recurrent expenditure—other State or Territory funded	Conditional	1
-	Recurrent expenditure—patient transport	Conditional	1
-	Recurrent expenditure—payments to visiting medical officers	Conditional	1
-	Recurrent expenditure—recoveries funded	Conditional	1
-	Recurrent expenditure—repairs and maintenance	Conditional	1
-	Recurrent expenditure—State or Territory health authority funded	Conditional	1
-	Recurrent expenditure—superannuation employer contributions	Conditional	1
-	Recurrent expenditure—total	Conditional	1
-	Region code	Conditional	1
-	Residual expenditure (mental health service)—academic positions	Mandatory	1
-	Residual expenditure (mental health service)—education and training	Mandatory	1
-	Residual expenditure (mental health service)—insurance	Mandatory	1
-	Residual expenditure (mental health service)—mental health promotion	Mandatory	1
-	Residual expenditure (mental health service)—mental health research	Mandatory	1
-	Residual expenditure (mental health service)—other indirect expenditure	Mandatory	1
-	Residual expenditure (mental health service)—patient transport services	Mandatory	1
-	Residual expenditure (mental health service)—program administration	Mandatory	1
-	Residual expenditure (mental health service)—property leasing costs	Mandatory	1
-	Residual expenditure (mental health service)—superannuation	Mandatory	1
-	Residual expenditure (mental health service)—support services	Mandatory	1
-	Residual expenditure (mental health service)—workers compensation	Mandatory	1
-	Separations	Mandatory	1
-	Specialised mental health service program type	Mandatory	1
-	Specialised mental health service setting	Mandatory	1
-	Specialised mental health service target population	Mandatory	1
-	Specialised mental health service—hours staffed	Conditional	1
-	Specialised mental health service—supported public housing places	Mandatory	1

Non-admitted patient emergency department care NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	363530
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	This metadata set is nationally mandated for collection and reporting. The scope of this National Minimum Data Set (NMDS) is non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication from the preceding financial year. The care provided to patients in emergency departments is, in most instances, recognised as being provided to 'non-admitted' patients. Patients being treated in emergency departments may subsequently become 'admitted'. The care provided to non-admitted patients who are treated in the emergency department prior to being admitted is included in this NMDS. Care provided to patients who are being treated in an emergency department site as an admitted patient (e.g. in an observation unit, short-stay unit, 'emergency department ward' or awaiting a bed in an admitted patient ward of the hospital) are excluded from the emergency department care NMDS since the recording of the care provided to these patients is part of the scope of the Admitted patient care NMDS.

Collection and usage attributes

Statistical unit:	Non-admitted patient emergency department service episodes.
Collection methods:	**National reporting arrangements** State and territory health authorities provide the NMDS data to the Australian Institute of Health and Welfare for national collation, on an annual basis within 3 months of the end of a reporting period. The Institute and the Commonwealth Department of Health and Ageing will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health and Ageing. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request. **Periods for which data are collected and nationally collated** Financial years, ending 30 June each year. Extraction of data for a financial year should be based on the date of the end of the non-admitted emergency department service episode.
Implementation start date:	01/07/2008
Comments:	**Scope links with other metadata sets** Episodes of care for admitted patients are reported through the

Admitted patient care NMDS.

Source and reference attributes

Submitting organisation: National Health Information Management Principal Committee

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence	Mandatory	1
-	Date of triage	Mandatory	1
-	Emergency department date of commencement of service event	Mandatory	1
-	Emergency department time of commencement of service event	Mandatory	1
-	Time of triage	Mandatory	1
-	Compensable status	Mandatory	1
-	Country of birth	Conditional	1
-	Date of birth	Mandatory	1
-	Date patient presents	Mandatory	1
-	Department of Veterans' Affairs patient	Mandatory	1
-	Emergency department arrival mode - transport	Mandatory	1
-	Emergency department departure date	Mandatory	1
-	Emergency department departure time	Mandatory	1
-	Emergency department episode end date	Mandatory	1
-	Emergency department episode end time	Mandatory	1
-	Emergency department service episode end status	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Length of non-admitted patient emergency department service episode	Mandatory	1
-	Person identifier	Mandatory	1
-	Sex	Mandatory	1
-	Time patient presents	Mandatory	1
-	Triage category	Mandatory	1
-	Type of visit to emergency department	Mandatory	1

Outpatient care NMDS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	336862
Registration status:	Health, Standard 04/07/2007
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this National Minimum Data Set (NMDS) is for services provided to non-admitted, non-emergency department, patients registered for care by specialist outpatient clinics of public hospitals that are classified as either principal referral and specialist women's and children's hospitals and large hospitals (Peer Group A or B) as reported in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication from the preceding financial year. Hospitals use the term 'clinic' to describe various arrangements under which they deliver specialist outpatient services to non-admitted non-emergency department patients. **Outpatient clinic services** should be interpreted as encompassing services provided through specific organisational units staffed to administer and provide a certain range of outpatient care: • in defined locations; • at regular or irregular times; and • where one or more specialist providers deliver care to booked patients. Generally, in such clinics, a booking system is administered and patient records are maintained to document patient attendances and care provided. The scope includes all arrangements made to deliver specialist care to non-admitted, non-emergency department patients whose treatment has been funded through the hospital, regardless of the source from which the hospital derives these funds. In particular, Department of Veterans' Affairs, compensable and other patients **funded through the hospital** (including Medicare ineligible patients) are included. For the purposes of the Outpatient care NMDS, outreach services are counted at the specialist clinic where the patient is booked. Outreach services involve travel by the service provider, or services provided by a service provider via ICT (including but not limited to telephone and telehealth consultations). Such services may also be provided in the home, place of work or other non-hospital site. Within the scope as defined, and subject to specific counting rules, occasions of service to be counted include outreach clinic services, services delivered in a multidisciplinary mode. A separate count of services delivered in group sessions is also collected. Excluded from scope are: • Outreach services which are not funded through the hospital and/or which deliver non- clinical care (activities such as home cleaning, meals on wheels, home maintenance); and • All private specialist services delivered under private

practice arrangements which are not funded through the hospital, regardless of whether or how these services may be funded by third party arrangements.

- All services covered by NMDS for:
  - Admitted Patient Care,
  - Admitted patient mental health care,
  - Alcohol and other drug treatment services,
  - Community mental health care,
  - Non-admitted patient emergency department.

Admitted patient services are excluded from scope. However, outpatient services booked for reasons independent of, or distinct from the admitted patient episode are in scope.

Collection and usage attributes

Statistical unit:
Occasions of service.
Group sessions.

Collection methods:
National reporting arrangements:
State and territory Health authorities provide the data to the Department of Health and Ageing and Australian Institute of Health and Welfare on an annual basis by 31 December each calendar year, for the previous financial year.
Periods for which data are collected and nationally collated:
Each financial year ending 30 June.

Implementation start date:
01/07/2007

Source and reference attributes

Submitting organisation:
Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references:
Supersedes Outpatient care NMDS Health, Superseded 04/07/2007

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Establishment identifier	Mandatory	1
-	Number of group sessions	Conditional	1
-	Number of occasions of service	Mandatory	1
-	Outpatient clinic type	Mandatory	1

Perinatal NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	362313
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this minimum data set is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400 grams birth weight.

Collection and usage attributes

Collection methods:	*National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare National Perinatal Statistics Unit for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2008

Relational attributes

Related metadata references:	Supersedes Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Actual place of birth	Mandatory	1
-	Apgar score at 5 minutes	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Birth order	Mandatory	1
-	Birth plurality	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Gestational age	Mandatory	1
-	Indigenous status	Mandatory	1
-	Infant weight, neonate, stillborn	Mandatory	1
-	Method of birth	Mandatory	1
-	Onset of labour	Mandatory	1
-	Person identifier	Mandatory	1
-	Presentation at birth	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1
-	State/Territory of birth	Mandatory	1
-	Status of the baby	Mandatory	1
-	Country of birth	Mandatory	1

Public hospital establishments NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	362302
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this dataset is establishment-level data for public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans' Affairs, and alcohol and drug treatment centres. Similar data for private hospitals and free standing day hospital facilities is collected by the Australian Bureau of Statistics in the Private Health Establishments Collection. Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Collection and usage attributes

Statistical unit:	Public hospital establishments.
Collection methods:	Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (for example, monthly). *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2008
Comments:	*Scope links with other NMDSs* Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: • Admitted patient care NMDS, version 1 • Admitted patient mental health care NMDS, version 1 • Admitted patient palliative care NMDS, version 1

Source and reference attributes

Submitting organisation:	National Health Information Group

Relational attributes

Related metadata references:	Supersedes Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Establishment identifier	Mandatory	1

-	Establishment type	Conditional	1
-	Full-time equivalent staff—administrative and clerical staff	Mandatory	1
-	Full-time equivalent staff—diagnostic and health professionals	Mandatory	1
-	Full-time equivalent staff—domestic and other staff	Mandatory	1
-	Full-time equivalent staff—enrolled nurses	Mandatory	1
-	Full-time equivalent staff—other personal care staff	Mandatory	1
-	Full-time equivalent staff—registered nurses	Mandatory	1
-	Full-time equivalent staff—salaried medical officers	Mandatory	1
-	Full-time equivalent staff—student nurses	Mandatory	1
-	Full-time equivalent staff—trainee/pupil nurses	Mandatory	1
-	Geographical location of establishment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—buildings and building services	Conditional	1
-	Gross capital expenditure (accrual accounting)—constructions	Conditional	1
-	Gross capital expenditure (accrual accounting)—equipment	Conditional	1
-	Gross capital expenditure (accrual accounting)—information technology	Mandatory	1
-	Gross capital expenditure (accrual accounting)—intangible assets	Mandatory	1
-	Gross capital expenditure (accrual accounting)—land	Mandatory	1
-	Gross capital expenditure (accrual accounting)—major medical equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—other equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—transport	Mandatory	1
-	Gross capital expenditure—computer equipment/installations	Mandatory	1
-	Gross capital expenditure—intangible assets	Mandatory	1
-	Gross capital expenditure—land and buildings	Mandatory	1
-	Gross capital expenditure—major medical equipment	Mandatory	1
-	Gross capital expenditure—other	Mandatory	1
-	Gross capital expenditure—plant and other equipment	Mandatory	1
-	Group sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient	Mandatory	1
-	Group sessions (public psychiatric, alcohol and drug hospital)—outreach and community	Mandatory	1
-	Group sessions—alcohol and other drug	Mandatory	1
-	Group sessions—allied health services	Mandatory	1
-	Group sessions—community health services	Mandatory	1
-	Group sessions—dental	Mandatory	1
-	Group sessions—dialysis	Mandatory	1
-	Group sessions—district nursing services	Mandatory	1
-	Group sessions—emergency services	Mandatory	1
-	Group sessions—endoscopy and related procedures	Mandatory	1
-	Group sessions—mental health	Mandatory	1
-	Group sessions—other medical/surgical/diagnostic	Mandatory	1
-	Group sessions—other outreach services	Mandatory	1

-	Group sessions—pathology	Mandatory	1
-	Group sessions—pharmacy	Mandatory	1
-	Group sessions—radiology and organ imaging	Mandatory	1
-	Individual sessions (public psychiatric, alcohol and drug hospital) - emergency and outpatient	Mandatory	1
-	Individual sessions (public psychiatric, alcohol and drug hospital)—outreach and community	Mandatory	1
-	Individual sessions—alcohol and drug	Mandatory	1
-	Individual sessions—allied health services	Mandatory	1
-	Individual sessions—community health services	Mandatory	1
-	Individual sessions—dental	Mandatory	1
-	Individual sessions—dialysis	Mandatory	1
-	Individual sessions—district nursing services	Conditional	1
-	Individual sessions—emergency services	Mandatory	1
-	Individual sessions—endoscopy and related procedures	Mandatory	1
-	Individual sessions—mental health	Mandatory	1
-	Individual sessions—other medical/surgical/diagnostic	Mandatory	1
-	Individual sessions—other outreach services	Mandatory	1
-	Individual sessions—pathology	Mandatory	1
-	Individual sessions—pharmacy	Mandatory	1
-	Individual sessions—radiology and organ imaging	Mandatory	1
-	Net capital expenditure (accrual accounting)—buildings and building services	Mandatory	1
-	Net capital expenditure (accrual accounting)—constructions	Mandatory	1
-	Net capital expenditure (accrual accounting)—equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—information technology	Mandatory	1
-	Net capital expenditure (accrual accounting)—intangible assets	Mandatory	1
-	Net capital expenditure (accrual accounting)—land	Mandatory	1
-	Net capital expenditure (accrual accounting)—major medical equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—other equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—transport	Mandatory	1
-	Number of available beds for admitted patients	Mandatory	1
-	Recurrent expenditure (indirect health care)— public health and monitoring services	Mandatory	1
-	Recurrent expenditure (indirect health care)—central administrations	Mandatory	1
-	Recurrent expenditure (indirect health care)—central and statewide support services	Mandatory	1
-	Recurrent expenditure (indirect health care)—other	Mandatory	1
-	Recurrent expenditure (indirect health care)—patient transport services	Mandatory	1
-	Recurrent expenditure (salaries and wages)—administrative and clerical staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—diagnostic and health professionals	Mandatory	1

-	Recurrent expenditure (salaries and wages) — domestic and other staff	Mandatory	1
-	Recurrent expenditure (salaries and wages) — enrolled nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages) — other personal care staff	Mandatory	1
-	Recurrent expenditure (salaries and wages) — registered nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages) — salaried medical officers	Mandatory	1
-	Recurrent expenditure (salaries and wages) — student nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages) — total	Mandatory	1
-	Recurrent expenditure (salaries and wages) — trainee/pupil nurses	Mandatory	1
-	Recurrent expenditure — administrative expenses	Mandatory	1
-	Recurrent expenditure — depreciation	Mandatory	1
-	Recurrent expenditure — domestic services	Mandatory	1
-	Recurrent expenditure — drug supplies	Mandatory	1
-	Recurrent expenditure — food supplies	Mandatory	1
-	Recurrent expenditure — interest payments	Mandatory	1
-	Recurrent expenditure — medical and surgical supplies	Mandatory	1
-	Recurrent expenditure — other recurrent expenditure	Mandatory	1
-	Recurrent expenditure — patient transport	Mandatory	1
-	Recurrent expenditure — payments to visiting medical officers	Mandatory	1
-	Recurrent expenditure — repairs and maintenance	Mandatory	1
-	Recurrent expenditure — superannuation employer contributions	Mandatory	1
-	Revenue — other	Mandatory	1
-	Revenue — patient	Mandatory	1
-	Revenue — recoveries	Mandatory	1
-	Specialised service indicators — acquired immune deficiency syndrome unit	Mandatory	1
-	Specialised service indicators — acute renal dialysis unit	Mandatory	1
-	Specialised service indicators — acute spinal cord injury unit	Mandatory	1
-	Specialised service indicators — alcohol and drug unit	Mandatory	1
-	Specialised service indicators — bone marrow transplantation unit	Mandatory	1
-	Specialised service indicators — burns unit (level III)	Mandatory	1
-	Specialised service indicators — cardiac surgery unit	Mandatory	1
-	Specialised service indicators — clinical genetics unit	Mandatory	1
-	Specialised service indicators — comprehensive epilepsy centre	Mandatory	1
-	Specialised service indicators — coronary care unit	Mandatory	1
-	Specialised service indicators — diabetes unit	Mandatory	1
-	Specialised service indicators — domiciliary care service	Mandatory	1
-	Specialised service indicators — geriatric assessment unit	Mandatory	1
-	Specialised service indicators — heart, lung transplantation unit	Mandatory	1
-	Specialised service indicators — hospice care unit	Mandatory	1
-	Specialised service indicators — in-vitro fertilisation unit	Mandatory	1

-	Specialised service indicators—infectious diseases unit	Mandatory	1
-	Specialised service indicators—intensive care unit (level III)	Mandatory	1
-	Specialised service indicators—liver transplantation unit	Mandatory	1
-	Specialised service indicators—maintenance renal dialysis centre	Mandatory	1
-	Specialised service indicators—major plastic/reconstructive surgery unit	Mandatory	1
-	Specialised service indicators—neonatal intensive care unit (level III)	Mandatory	1
-	Specialised service indicators—neuro surgical unit	Mandatory	1
-	Specialised service indicators—nursing home care unit	Mandatory	1
-	Specialised service indicators—obstetric/maternity	Mandatory	1
-	Specialised service indicators—oncology unit, cancer treatment	Mandatory	1
-	Specialised service indicators—pancreas transplantation unit	Mandatory	1
-	Specialised service indicators—psychiatric unit/ward	Mandatory	1
-	Specialised service indicators—rehabilitation unit	Mandatory	1
-	Specialised service indicators—renal transplantation unit	Mandatory	1
-	Specialised service indicators—sleep centre	Mandatory	1
-	Specialised service indicators—specialist paediatric	Mandatory	1
-	Teaching status	Mandatory	1

Residential mental health care NMDS 2008-2009

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	362316
Registration status:	Health, Standard 05/02/2008
DSS type:	National Minimum Data Set (NMDS)
Scope:	Episodes of residential care for residents in all government-funded residential mental health care services in Australia, except those residential care services that are in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection).

Collection and usage attributes

Statistical unit:	**Episodes of residential care.** Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
Collection methods:	Data are collected at each service from resident administrative and care related record systems. Services forward data to the relevant state or territory health authority on a regular basis (e.g. monthly). **National reporting arrangements** State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collection, on an annual basis. Western Australia will be able to only collect data for 2004-05 for those data elements that were included in the *National Health Data Dictionary version 12*. Government-operated services that employ mental health trained staff on-site 24 hours per day are to be included from 1 July 2004. Government-funded, non-government operated services and non 24-hour staffed services can be included from 1 July 2004, optionally. For non 24-hour staffed services to be included they must employ mental health-trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day. **Periods for which data are collected and nationally collated** Financial years ending 30 June each year. The reference period starts on 1 July and ends on 30 June each year.
Implementation start date:	01/07/2008
Comments:	Some admitted patient care services may meet the definition of a residential mental health service. However, as they are admitted patient care services, relevant data on their patients are reported to the National Minimum Data Set for Admitted Patient Care. Glossary items Some previous Knowledgebase data element concepts are available in the METeOR glossary. Currently the metadata

search in METeOR does not cover glossary items however these items are available through links in the relevant metadata items. In addition links to the glossary terms that are relevant to this National minimum data set are included here.

Episode of residential care end

Episode of residential care start

Resident

Residential mental health care service

Relational attributes

Related metadata references: Supersedes Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Country of birth	Conditional	1
-	Date of birth	Mandatory	1
-	Episode of residential care end date	Mandatory	1
-	Episode of residential care end mode	Mandatory	1
-	Episode of residential care start date	Mandatory	1
-	Episode of residential care start mode	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Indigenous status	Mandatory	1
-	Leave days from residential care	Mandatory	1
-	Marital status	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Person identifier	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Referral destination to further care (from specialised mental health residential care)	Mandatory	1
-	Region code	Mandatory	1
-	Residential stay start date	Mandatory	1
-	Sex	Mandatory	1

Data Set Specifications

A data set specification (DSS) specifies a group of data elements and the conditions under which this group is collected. A DSS can define the sequence in which data elements are included, whether they are mandatory, what verification rules should be employed and the characteristics of the collection (e.g. its scope). Data Set Specifications (DSS) are metadata sets that are not mandated for collection but are recommended as best practice.

Acute coronary syndrome (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	319741
Registration status:	Health, Standard 07/12/2005
DSS type:	Data Set Specification (DSS)
Scope:	The collection of acute coronary syndrome core data (ACS-Data) is a voluntary data collection with individual hospitals or health service areas developing collection methods and policies appropriate for their service. Acute coronary syndromes reflect the spectrum of coronary artery disease resulting in acute myocardial ischaemia, and span unstable angina, non-ST segment elevation myocardial infarction (NSTEMI) and ST-segment elevation myocardial infarction (STEMI). Clinically these diagnoses encompass a wide variation in risk, require complex and time urgent risk stratification and represent a large social and economic burden. The definitions used in this data set specification are designed to underpin the data collected by health professionals in their day-to-day acute care practice. They relate to the realities of an acute clinical consultation for patients presenting with chest pain/ discomfort and the need to correctly identify, evaluate and manage patients at increased risk of a coronary event. The data elements specified in this metadata set provide a framework for: 1. promoting the delivery of evidenced-based acute coronary syndrome management care to patients; 2. facilitating the ongoing improvement in the quality and safety of acute coronary syndrome management in acute care settings in Australia and New Zealand; 3. improving the epidemiological and public health understanding of this syndrome; and 4. supporting acute care services as they develop information systems to complement the above. This is particularly important as the scientific evidence supporting the development of the data elements within the ACS data set specification indicate that accurate identification of the evolving myocardial infarction patient or the high/intermediate risk patient leading to the implementation of the appropriate management pathway impacts on the patient's outcome. Having a nationally recognised set of definitions in relation to defining a patient's diagnosis, risk status and outcomes is a prerequisite to achieving the above aims. The ACS data set specification is based on the American College of Cardiology (ACC) Data Set for Acute Coronary Syndrome as published in the Journal of the American College of Cardiology in December 2001 (38:2114-30) as well as more recent scientific evidence around the diagnosis of myocardial infarction. The data elements are alphabetically listed and grouped in a similar manner to the American College of Cardiology's data set format. These features of the Australian ACS data set should ensure that the data is internationally comparable.

The data elements described here have been identified as high priority for inclusion in the NHDD for the collection of data relating to ACS management, along with supporting elements already existing within the NHDD (as listed). It is recommended that other data elements be collected as best practice - however, these are not listed here, as they are considered to be of a secondary priority. Such data elements include date of Coronary Artery Bypass Grafting (CABG), Percutaneous Coronary Intervention (PCI) and diagnostic cardiac catheterisation/angiography and recording the number of units of blood transfused.

However, the working group will approach the Australian Institute of Health and METeOR website.

Many of the data elements in this data set specification may also be used in the collection of other cardiovascular clinical information.

Where appropriate, it may be useful if the data definitions in this data set specification were used to address data definition needs in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from, clinical settings (i.e. using application of the ACS data set specification), with that collected through other means (e.g. public health surveys, reports).

A set of core ACS data elements and standardised definitions can inform the development and conduct of future registries at both the national and local level.

The working group formed under the National Heart Foundation of Australia (NHFA) and the Cardiac Society of Australia and New Zealand (CSANZ) initiative was diverse and included representation from the following organizations: the NHFA, the CSANZ, the Australasian College of Emergency Medicine, the Australian Institute of Health and Welfare, the Australasian Society of Cardiac & Thoracic Surgeons, Royal Australian College of Physicians (RACP), RACP - Towards a Safer Culture, National Centre for Classification in Health (Brisbane), the NSW Aboriginal Health & Medical Research Council, the George Institute for International Health, the School of Population Health at the University of Western Australia and the National Cardiovascular Monitoring System Advisory Committee.

To ensure the broad acceptance of the data set, the working group also sought consultation from the heads of cardiology departments, other specialist professional bodies and regional key opinion leaders in the field of acute coronary syndromes.

Collection and usage attributes

Collection methods:

This data set specification is primarily concerned with the clinical use of ACS-Data. Acute care environments such as hospital emergency departments, coronary care units or similar acute care areas are the settings in which implementation of the core ACS data set specification should be considered. A wider range of health and health related establishments that create, use or maintain, records on health care clients, could also use it.

Relational attributes

Related metadata references: Supersedes Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Acute coronary syndrome procedure type	Mandatory	1
-	Acute coronary syndrome stratum	Mandatory	1
-	Angiotensin converting enzyme (ACE) inhibitors therapy status	Mandatory	1
-	Aspirin therapy status	Mandatory	1
-	Beta-blocker therapy status	Mandatory	1
-	Bleeding episode using TIMI criteria (status)	Mandatory	1
-	Blood pressure—diastolic (measured)	Mandatory	1
-	Blood pressure—systolic (measured)	Mandatory	1
-	Chest pain pattern category	Mandatory	1
-	Cholesterol—HDL (measured)	Mandatory	1
-	Cholesterol—LDL (calculated)	Mandatory	1
-	Cholesterol—total (measured)	Mandatory	1
-	Clinical evidence of chronic lung disease (status)	Mandatory	1
-	Clinical evidence of heart failure (status)	Mandatory	1
-	Clinical evidence of peripheral arterial disease (status)	Mandatory	1
-	Clinical evidence of sleep apnoea syndrome (status)	Mandatory	1
-	Clinical evidence of stroke (status)	Mandatory	1
-	Clinical procedure timing (status)	Conditional	1
-	Clopidogrel therapy status	Mandatory	1
-	Concurrent clinical condition (on presentation)	Mandatory	1
-	Country of birth	Mandatory	1
-	Creatine kinase MB isoenzyme level (index code)	Mandatory	1
-	Creatine kinase MB isoenzyme level (international units)	Mandatory	1
-	Creatine kinase MB isoenzyme level (kCat per litre)	Optional	1
-	Creatine kinase MB isoenzyme level (micrograms per litre)	Optional	1
-	Creatine kinase MB isoenzyme level (nanograms per decilitre)	Optional	1
-	Creatine kinase MB isoenzyme level (percentage)	Mandatory	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (index code)	Mandatory	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (international units)	Optional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (kCat per litre)	Optional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)	Optional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (nanograms per decilitre)	Conditional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (percentage)	Mandatory	1
-	Creatinine serum level (measured)	Optional	1

-	Date creatine kinase MB isoenzyme measured	Optional	1
-	Date of birth	Mandatory	1
-	Date of first angioplasty balloon inflation or stenting	Conditional	0
-	Date of intravenous fibrinolytic therapy	Mandatory	1
-	Date of referral to rehabilitation	Mandatory	1
-	Date of triage	Mandatory	1
-	Date patient presents	Mandatory	1
-	Date troponin measured	Mandatory	1
-	Diabetes status	Mandatory	1
-	Electrocardiogram change location	Conditional	1
-	Electrocardiogram change type	Mandatory	1
-	Fibrinolytic drug used	Mandatory	1
-	Fibrinolytic therapy status	Mandatory	1
-	Functional stress test element	Mandatory	1
-	Functional stress test ischaemic result	Mandatory	1
-	Glycoprotein IIb/IIIa receptor antagonist (status)	Mandatory	1
-	Heart rate	Mandatory	1
-	Heart rhythm type	Mandatory	1
-	Height (self-reported)	Mandatory	1
-	Indigenous status	Mandatory	1
-	Killip classification code	Mandatory	1
-	Lipid-lowering therapy status	Mandatory	1
-	Mode of separation	Mandatory	1
-	Myocardial infarction (history)	Mandatory	1
-	Person identifier	Mandatory	1
-	Premature cardiovascular disease family history (status)	Mandatory	1
-	Reason for readmission—acute coronary syndrome	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1
-	Time creatine kinase MB isoenzyme measured	Optional	1
-	Time of first angioplasty balloon inflation or stenting	Mandatory	1
-	Time of intravenous fibrinolytic therapy	Mandatory	1
-	Time of triage	Mandatory	1
-	Time patient presents	Mandatory	1
-	Time troponin measured	Mandatory	1
-	Tobacco smoking status	Mandatory	1
-	Triage category	Optional	1
-	Triglyceride level (measured)	Mandatory	1
-	Troponin assay type	Mandatory	1
-	Troponin assay—upper limit of normal range (micrograms per litre)	Optional	1
-	Troponin level (measured)	Mandatory	1
-	Type of visit to emergency department	Mandatory	1
-	Vascular history	Mandatory	1

-	Weight (self-reported)	Mandatory	1

Cancer (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	334019
Registration status:	Health, Standard 07/12/2005
DSS type:	Data Set Specification (DSS)
Scope:	This Cancer (clinical) data set specification is not mandated for collection but is recommended as best practice if cancer clinical data are to be collected. The Cancer (clinical) data set underpins the evaluation of cancer treatment services and this can occur at a number of levels; the individual clinician, the health care institution, at state or territory level and ultimately at a national level. Clinicians use such data for ongoing patient management and the ability to link patient management to outcomes allows treatments or outcomes to be identified and assessed. Institutions can monitor through-put in their centres for planning and resource allocation purposes to obtain optimum return for cancer expenditure. End-points can be monitored to ensure that objectives are being met. The principal aim of good-quality and consistent data is to provide information that can lead to improved quality and length of life for all patients by providing a systematic foundation for evidence-based medicine, informing quality assurance and improvement decisions and guiding successful planning and evaluation of cancer control activities.

Collection and usage attributes

Collection methods:	This data set is primarily concerned with the clinical use of cancer data. It can also be used by a wider range of health and health-related establishments that create, use, or maintain records on health-care clients.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative (NCCI)

Relational attributes

Related metadata references:	Supersedes Cancer (clinical) DSS Health, Superseded 07/12/2005

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address line (person)	Mandatory	1
-	Cancer initial treatment completion date	Mandatory	1
-	Cancer initial treatment starting date	Mandatory	1
-	Cancer staging—M stage code	Conditional	1
-	Cancer staging—N stage code	Conditional	1
-	Cancer staging—T stage code	Conditional	1
-	Cancer staging—TNM stage grouping code	Conditional	1
-	Cancer treatment type	Mandatory	1

-	Cancer treatment—target site (ICD-10-AM)	Mandatory	1
-	Cancer treatment—target site (ICDO-3)	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Mandatory	1
-	Date of diagnosis of cancer	Mandatory	1
-	Date of diagnosis of first recurrence	Mandatory	1
-	Date of surgical treatment for cancer	Mandatory	1
-	Establishment number	Mandatory	1
-	Family name	Mandatory	1
-	Given name(s)	Mandatory	1
-	Histopathological grade	Mandatory	1
-	Intention of treatment for cancer	Mandatory	1
-	Laterality of primary cancer	Conditional	1
-	Medicare card number	Mandatory	1
-	Morphology of cancer	Conditional	0
-	Most valid basis of diagnosis of cancer	Conditional	1
-	Oestrogen receptor assay status	Mandatory	1
-	Outcome of initial treatment	Mandatory	1
-	Person identifier	Mandatory	1
-	Primary site of cancer (ICD-10-AM code)	Mandatory	1
-	Primary site of cancer (ICDO-3 code)	Conditional	1
-	Progesterone receptor assay results	Conditional	1
-	Radiotherapy treatment type	Mandatory	1
-	Received radiation dose	Mandatory	1
-	Region of first recurrence	Mandatory	1
-	Regional lymph nodes examined	Mandatory	1
-	Regional lymph nodes positive	Conditional	1
-	Sex	Mandatory	1
-	Staging basis of cancer	Mandatory	1
-	Staging scheme source	Conditional	1
-	Staging scheme source edition number	Conditional	1
-	Surgical treatment procedure for cancer	Mandatory	1
-	Systemic therapy agent name	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Mandatory	1
-	Tumour thickness at diagnosis (melanoma)	Mandatory	1

Cardiovascular disease (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	353668
Registration status:	Health, Standard 04/07/2007
DSS type:	Data Set Specification (DSS)
Scope:	The collection of cardiovascular data (CV-Data) in this metadata set is voluntary. The definitions used in CV-Data are designed to underpin the data collected by health professionals in their day-to-day practice. They relate to the realities of a clinical consultation and the ongoing nature of care and relationships that are formed between doctors and patients in clinical practice. The data elements specified in this metadata set provide a framework for: • promoting the delivery of high quality cardiovascular disease preventive and management care to patients, • facilitating ongoing improvement in the quality of cardiovascular and chronic disease care predominantly in primary care and other community settings in Australia, and • supporting general practice and other primary care services as they develop information systems to complement the above. This is particularly important as general practice is the setting in which chronic disease prevention and management predominantly takes place. Having a nationally recognised set of definitions in relation to defining a patient's cardiovascular behavioural, social and biological risk factors, and their prevention and management status for use in these clinical settings, is a prerequisite to achieving these aims. Many of the data elements in this metadata set are also used in the collection of diabetes clinical information. Where appropriate, it may be useful if the data definitions in this metadata set were used to address data definition needs for use in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from clinical settings (i.e. using application of CV-Data), with that collected through other means (e.g. public health surveys).

Collection and usage attributes

Collection methods:	This metadata set is primarily concerned with the clinical use of CV-data. It could also be used by a wider range of health and health related establishments that create, use or maintain, records on health care clients.

Relational attributes

Related metadata references:	Supersedes Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Metadata items in this Data Set Specification

Seq No.	Metadata item	Obligation	Max occurs
-	Alcohol consumption frequency (self reported)	Mandatory	1
-	Alcohol consumption in standard drinks per day (self reported)	Mandatory	1
-	Behaviour-related risk factor intervention	Mandatory	8
-	Behaviour-related risk factor intervention - purpose	Mandatory	5
-	Blood pressure—diastolic (measured)	Mandatory	1
-	Blood pressure—systolic (measured)	Mandatory	1
-	Cholesterol—HDL (measured)	Mandatory	1
-	Cholesterol—LDL (calculated)	Mandatory	1
-	Cholesterol—total (measured)	Mandatory	1
-	Country of birth	Mandatory	1
-	Creatinine serum level (measured)	Mandatory	1
-	CVD drug therapy—condition	Mandatory	1
-	Date of birth	Mandatory	99
-	Date of diagnosis	Mandatory	1
-	Date of referral to rehabilitation	Conditional	1
-	Diabetes status	Mandatory	1
-	Diabetes therapy type	Mandatory	1
-	Division of General Practice number	Mandatory	1
-	Fasting status	Mandatory	1
-	Formal community support access status	Mandatory	1
-	Height (measured)	Mandatory	1
-	Indigenous status	Mandatory	1
-	Informal carer existence indicator	Mandatory	1
-	Labour force status	Mandatory	1
-	Living arrangement	Mandatory	1
-	Person identifier	Mandatory	1
-	Physical activity sufficiency status	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Preferred language	Mandatory	1
-	Premature cardiovascular disease family history (status)	Mandatory	1
-	Proteinuria status	Mandatory	1
-	Renal disease therapy	Mandatory	1
-	Service contact date	Mandatory	99
-	Sex	Mandatory	1
-	Tobacco smoking status	Mandatory	1
-	Tobacco smoking—consumption/quantity (cigarettes)	Mandatory	1
-	Triglyceride level (measured)	Mandatory	1
-	Vascular history	Mandatory	1
-	Vascular procedures	Mandatory	1
-	Waist circumference (measured)	Mandatory	1
-	Weight in kilograms (measured)	Mandatory	1

Computer Assisted Telephone Interview demographic module DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	291112
Registration status:	Health, Standard 04/05/2005
DSS type:	Data Set Specification (DSS)
Scope:	Key demographic set for use in Computer Assisted Telephone Interviewing (CATI) health surveys. It is intended to be used by anyone conducting population health surveys using the CATI mode, such as State/Territory government health agencies. This data set is to standardise demographic collection in all CATI surveys of health topics, such as CATI asthma and CATI diabetes surveys. The standardisation of the collection of health survey data is a major focus of the National Public Health Partnership (NPHP) work plan. The CATI demographic module DSS is not mandated for collection but recommended as best practice.

Collection and usage attributes

Collection methods:	Population health surveys conducted by CATI

Source and reference attributes

Submitting organisation:	National Public Health Information Working Group.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Age	Optional	1
-	Age range	Optional	1
-	Country of birth	Conditional	1
-	Date of birth	Optional	1
-	Household annual gross income range	Optional	1
-	Household annual gross income range ($ 10,000 range)	Optional	1
-	Indigenous status	Optional	1
-	Marital status	Optional	1
-	Postcode—Australian (person)	Optional	1
-	Sex	Optional	1
-	Suburb/town/locality name (person)	Optional	1
-	Year of arrival in Australia	Optional	1

Diabetes (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	304865
Registration status:	Health, Standard 21/09/2005
DSS type:	Data Set Specification (DSS)
Scope:	The use of this standard is voluntary. However, if data is to be collected the Diabetes (clinical) Data Set Specification (DSS) aims to ensure national consistency in relation to defining, monitoring and recording information on patients diagnosed with diabetes. The Diabetes (clinical) DSS relates to the clinical status of, the provision of services for, and the quality of care delivered to individuals with diabetes, across all health care settings including: • General Practitioners; • Divisions of General Practice; • Diabetes Centres • Specialists in private practice; and • Community Health Nurses and Diabetes Educators. The Diabetes (clinical) DSS: • provides concise, unambiguous definitions for items/conditions related to diabetes quality care, and • aims to ensure standardised methodology of data collection in Australia. The expectation is that collection of this data set facilitates good quality of care, contributes to preventive care and has the potential to enhance self-management by patients with diabetes. The underlying goal is improvement of the length and quality of life of patients with diabetes, and prevention or delay in the development of diabetes related complications.

Collection and usage attributes

Collection methods:	This metadata set is primarily concerned with the clinical use of Diabetes data. It could/should be used by health and health related establishments that create, use or maintain, records on health care clients. One methodology is for data to be collected over a 1-month period of all diabetes patients presenting at sites participating in the collection. The information is de-identified to protect the privacy of individuals. The participation is voluntary. An individual Benchmarking report is provided. The results provide a snapshot of care of people with diabetes.
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published. **Scope links with other Metadata sets** Cardiovascular disease (clinical) DSS.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Relational attributes

Related metadata references: Supersedes Diabetes (clinical) DSS Health, Superseded 21/09/2005

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Blindness (diabetes complication)	Mandatory	1
-	Blood pressure—diastolic (measured)	Mandatory	1
-	Blood pressure—systolic (measured)	Mandatory	1
-	Cardiovascular medication (current)	Mandatory	1
-	Cataract - history	Mandatory	4
-	Cerebral stroke due to vascular disease (history)	Mandatory	1
-	Cholesterol—HDL (measured)	Mandatory	1
-	Cholesterol—total (measured)	Mandatory	1
-	Coronary artery disease—history of intervention or procedure	Mandatory	1
-	Creatinine serum level (measured)	Mandatory	1
-	Date of birth	Mandatory	1
-	Diabetes status	Mandatory	1
-	Diabetes therapy type	Mandatory	1
-	Dyslipidaemia treatment indicator	Mandatory	1
-	Erectile dysfunction	Mandatory	1
-	Fasting status	Mandatory	1
-	Foot deformity	Mandatory	1
-	Foot lesion (active)	Mandatory	1
-	Foot ulcer (history)	Mandatory	1
-	Foot ulcer (current)	Mandatory	1
-	Glycosylated haemoglobin level (measured)	Mandatory	1
-	Glycosylated Haemoglobin—upper limit of normal range (percentage)	Mandatory	1
-	Health professionals attended (diabetes mellitus)	Mandatory	1
-	Height (measured)	Mandatory	1
-	Hypertension - treatment	Mandatory	1
-	Hypoglycaemia - severe	Mandatory	1
-	Indigenous status	Mandatory	1
-	Initial visit indicator—diabetes mellitus	Mandatory	1
-	Lower limb amputation due to vascular disease	Mandatory	1
-	Microalbumin level—albumin/creatinine ratio (measured)	Conditional	1
-	Microalbumin level—micrograms per minute (measured)	Conditional	1
-	Microalbumin level—milligrams per 24 hour (measured)	Conditional	1
-	Microalbumin level—milligrams per litre (measured)	Conditional	1
-	Microalbumin level—upper limit of normal range (albumin/creatinine ratio)	Conditional	1
-	Microalbumin level—upper limit of normal range	Conditional	1

	(micrograms per minute)		
-	Microalbumin level—upper limit of normal range (milligrams per 24 hour)	Conditional	1
-	Microalbumin level—upper limit of normal range (milligrams per litre)	Conditional	1
-	Myocardial infarction (history)	Mandatory	1
-	Ophthalmological assessment—outcome (left retina)	Mandatory	1
-	Ophthalmological assessment—outcome (right retina)	Mandatory	1
-	Ophthalmoscopy performed indicator	Mandatory	1
-	Peripheral neuropathy (status)	Mandatory	1
-	Peripheral vascular disease in feet (status)	Mandatory	1
-	Pregnancy—current status	Mandatory	1
-	Referred to ophthalmologist (diabetes mellitus)	Mandatory	1
-	Renal disease—end-stage (diabetes complication)	Mandatory	1
-	Service contact date	Mandatory	1
-	Sex	Mandatory	1
-	Tobacco smoking status (diabetes mellitus)	Mandatory	1
-	Triglyceride level (measured)	Mandatory	1
-	Visual acuity (left eye)	Mandatory	1
-	Visual acuity (right eye)	Mandatory	1
-	Weight in kilograms (measured)	Mandatory	1
-	Year insulin started	Mandatory	1
-	Year of diagnosis of diabetes mellitus	Mandatory	1

Functioning and Disability DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	320319
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
DSS type:	Data Set Specification (DSS)
Scope:	The Functioning and Disability DSS aims to ensure national consistency in relation to defining and measuring human functioning and disability. This DSS has been developed to be consistent with the International Classification of Functioning, Disability and Health (ICF). Functioning and disability are dual concepts in a broad framework. **Functioning** is the umbrella term for any or all of: body functions, body structures, activities and participation. Functioning is a multidimensional concept denoting the neutral aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal factors. **Disability** is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multi-dimensional and complex concept and is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6). A health condition may be a disease (acute or chronic), disorder, injury or trauma. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. Personal factors relate to the individual, such as age, sex and Indigenous status. The components of functioning and disability are classified and defined in the ICF as **body structures** and **body functions**, **activities** and **participation** and **environmental factors**. Each component is composed of various domains; these are sets of related physiological functions, anatomical structures, actions, tasks, areas of life, and external influences. Qualifiers, the numeric measures coded after the relevant domain, are usually essential to the meaningful use of the classification because of the neutral terms of the domains. Many different 'definitions' of disability are used in Australia, both in administrative data collections and in Acts of Parliament. The consistent identification of disability in national data collections has been recommended in a number of reports, for instance to enable: • the monitoring of access to generic services by people with disability; • the collection of more consistent data on disability support and related services, including data on service use by different groups; • population data and service data to be related, thereby improving the nation's analytical capacity in relation to the need for and supply of services; and • improved understanding of the relationship between disability, health conditions and other health outcomes. Defining disability makes it possible to determine the number of

people in the population with disability, those who are accessing services, both disability specific and generic, and those with a disability in the general population with unmet need. Better definition of disability will aid better targeting of resources to those in need.

The concept 'Disability' can be operationalised in a wide variety of settings and for various purposes, using a combination of related metadata items as building blocks.

The metadata items selected for a particular application may vary depending on the approach to functioning and disability. For example, in hospital rehabilitation, the focus may be on the impairment and activity dimensions, and in community-based care the focus may be primarily on participation. Some applications may require a broad scope for inclusion (e.g. discrimination legislation). Data collections relating to services will select combinations of the data elements, which best reflect the eligibility criteria for the service.

The Functioning and Disability DSS comprises the following four clusters to describe level of human functioning:

1. Body functioning, qualified by extent of impairment
2. Body structure, qualified by extent, nature and location of impairment
3. Activities and participation, qualified by level of difficulty and need for assistance with undertaking activities and extent of and satisfaction with participation
4. Environmental factors, qualified by extent of influence of the environment

Data collected using this DSS can be related to national data collections which use ICF concepts such as the Commonwealth State Territory Disability Agreement (CSTDA) NMDS collection and the ABS Survey of Ageing, Disability and Carers and, from 2006, the Census.

Collection and usage attributes

Collection methods:

Each of the four clusters that make up the Functioning and Disability DSS should be recorded for a complete description of human functioning. This information can be gathered over time by a range of health and community care providers.

Completion of the DSS will record a person-centred description of the experience of functioning of the individual who is the subject of the data. The experience of functioning is in relation to a health condition, and does not consider decrements in functioning that may be associated with social factors such as ethnic background or economic status. For example, the level of communication is recorded in relation to the heath condition, not to the fact that a person does not speak English at home.

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an umbrella term for 'disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

This DSS may be used in data collections in the community

services, housing and health sectors.

Comments: The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF is grounded in a human rights philosophy, and its relationship to the UN Standard Rules on Equalization of Opportunities for Persons with Disabilities endorsed by the United Nations in 1994 is acknowledged. The purpose of the Rules is to ensure that people with disabilities, as members of their societies, may exercise the same rights and obligations as others.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Steward: Advisory Committee on Australian and International Disability Data (ACAIDD)

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
  http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website
  http://www.aihw.gov.au/disability/icf/index.cfm

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activities and Participation cluster	Optional	1
-	Body functions cluster	Optional	1
-	Body structures cluster	Optional	1
-	Environmental factors cluster	Optional	1

Health care client identification DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 288765

Registration status: Health, Standard 04/05/2005

DSS type: Data Set Specification (DSS)

Scope: The data elements specified in this metadata set provide a framework for improving the positive identification of persons in health care organisations. This metadata set applies in respect of all potential or actual clients of the Australian health care system. It defines demographic and other identifying data elements suited to capture and use for person identification in health care settings.

The objectives in collecting the data elements in this metadata set are to promote uniformly good practice in:

- identifying individuals
- recording identifying data so as to ensure that each individual's health records will be associated with that individual and no other.

The process of positively identifying people within a health care service delivery context entails matching data supplied by those individuals against data the service provider holds about them. The positive and unique identification of health care clients is a critical event in health service delivery, with direct implications for the safety and quality of health care.

There are many barriers to successfully identifying individuals in health care settings, including variable data quality; differing data capture requirements and mechanisms; and varying data matching methods. These definitions provide a base for improving the confidence of health service providers and clients alike that the data being associated with any given individual, and upon which clinical decisions are made, is appropriately associated.

Collection and usage attributes

Collection methods: This metadata set is primarily concerned with the clinical use of Health care client identification data. It should be used by health and health-related establishments that create, use or maintain, records on health care clients.

Establishments should use this metadata set, where appropriate, for collecting data when registering health care clients or potential health care clients.

The collection of data based on this metadata set is voluntary.

National reporting arrangements

Collectors of this metadata set should refer to relevant privacy legislation, codes of fair information practice and other guidelines so as not to breach personal privacy in their collection, use, storage and disclosure of health care client information. There is no comprehensive privacy legislation covering both the public and private sectors across Australia so users need to consider their particular set of circumstances (i.e. location and sector) and whether privacy legislation covers

those circumstances.

A Commonwealth legislative scheme applies to the private sector. Users may refer to the Federal Privacy Commissioner's web site for assistance in complying with their privacy obligations. In the public sector, in instances where no legislation, code of fair information practice or other guidelines covers the particular circumstances, users should refer to AS 4400 Personal privacy protection in health care information systems.

Relational attributes

Related metadata references: Supersedes Health care client identification Health, Superseded 04/05/2005

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address line (person)	Mandatory	1
-	Address type (person)	Mandatory	1
-	Address—country identifier (person)	Mandatory	1
-	Australian state/territory identifier	Conditional	0
-	Birth order	Mandatory	1
-	Birth plurality	Mandatory	1
-	Building/complex sub-unit number (person)	Mandatory	1
-	Building/complex sub-unit type—abbreviation (person)	Mandatory	1
-	Building/property name (person)	Mandatory	1
-	Centrelink customer reference number	Mandatory	1
-	Country of birth	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Electronic communication address (person)	Mandatory	1
-	Electronic communication medium (person)	Mandatory	1
-	Electronic communication usage code (person)	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Family name	Mandatory	1
-	Floor/level number (person)	Mandatory	1
-	Floor/level type (person)	Mandatory	1
-	Given name sequence number	Mandatory	1
-	Given name(s)	Mandatory	1
-	House/property number (person)	Mandatory	1
-	Indigenous status	Conditional	1
-	Lot/section number (person)	Mandatory	1
-	Medicare card number	Mandatory	1
-	Mother's original family name	Mandatory	1
-	Name context flag	Mandatory	1
-	Name suffix	Mandatory	1

-	Name suffix sequence number	Mandatory	1
-	Name title	Mandatory	1
-	Name title sequence number	Mandatory	1
-	Name type	Mandatory	1
-	Non-Australian state/province (person)	Mandatory	1
-	Person identifier	Mandatory	1
-	Person identifier type—health care (person)	Mandatory	1
-	Postal delivery point identifier (person)	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Postcode—international (person)	Mandatory	1
-	Region code	Mandatory	1
-	Sex	Mandatory	1
-	State/Territory of birth	Mandatory	1
-	Street name (person)	Mandatory	1
-	Street suffix code (person)	Mandatory	1
-	Street type code (person)	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1

Health care provider identification DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	356020
Registration status:	Health, Standard 04/07/2007
DSS type:	Data Set Specification (DSS)
Scope:	The scope of these data elements includes identification of individual and organisation health care providers. The data elements also allow for identification of an individual in a health care organisation. The definition of health care provider is: 'any person or organisation who is involved in or associated with the delivery of healthcare to a client, or caring for client wellbeing'. The data elements have been defined to enable a common, best practice approach to the way data are captured and stored, to ensure that records relating to a provider will be associated with that individual and/or organisation and no other. The definitions are proposed for clinical and administrative data management purposes. The ability to positively identify health care providers and locate their relevant details is an important support to the provision of speedy, safe, high quality, comprehensive and efficient health care. Unambiguous identification of individual health care providers is necessary for: • Requesting and reporting of orders, tests and results (e.g. pathology, diagnostic imaging) • Other communications and referrals between health care providers regarding ongoing care of patients (e.g. a referral from a GP to a specialist, a hospital discharge plan) • Reporting on health care provision to statutory authorities (e.g. reporting of hospital patient administration systems data to State/Territory government health agencies) • Payments to providers • Registration of providers • Directories or lists of providers and their service locations for consumer information.

Collection and usage attributes

Collection methods:	Collected at point of entry to health care for the purposes of the identification of the provider of that health care.
Comments:	There are many barriers to successfully identifying individuals in health care settings, including variable data quality; differing data capture requirements and mechanisms; and varying data matching methods. This data set specification provides a framework for improving the confidence that the data being associated with any given individual or organisation, is appropriately associated.

Source and reference attributes

Submitting organisation:	Standards Australia Inc Health Informatics Committee (IT-014)

Reference documents:

Health care client identification DSS

The Australian Standard AS4846 Health Care Provider Identification identifies other data that should be collected. These data are collections of free text information and as such are not capable of standardisation as a national health data standard. Within AS4846 however they form part of the data collection necessary for the complete identification of a heath care provider.

These data elements are identified in the section Standardised elsewhere section below.

If these data elements are collected in conjunction with those of the Data set specification they form a collection equivalent to that of the Australian Standard AS4846.

Relational attributes

Related metadata references:

Supersedes Health care provider identification DSS Health, Superseded 04/07/2007

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address line (person)	Mandatory	1
-	Address line (service provider organisation)	Mandatory	1
-	Address type (person)	Mandatory	1
-	Address type (service provider organisation)	Mandatory	1
-	Address—country identifier (person)	Mandatory	1
-	Australian state/territory identifier	Mandatory	1
-	Australian state/territory identifier (service provider organisation)	Mandatory	1
-	Building/complex sub-unit number (person)	Mandatory	1
-	Building/complex sub-unit number (service provider organisation)	Mandatory	1
-	Building/complex sub-unit type—abbreviation (person)	Mandatory	1
-	Building/complex sub-unit type—abbreviation (service provider organisation)	Mandatory	1
-	Building/property name (person)	Mandatory	1
-	Building/property name (service provider organisation)	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Mandatory	1
-	Electronic communication address (person)	Mandatory	1
-	Electronic communication address (service provider organisation)	Mandatory	1
-	Electronic communication medium (person)	Mandatory	1
-	Electronic communication medium (service provider organisation)	Mandatory	1
-	Electronic communication usage code (person)	Mandatory	1
-	Family name	Mandatory	1
-	Floor/level number (person)	Mandatory	1

-	Floor/level number (service provider organisation)	Mandatory	1
-	Floor/level type (person)	Mandatory	1
-	Floor/level type (service provider organisation)	Mandatory	1
-	Given name sequence number	Mandatory	1
-	Given name(s)	Mandatory	1
-	House/property number (person)	Mandatory	1
-	House/property number (service provider organisation)	Mandatory	1
-	Lot/section number (person)	Mandatory	1
-	Lot/section number (service provider organisation)	Mandatory	1
-	Name context flag	Mandatory	1
-	Name suffix	Mandatory	1
-	Name suffix sequence number	Mandatory	1
-	Name title	Mandatory	1
-	Name title sequence number	Mandatory	1
-	Name type	Mandatory	1
-	Name type (service provider organisation)	Mandatory	1
-	Non-Australian state/province (person)	Mandatory	1
-	Non-Australian state/province (service provider organisation)	Mandatory	1
-	Organisation end date	Mandatory	1
-	Organisation name	Mandatory	1
-	Organisation start date	Mandatory	1
-	Person identifier	Mandatory	1
-	Postal delivery point identifier (person)	Mandatory	1
-	Postal delivery point identifier (service provider organisation)	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Postcode—Australian (service provider organisation)	Mandatory	1
-	Postcode—international (person)	Mandatory	1
-	Postcode—international (service provider organisation)	Mandatory	1
-	Provider occupation category (self-identified) (ANZSCO 1st edition)	Mandatory	1
-	Provider occupation end date	Mandatory	1
-	Provider occupation start date	Mandatory	1
-	Sex	Mandatory	1
-	Street name (person)	Mandatory	1
-	Street name (service provider organisation)	Mandatory	1
-	Street suffix code (person)	Mandatory	1
-	Street suffix code (service provider organisation)	Mandatory	1
-	Street type code (person)	Mandatory	1
-	Street type code (service provider organisation)	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Suburb/town/locality name (service provider organisation)	Mandatory	1

Injury surveillance DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	361954
Registration status:	Health, Standard 05/02/2008
DSS type:	Data Set Specification (DSS)
Scope:	The scope of this minimum data set is patient level data from selected emergency departments of hospitals and other settings.

Collection and usage attributes

Collection methods:	*National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.

Source and reference attributes

Submitting organisation:	National Health Information Group

Relational attributes

Related metadata references:	Supersedes Injury surveillance DSS Health, Superseded 05/02/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activity when injured	Mandatory	1
-	Activity when injured (non-admitted patient)	Mandatory	1
-	Bodily location of main injury	Mandatory	1
-	External cause (admitted patient)	Mandatory	99
-	External cause—human intent	Mandatory	1
-	Narrative description of injury event	Mandatory	1
-	Nature of main injury (non-admitted patient)	Mandatory	1
-	Place of occurrence of external cause of injury (ICD-10-AM)	Mandatory	1
-	Place of occurrence of external cause of injury (non-admitted patient)	Mandatory	1

Palliative care performance indicators DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 295806

Registration status: Health, Standard 05/12/2007

DSS type: Data Set Specification (DSS)

Scope: This data set specification specifies information for collection about all administrative health regions, and whether they have developed strategic plans which incorporate specified palliative care elements. It also specifies information for collection about all government-funded **palliative care agencies** (service provider organisations), their approach to some aspects of service delivery, and their efforts in specific areas of quality improvement.

This information enables reporting of nationally-agreed palliative care performance indicators. Currently, there are four national performance indicators that have been agreed for reporting by the Palliative Care Intergovernmental Forum. These are:

1. The proportion of administrative health regions that have a written plan for palliative care that incorporates palliative care elements,

2. The proportion of palliative care agencies, within their setting of care, that routinely undertake or undergo formal assessment against the Palliative Care Australia standards,

3. The proportion of palliative care agencies, within their setting of care, that actively collect feedback from clients and staff (within the workforce) relating to services and service delivery,

4. The proportion of palliative care agencies, within their setting of care, that have formal working partnerships with other services provider(s) or organisation(s).

Collection and usage attributes

Collection methods: The data for this DSS are obtained from two sources: a survey of administrative health regions and a survey of all government-funded palliative care agencies (service provider organisations) that provide care in community and/or admitted patient settings.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Administrative health region name	Mandatory	1
-	Administrative health region palliative care strategic plan indicator	Mandatory	1
-	Coordinator of volunteers indicator	Mandatory	1
-	Feedback collection indicator	Mandatory	1
-	Feedback collection method	Conditional	8
-	Level of palliative care service	Mandatory	1
-	Most common service delivery setting	Mandatory	1

-	Palliative care agency service delivery setting	Mandatory	7
-	Partner organisation type	Conditional	8
-	Standards assessment indicator	Mandatory	1
-	Standards assessment level	Conditional	1
-	Standards assessment method	Conditional	2
-	Working partnership indicator	Mandatory	1

Data Element Clusters

A data element cluster is a grouping of data elements used to describe how some data elements relate to each other for a specific purpose. It can be included in a data set specification when there is a need to better describe a group of data elements and how they should be collected or reported.

Activities and Participation cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	320111
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
DSS type:	Data element cluster
Scope:	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers: 1. Body functions cluster 2. Body structures cluster 3. Environmental factors cluster In the context of health, activity refers to the execution of a task or action by an individual, and participation refers to involvement in a life situation. The Activities and Participation cluster collects information on a person's level of difficulty with activities, assistance needed to perform activities, extent of participation, and satisfaction with participation in the following life areas: 1. Learning and applying knowledge 2. General tasks and demands 3. Communication 4. Mobility 5. Self-care 6. Domestic life 7. Interpersonal interactions and relationships 8. Major life areas 9. Community, social and civic life The use of this cluster to collect information on activity limitations and participation restrictions should enhance data quality for medical purposes as well as for a range of purposes related to understanding human functioning. This data cluster should be complementary to information on diseases. The information collected in the Activities and Participation cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Guide for use:	The following four measures are used to describe activities and participation in life areas: 1. **Difficulty** with activities may include pain involved, time taken, effort, number of errors, clumsiness, and modification of the manner in

which the activity is performed. Difficulty is the combination of the frequency with which the problem exists, the duration of the problem and the intensity of the problem.

2. **Need for assistance** with activities includes personal assistance and/or supervision.
3. **Extent of participation** indicates the level of participation restriction. This corresponds to an externally observable measure of participation.
4. **Satisfaction with participation** corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in which are embedded the concepts of choice, opportunity and importance.

For each life area code recorded there can be one response for each of the measures. The choice of measure will depend on the user and their information requirements.

There are numerous possible methods for collecting activity, activity limitation, participation and participation restriction. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

See also the *ICF Australian User Guide* for further guidelines.

Collection methods:

The Person—activities/participation life area, code (ICF 2001) AN[NNN] data element is supported by a value domain - Activities and participation code (ICF 2001) AN[NNN] - representing a single list of activity and participation domains that are grouped together.

The World Health Organization suggests the list be used in one of four operational ways.

a) To designate some domains as activities and others as participation, not allowing any overlap.

b) Same as (a) above, but allowing partial overlap.

c) To designate all detailed domains as activities and the broad category headings as participation.

d) To use all domains as both activities and participation.

The ICF Australian User Guide proposes the use of either option (b) or (d) with the use of additional qualifiers to delineate between activity and participation.

The Person—activities and participation life area, code (ICF 2001) AN[NNN] data element can be used on its own as a neutral list of tasks, actions and life situations, or together with the four additional data elements in this cluster to record positive or neutral performance as well as activity limitations and participation restrictions. (It is important to note that the Person—activities and participation life area, code (ICF 2001) AN[NNN] data element must always be used when recording any of the other four data elements.)

Comments:

This cluster is based on the International Classification of

Functioning, Disability and Health (ICF). The ICF is a reference member of the WHO Family of International Classifications (endorsed by the World Health Assembly in 2001) and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

The ICF recognises two constructs that can be used with 'Activities and Participation': performance and capacity. 'Performance' is what the person does in their usual environment. 'Capacity' describes 'an individual's ability to execute a task or an action in a standardised environment, where a standardised environment may be:

- an actual environment commonly used for assessment in test settings; or
- in cases where this is not possible, an assumed environment which can be thought to have a uniform impact' (WHO 2001).

The standardised environment has not been generally operationalised. However, the recognition of these two constructs in the ICF underscores the importance of recording the environment in which activities are being performed.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activity and participation life area	Mandatory	1
-	Assistance with activities	Optional	1
-	Difficulty with activities	Optional	1
-	Extent of participation	Optional	1
-	Satisfaction with participation	Optional	1

Body functions cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	320117
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
DSS type:	Data element cluster
Scope:	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that it be collected along with the following three clusters over time and by a range of health and community care providers: 1. Body Structures cluster 2. Activities and Participation cluster 3. Environmental factors cluster Body functions are the physiological functions of body systems (including psychological functions). The term 'body' refers to the human organism as a whole; hence it includes the brain and its functions, that is, the mind. The Body functions cluster collects information on the presence and extent of impairment of the eight body function domains listed below: 1. Mental functions 2. Sensory functions and pain 3. Voice and speech functions 4. Functions of the cardiovascular, haematological, immunological and respiratory systems 5. Functions of the digestive, metabolic and the endocrine system 6. Genitourinary and reproductive functions 7. Neuromusculoskeletal and movement-related functions 8. Functions of the skin and related structures Impairments of body functions, as defined in the ICF, are problems in body functions such as a loss or significant departure from population standards or averages. The ICD uses impairment as 'signs and symptoms', a 'component of disease' or sometimes 'reason for contact with health services'. Impairments are recorded in terms of their extent or magnitude, nature and/or location. Determination of impairment is undertaken primarily by those qualified to evaluate physical and mental functioning or structure according to these standards. Impairments should be detectable or noticeable by others or the person by direct observation or by inference from indirect observation. Impairments are not the same as the underlying pathology, but are manifestations of that pathology. Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The

deviation from the population norm may be slight or severe and may fluctuate over time. Impairments may result in other impairments.

Impairments may be part, or an expression of a health condition, but do not necessarily indicate that a disease is present or that the individual should be regarded as sick.

The use of this cluster to collect information on impairments of body functions should enhance data quality for medical purposes as well as for a range of purposes related to human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Body functions cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Collection methods:

The Person—body function, code (ICF 2001) AN[NNNN] data element is a neutral list of functions that can be used to record positive or neutral body function, as well as impairment of a specified body function when used in conjunction with Person—extent of impairment of body function, code (ICF 2001)N. For each body function code recorded there should be a code for impairment of body functions.

There are numerous possible methods for collecting body functions and impairments. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

See also the *ICF Australian User Guide* for further guidelines.

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification:	Functioning and Disability DSS Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Body function	Mandatory	1
-	Impairment of body function	Mandatory	1

Body structures cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	320151
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
DSS type:	Data element cluster
Scope:	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers: 1. Body functions cluster 2. Activities and participation cluster 3. Environmental factors cluster Body structures are anatomical parts of the body such as organs, limbs and their components. The Body structures cluster collects information on the presence and extent of impairment, the nature of the change and the location of the impairment for the eight body structure domains listed below: 1. Structures of the nervous system 2. The eye, ear and related structures 3. Structures involved in voice and speech 4. Structures of the cardiovascular, immunological and respiratory systems 5. Structures related to the digestive, metabolism and endocrine systems 6. Structures related to genitourinary and reproductive systems 7. Structures related to movement 8. Skin and related structures Impairments of body structures, as defined in the ICF, are problems in body structure such as a loss or significant departure from population standards or averages. The ICD uses impairment as 'signs and symptoms', a 'component of disease' or sometimes 'reason for contact with health services'. Impairments are recorded in terms of their extent or magnitude, nature and/or location. Determination of impairment is undertaken primarily by those qualified to evaluate physical and mental functioning or structure according to population standards or averages. Impairments should be detectable or noticeable by others or the person by direct observation or by inference from indirect observation. Impairments are not the same as the underlying pathology, but are manifestations of that pathology. Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the population norm may be slight or

severe and may fluctuate over time. Impairments may result in other impairments.

Impairments may be part, or an expression of a health condition, but do not necessarily indicate that a disease is present or that the individual should be regarded as sick.

The use of this cluster to collect information on impairments should enhance data quality for medical purposes as well as for a range of purposes related to understanding human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Body structures cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Guide for use:

The Person—body structure, code (ICF 2001) AN[NNNN] is a data element supported by the value domain Body structure code (ICF 2001) AN(NNNN) that represents a neutral list of structures from the ICF.This data element can be used to record positive or neutral body structure, as well as impairment of a specified body structure when used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N.

It is optional to record the location and nature of the impairment using Person—nature of impairment of body structure, code (ICF 2001) X and Person—location of impairment of body structure, code (ICF 2001) X respectively.

There are numerous possible methods for collecting body structures and impairments. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Body structure	Mandatory	1
-	Change to body structure	Optional	1
-	Impairment of body structure	Mandatory	1
-	Location of impairment	Optional	1

Environmental factors cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	320195
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
DSS type:	Data element cluster
Scope:	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers: 1. Body functions cluster 2. Body structures cluster 3. Activities and participation cluster Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. These factors can have a positive or negative influence on a person's participation as a member of society, on performance of activities, or on a person's body function or structure. The Environmental Factors cluster collects information on the extent to which each of the domains in the five chapters listed below influence the body function or structure, activity or participation of a person: 1. Products and technology 2. Natural environment and human-made changes to environment 3. Support and relationships 4. Attitudes 5. Services, systems and policies Each chapter contains categories at different levels ordered from general to detailed. For detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. Codes at the ICF chapter headings may be recorded. If further detail is required the Environmental Factors classification includes 3 and 4 digit codes: e5 Services, systems and policies e580 Health services, systems and policies e5800 Health services Where multiple environmental factors and the extent of influence are recorded, the following prioritising system may be useful: • The first recorded environmental factor is the one having the greatest impact on the individual. • Second and subsequent environmental factors are also of relevance to the individual. The Environmental factors cluster may be used in health,

community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identifying whether, and by how much, these environmental factors are influencing an individual's level of functioning, and whether the influence is a facilitator or barrier, may indicate the sorts of interventions that will optimise the individual's functioning. This information may be useful for policy development, service provision, or advocacy purposes. Preventative strategies could also be indicated by this information.

Collection and usage attributes

Guide for use:

For each environmental factor code recorded there should be one response for the influence of the environmental factor.

There are numerous possible methods for collecting environmental factors. Information can be collected on:

- all environmental factors;
- environmental factors of particular relevance;
- a number of environmental factors, prioritised according to specified criteria;
- one environmental factor per person; or
- record environmental factors for each recorded body function, body structure, and activities and participation.

See also the *ICF Australian User Guide* for further guidelines.

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification:

Functioning and Disability DSS Health, Standard

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Environmental factor	Mandatory	1
-	Influence of environmental factor	Mandatory	1

Government health expenditure function revenue data cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	352476
Registration status:	Health, Standard 05/12/2007
DSS type:	Data element cluster
Scope:	The scope of this data cluster is revenue relating to direct government and government-funded expenditure on health and health–related goods and services or non-health care goods and services to support these activities.

Collection and usage attributes

Guide for use:	Revenues are to be reported in millions to the nearest 100,000 e.g. $4.1 million.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Implementation in Data Set Specification:	Government health expenditure NMDS 2008-2009 Health, Standard 05/12/2007 *Implementation start date:* 01/07/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Type of health or health related function	Conditional	1
2	Source of public and private revenue	Conditional	1
3	Organisation revenues	Conditional	99

Government health expenditure organisation expenditure data cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	352473
Registration status:	Health, Standard 05/11/2007
DSS type:	Data element cluster
Scope:	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation on health and health–related goods and services or non-health care goods and services to support these activities.

Collection and usage attributes

Guide for use:	Expenses are to be reported in millions to the nearest 100,000 e.g. $4.1 million.

Relational attributes

Implementation in Data Set Specification:	Government health expenditure NMDS 2008-2009 Health, Standard 05/12/2007
	Implementation start date: 01/07/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Health industry relevant organisation type	Mandatory	1
2	Type of health or health related function	Mandatory	1
3	Organisation expenses, total Australian currency	Mandatory	1
4	Purchase of goods and services	Mandatory	1
5	Employee expenses	Mandatory	1
6	Depreciation expenses	Mandatory	1

Government health expenditure organisation revenue data element cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	352462
Registration status:	Health, Standard 05/12/2007
DSS type:	Data element cluster
Scope:	The scope of this data cluster is revenue relating to direct government and government-funded expenditure by a health industry relevant organisation.

Collection and usage attributes

Guide for use:	Revenues are to be reported in millions to the nearest 100,000 e.g. $4.1 million.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Implementation in Data Set Specification:	Government health expenditure NMDS 2008-2009 Health, Standard 05/12/2007 *Implementation start date:* 01/07/2008

Metadata items in this Data Set Specification

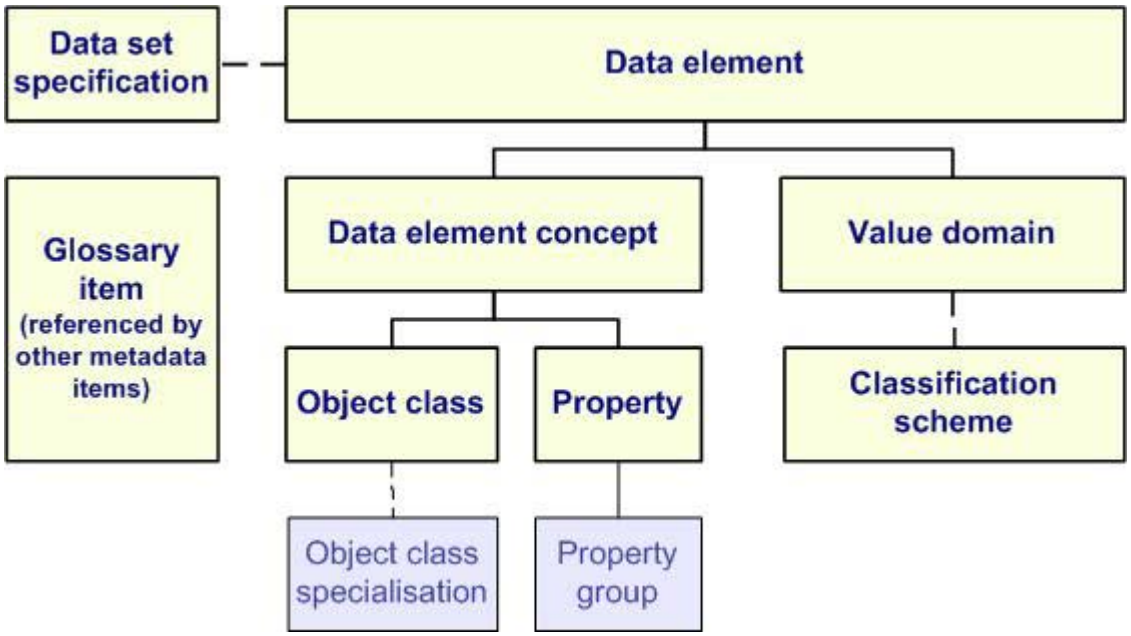
Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Health industry relevant organisation type	Mandatory	1
2	Source of public and private revenue	Mandatory	1
3	Organisation revenues	Conditional	99

Supporting metadata items

Metadata structure

The data standards are s based on the 2003 version of the ISO/IEC 11179 international standard for metadata registries. Part three of the standard is a model for a metadata registry and the formulation of metadata items.

In METeOR there are eight types of metadata (i.e. object class, property, data element concept, data element, value domain, classification scheme, data set specification and glossary item) based on the AIHW's interpretation of the ISO 11179 standards.



Diagrammatic representation of METeOR metadata structures

Object classes

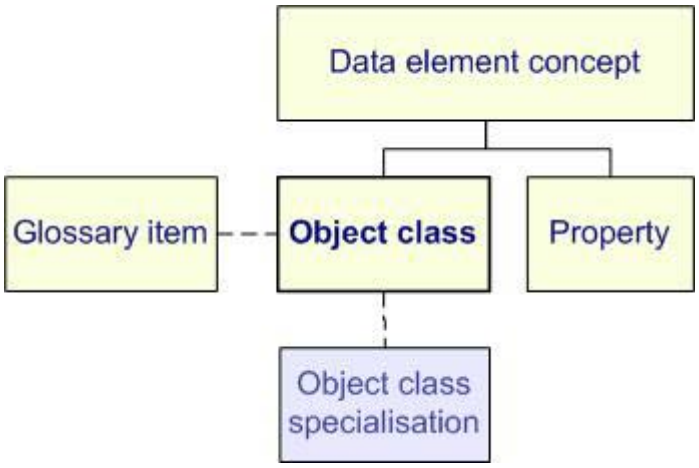
An object class represents a person, organisation, structure or event that is of interest and needs to be described. Within METeOR examples of object classes include Person, Dwelling and Family.

The union of a specific object class with a specific property creates a data element concept. For example, some of the above mentioned object classes can be combined with a Religious affiliation property to create the data element concepts: Person—religious affiliation and Family—religious affiliation.

Object classes can be specialisations of other object classes. For example, Adult is an age group related specialisation of Person.

Specialisations allow object classes to be grouped and subtyped in a meaningful manner and help users in browsing and locating relevant object classes. In a specialisation tree an object class can only be associated with a single parent object class but may have more than one child object classes. A child object class inherits all characteristics of its parent object class, but a child object class may have unique characteristics.

Below is a graphical representation of the relationship between object classes and related metadata item types.



Administrative health region

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	288313
Registration status:	Health, Standard 05/12/2007
Definition:	The administrative unit with responsibility for administering health services in a region, area, district or zone, and for developing and implementing strategic and other plans for health service delivery.

Relational attributes

Data Element Concepts implementing this Object Class:	Administrative health region—palliative care strategic plan indicator Health, Standard 05/12/2007 Administrative health region—region name Health, Standard 05/12/2007

Admitted patient

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268957
Registration status:	Health, Standard 01/03/2005
Definition:	A patient who undergoes a hospital's **admission** process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for **hospital-in-the-home** patients). The patient may be admitted if one or more of the following apply: • the patient's condition requires clinical management and/or facilities not available in their usual residential environment • the patient requires observation in order to be assessed or diagnosed • the patient requires at least daily assessment of their medication needs • the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation) • there is a legal requirement for admission (e.g. under child protection legislation) • the patient is aged nine days or less.
Specialisation of:	Hospital patient (Admission status)

Collection and usage attributes

Guide for use:	This metadata item should be used in conjunction with the definition of same-day patient in the glossary item same-day patient. Part 2 of Schedule 3 of the National Health Act (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients. All babies born in hospital are admitted patients.
Comments:	This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Healthcare Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria: • is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; • is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care; • remains in hospital without its mother; • is admitted to the hospital without its mother. Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian

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

Relational attributes

Related metadata references:	Supersedes Admitted patient, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.17 KB)
Data Element Concepts implementing this Object Class:	Admitted patient (neonate)—neonatal morbidity Health, Standard 01/03/2005

Admitted patient care waiting list episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269012
Registration status:	Health, Standard 01/03/2005
Definition:	The period between entry to and removal from a waiting list for admitted patient care.
Specialisation of:	Service/care event (Episode of admitted patient care waiting list status)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Admitted patient care waiting list episode—scheduled admission date Health, Standard 01/03/2005

Admitted patient hospital stay

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268995
Registration status:	Health, Standard 01/03/2005
Definition:	The period of treatment and/or care and/or accommodation provided between a formal hospital **admission** and **separation**.
Specialisation of:	Service/care event (Admitted patient hospital stay status)

Collection and usage attributes

Comments:	An admitted patient hospital stay is composed of one or more episodes of care, each of which is defined by a single care type (for example acute care, palliative care or rehabilitation care).

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Admitted patient hospital stay—number of patient days (of contracted care) Health, Standard 01/03/2005 Admitted patient hospital stay—operating theatre time Health, Standard 01/03/2005

Adult

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269001
Registration status:	Health, Standard 01/03/2005
Definition:	An individual aged 18 years or older.
Specialisation of:	Person (Age group)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Adult—body mass index Health, Standard 01/03/2005 Adult—waist circumference risk indicator Health, Standard 01/03/2005 Adult—waist-to-hip ratio Health, Standard 01/03/2005 Adult—weight Health, Superseded 14/07/2005

Birth

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268999
Registration status:	Health, Standard 01/03/2005
Definition:	The complete expulsion or extraction from its mother of a product of conception of at least 20 weeks of gestation or of 400 g or more **birthweight**, where the product can be liveborn or stillborn.
Context:	Perinatal
Specialisation of:	Person (Birth status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Birth—Apgar score Health, Superseded 07/12/2005 Birth—Apgar score Health, Standard 07/12/2005 Birth—birth order Health, Standard 01/03/2005 Birth—birth status Health, Standard 01/03/2005 Birth—birth weight Health, Standard 01/03/2005

Birth event

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268965
Registration status:	Health, Standard 01/03/2005
Definition:	The sequence of actions by which a baby and the afterbirth (placenta) are expelled or extracted from the uterus at childbirth. The process usually starts spontaneously about 280 days after conception with onset of labour, but it may be started by artificial means.
Specialisation of:	Life event (Birth event status)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	University of Oxford 2002. Concise Colour Medical Dictionary 3rd ed. UK: Oxford University Press

Relational attributes

Data Element Concepts implementing this Object Class:	Birth event—anaesthesia administered Health, Superseded 07/12/2005 Birth event—anaesthesia administered Health, Standard 07/12/2005 Birth event—analgesia administered Health, Superseded 07/12/2005 Birth event—analgesia administered Health, Standard 07/12/2005 Birth event—baby resuscitation method Health, Standard 01/03/2005 Birth event—birth method Health, Standard 06/09/2006 Birth event—birth plurality Health, Standard 01/03/2005 Birth event—birth presentation Health, Standard 06/09/2006 Birth event—birth presentation Health, Superseded 06/09/2006 Birth event—complication Health, Standard 01/03/2005 Birth event—complication (postpartum) Health, Standard 01/03/2005 Birth event—delivery method Health, Superseded 06/09/2006 Birth event—labour augmentation type Health, Standard 01/03/2005 Birth event—labour induction type Health, Standard 01/03/2005 Birth event—labour onset type Health, Standard 01/03/2005 Birth event—setting (intended) Health, Superseded 08/12/2005 Birth event—setting of birth Health, Standard 01/03/2005 Birth event—state/territory of birth Health, Standard 01/03/2005

Cancer staging

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	313434
Registration status:	Health, Standard 13/10/2005
Definition:	System of determining the extent or stage of cancer.

Relational attributes

Data Element Concepts implementing this Object Class:	Cancer staging—cancer staging scheme source Health, Standard 04/06/2004 Cancer staging—cancer staging scheme source edition number Health, Standard 04/06/2004 Cancer staging—staging basis of cancer Health, Standard 04/06/2004

Cancer treatment

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	288059
Registration status:	Health, Standard 04/06/2004
Definition:	The course of cancer directed treatment or treatments, with defined dates of commencement and cessation, given to the patient by a treatment provider or team of providers. It includes all treatments administered to the patient before disease progression or recurrence and applies to surgical treatment, radiation therapy and systemic agent therapy for cancer.
Context:	This metadata item is required to provide the basis for a standard approach to recording and monitoring patterns of initial treatment for cancer patients.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Commission on Cancer, Facility Oncology Registry Data Standards (2002)

Relational attributes

Data Element Concepts implementing this Object Class:	Cancer treatment—cancer treatment type Health, Standard 04/06/2004 Cancer treatment—intention of treatment Health, Standard 04/06/2004 Cancer treatment—non-surgical cancer treatment completion date Health, Standard 04/06/2004 Cancer treatment—non-surgical cancer treatment start date Health, Standard 04/06/2004 Cancer treatment—outcome of treatment Health, Standard 04/06/2004 Cancer treatment—radiation dose received Health, Standard 13/06/2004 Cancer treatment—radiotherapy treatment type Health, Standard 13/06/2004 Cancer treatment—surgical procedure date Health, Standard 04/06/2004 Cancer treatment—surgical procedure for cancer Health, Standard 04/06/2004 Cancer treatment—systemic therapy agent name (primary cancer) Health, Standard 04/06/2004 Cancer treatment—target site for cancer treatment Health, Standard 13/06/2004

Child

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268987
Registration status:	Health, Standard 25/02/2005 Community services, Standard 01/12/2004
Definition:	An individual under the age of 18 years.
Specialisation of:	Person (Age group)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Child—body mass index Health, Standard 01/03/2005

Client

Identifying and definitional attributes

Metadata item type:	Object Class
Synonymous names:	Client
METeOR identifier:	268969
Registration status:	Community services, Standard 01/03/2005
Definition:	A person, group or organisation eligible to receive services either directly or indirectly from an agency.
Context:	Agencies may provide assistance to individual persons, groups of persons (e.g. support groups) or to other organisations. All of these may be considered clients of an agency. Specific data collections may circumscribe the Type of clients that are included in the collection. For example, at the current stage of development of the Home and Community Care (HACC) Minimum Data Set (MDS), HACC funded agencies are only required to report on clients who are individual persons. Future developments may extend the coverage of the HACC MDS collection to include organisational or group clients. The definition of a 'client' may also be circumscribed by the definition of 'assistance'. What is included as 'assistance' may depend on what activities are considered significant enough to warrant separate recording and reporting of the nature and/or amount of the assistance provided to a person. For example, an agency worker answering a telephone call from an anonymous member of the public seeking some basic information (e.g. a phone number for someone) would not usually consider that this interaction constituted assistance of sufficient significance to warrant recording that person as a 'client'. Furthermore, what constitutes 'assistance' may be influenced by the type of assistance the agency was established to provide. In the above example, the agency in question was funded specifically to provide telephone advice, and referral information, to members of the public or specific sub-groups of the public. The agency may have a policy that all persons telephoning the agency for information are classified as clients, albeit anonymous clients. The level of support or the amount of support given to a person by an agency can also be used to define them as a client or not. For example in the Supported Accommodation Assistance Program (SAAP) National data collection, clients are defined by either taking up an amount of time of an agency; being accommodated by an agency; or by entering an ongoing support relationship with an agency.
Specialisation of:	Person (Client status)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Client, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.7 KB)
Data Element Concepts	Client—injecting drug use status Health, Standard 01/03/2005

implementing this Object Class:	Client—method of drug use (principal drug of concern) Health, Standard 01/03/2005

Community nursing service episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268998
Registration status:	Health, Standard 01/03/2005
Definition:	A period of time during which a person receives care from a community nursing service.
Specialisation of:	Episode of care (Community nursing service episode status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Community nursing service episode—first contact date Health, Standard 01/03/2005
	Community nursing service episode—goal of care Health, Standard 01/03/2005
	Community nursing service episode—last contact date Health, Standard 01/03/2005
	Community nursing service episode—nursing intervention Health, Standard 01/03/2005

Contracted hospital care

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268981
Registration status:	Health, Standard 01/03/2005
Definition:	Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).
Specialisation of:	Service/care event (Contracted hospital care status)

Collection and usage attributes

Guide for use:

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

Contracted hospital care must involve all of the following:

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

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

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

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

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

Relational attributes

Related metadata references:	Supersedes Contracted hospital care, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.92 KB)
Data Element Concepts implementing this Object Class:	Contracted hospital care—contracted care commencement date Health, Standard 01/03/2005 Contracted hospital care—contracted care completed date Health, Standard 01/03/2005 Contracted hospital care—organisation identifier Health, Standard 01/03/2005

Date

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	294409
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The day of the month and year as specified by a number.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Oxford English dictionary.

Relational attributes

Data Element Concepts implementing this Object Class:	Date—accuracy indicator Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Division of general practice

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268989
Registration status:	Health, Standard 01/03/2005
Definition:	A geographically based network of general practitioners.
Specialisation of:	Health service provider (Division of general practice status)

Collection and usage attributes

Guide for use:	In geographical terms, each Division of General Practice can be described by the postcodes that fall within its jurisdiction.

Source and reference attributes

Submitting organisation:	Cardiovascular data working group

Relational attributes

Data Element Concepts implementing this Object Class:	Division of general practice—organisation identifier Health, Standard 01/03/2005

Elective care waiting list episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268974
Registration status:	Health, Standard 01/03/2005
Definition:	The period between entry to and removal from an elective care waiting list.
Specialisation of:	Episode of admitted care waiting list (Elective care status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Elective care waiting list episode—category reassignment date Health, Standard 01/03/2005 Elective care waiting list episode—elective care type Health, Standard 01/03/2005 Elective care waiting list episode—listing date for care Health, Standard 01/03/2005

Elective surgery waiting list episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269007
Registration status:	Health, Standard 01/03/2005
Definition:	The period between entry to and removal from an elective surgery waiting list.
Specialisation of:	Elective care waiting list episode (Elective surgery status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Elective surgery waiting list episode—anticipated accommodation status Health, Standard 01/03/2005
	Elective surgery waiting list episode—clinical urgency Health, Standard 01/03/2005
	Elective surgery waiting list episode—extended wait patient indicator Health, Standard 01/03/2005
	Elective surgery waiting list episode—indicator procedure Health, Standard 01/03/2005
	Elective surgery waiting list episode—overdue patient status Health, Standard 01/03/2005
	Elective surgery waiting list episode—patient listing status Health, Standard 01/03/2005
	Elective surgery waiting list episode—reason for removal from a waiting list Health, Standard 01/03/2005
	Elective surgery waiting list episode—surgical specialty (of scheduled doctor) Health, Standard 01/03/2005
	Elective surgery waiting list episode—waiting list removal date Health, Standard 01/03/2005
	Elective surgery waiting list episode—waiting time Health, Standard 01/03/2005

Emergency department stay

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	322591
Registration status:	Health, Standard 24/03/2006
Definition:	The period between when a patient presents at an emergency department and when that person departs.
Context:	Emergency department care.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Object Class:	Emergency department stay—physical departure date Health, Standard 24/03/2006
	Emergency department stay—physical departure time Health, Standard 24/03/2006

Episode of admitted patient care

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268956
Registration status:	Health, Standard 01/03/2005
Definition:	The period of admitted patient care between a formal or statistical **admission** and a formal or statistical **separation**, characterised by only one care type.
Context:	Admitted patient care.
Specialisation of:	Episode of care (Episode of admitted patient care status)

Collection and usage attributes

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

Source and reference attributes

Origin:	Health Data Standards Committee.

Relational attributes

Related metadata references:	Supersedes Episode of admitted patient care, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005 02/10/2003.pdf (13 KB)
Data Element Concepts implementing this Object Class:	Episode of admitted patient care (newborn)—date of change to qualification status Health, Standard 01/03/2005 Episode of admitted patient care (newborn)—number of qualified days Health, Standard 01/03/2005 Episode of admitted patient care (procedure)—procedure commencement date Health, Standard 01/03/2005 Episode of admitted patient care—admission date Health, Standard 01/03/2005 Episode of admitted patient care—admission mode Health, Standard 01/03/2005 Episode of admitted patient care—admission time Health, Standard 01/03/2005 Episode of admitted patient care—admission urgency status Health, Standard 01/03/2005 Episode of admitted patient care—condition onset flag Health, Standard 05/02/2008 Episode of admitted patient care—diagnosis onset type Health, Superseded 05/02/2008 Episode of admitted patient care—diagnosis related group Health, Standard 01/03/2005 Episode of admitted patient care—elected accommodation status Health, Superseded 28/11/2006 Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005 Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005 Episode of admitted patient care—length of stay (including

leave days) Health, Standard 01/03/2005

Episode of admitted patient care—length of stay (special/neonatal intensive care) Health, Standard 01/03/2005

Episode of admitted patient care—major diagnostic category Health, Standard 01/03/2005

Episode of admitted patient care—number of days of hospital-in-the-home care Health, Standard 01/03/2005

Episode of admitted patient care—number of leave days Health, Standard 01/03/2005

Episode of admitted patient care—number of leave periods Health, Standard 01/03/2005

Episode of admitted patient care—patient election status Health, Standard 28/11/2006

Episode of admitted patient care—procedure Health, Standard 01/03/2005

Episode of admitted patient care—referral destination Health, Standard 01/03/2005

Episode of admitted patient care—referral source Health, Standard 01/03/2005

Episode of admitted patient care—separation date Health, Standard 01/03/2005

Episode of admitted patient care—separation mode Health, Standard 01/03/2005

Episode of admitted patient care—separation time Health, Standard 01/03/2005

Episode of care

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268978
Registration status:	Health, Standard 01/03/2005
Definition:	A period of health care with a defined start and end.
Specialisation of:	Service/care (Episode of care)

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Data Element Concepts implementing this Object Class:	Episode of admitted patient care—inter-hospital contracted patient status Health, Standard 01/03/2005
	Episode of care (procedure)—contracted procedure flag Health, Standard 01/03/2005
	Episode of care—additional diagnosis Health, Standard 01/03/2005
	Episode of care—behaviour-related risk factor intervention Health, Standard 01/03/2005
	Episode of care—behaviour-related risk factor intervention purpose Health, Standard 01/03/2005
	Episode of care—expected principal source of funding Health, Superseded 29/11/2006
	Episode of care—first service delivery date (community setting) Health, Standard 01/03/2005
	Episode of care—funding eligibility indicator Health, Standard 01/03/2005
	Episode of care—mental health legal status Health, Standard 01/03/2005
	Episode of care—number of psychiatric care days Health, Standard 01/03/2005
	Episode of care—nursing diagnosis Health, Standard 01/03/2005
	Episode of care—principal diagnosis Health, Standard 01/03/2005
	Episode of care—principal source of funding Health, Standard 29/11/2006
	Episode of care—specialist private sector rehabilitation care indicator Health, Standard 01/03/2005

Episode of residential care

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268968
Registration status:	Health, Standard 01/03/2005
Definition:	The period of care between the start of residential care (either through the formal start of the residential stay or the start of new reference period) and the end of the residential care (either through the formal end of residential care, commencement of leave intended to be greater than seven days or the end of the reference period i.e. 30 June).
Specialisation of:	Episode of care (Episode of residential care status)

Collection and usage attributes

Comments:	For **resident**s provided with care intended to be on an overnight basis. This may occasionally include episodes of residential care that unexpectedly ended on the same day as they started (for example, the resident died or left against advice) or began at the end of the reference period (i.e. starting care on 30 June).

Relational attributes

Data Element Concepts implementing this Object Class:	Episode of residential care—episode end date Health, Standard 01/03/2005
	Episode of residential care—episode end mode Health, Standard 01/03/2005
	Episode of residential care—episode start date Health, Standard 01/03/2005
	Episode of residential care—episode start mode Health, Standard 01/03/2005
	Episode of residential care—number of episodes of residential care Health, Standard 08/12/2004
	Episode of residential care—number of leave days Health, Standard 01/03/2005
	Episode of residential care—referral destination (mental health care) Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268961
Registration status:	Health, Standard 01/03/2005
Definition:	The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than three months.
Context:	Alcohol and drug treatment services. This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.
Specialisation of:	Episode of care (Episode of treatment for alcohol and other drugs status)

Collection and usage attributes

Guide for use:	A treatment episode must have a defined date of commencement of treatment episode for alcohol and other drugs and a date of cessation of treatment episode for alcohol and other drugs. A treatment episode can have only one main treatment type for alcohol and other drugs and only one principal drug of concern. If the main treatment or principal drug changes then the treatment episode is closed and a new treatment episode is opened. A treatment episode may also be considered closed (ceased) if there is a change in the treatment delivery setting or the service delivery outlet. Where the change reflects a substantial alteration in the nature of the treatment episode, for instance where an agency operates in more than one treatment setting (or outlet) they may consider that a change from one setting (or outlet), to another necessitates closure of one episode and commencement of a new one.
Collection methods:	Is taken as the period starting from the date of commencement of treatment and ending at the date of cessation of treatment episode.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set - Working Group

Relational attributes

Related metadata references:	Supersedes Treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.13 KB)
Data Element Concepts implementing this Object Class:	Episode of treatment for alcohol and other drugs—cessation reason Health, Standard 01/03/2005 Episode of treatment for alcohol and other drugs—client type Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—drug of concern Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—drug of concern (principal) Health, Superseded 13/10/2005

Episode of treatment for alcohol and other drugs—number of service contacts Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—referral source Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—service delivery setting Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment cessation date Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment commencement date Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment type Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment type (other) Health, Superseded 13/10/2005

Establishment

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268953
Registration status:	Health, Standard 01/03/2005
Definition:	Institutions, organisations or the community from which health services are provided. The term establishment covers conventional health establishments and also organisations which may provide services in the community.
Specialisation of:	Health service provider (Establishment status)

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Data Element Concepts implementing this Object Class:	Establishment (residential aged care service)—number of occasions of service Health, Standard 01/03/2005 Establishment—accrued mental health care days Health, Standard 08/12/2004 Establishment—Australian state/territory identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Establishment—establishment type Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (trainee/pupil nurses) Health, Standard 01/03/2005

Establishment—geographic location Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment—gross capital expenditure (computer equipment/installations) Health, Standard 01/03/2005

Establishment—gross capital expenditure (intangible assets) Health, Standard 01/03/2005

Establishment—gross capital expenditure (land and buildings) Health, Standard 01/03/2005

Establishment—gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (other capital expenditure) Health, Standard 01/03/2005

Establishment—gross capital expenditure (plant and other equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (land)

Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment—number of available beds for admitted patients/residents Health, Standard 01/03/2005

Establishment—number of day centre attendances Health, Standard 01/03/2005

Establishment—number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005

Establishment—number of group sessions Health, Superseded 04/07/2007

Establishment—number of group sessions Health, Standard 04/07/2007

Establishment—number of individual session occasions of service for non-admitted patients Health, Standard 01/03/2005

Establishment—number of non-admitted patient service events Health, Standard 01/03/2005

Establishment—number of occasions of service Health, Standard 04/05/2005

Establishment—number of patient days Health, Standard 01/03/2005

Establishment—number of separations Health, Standard 01/03/2005

Establishment—organisation identifier Health, Standard 01/03/2005

Establishment—organisation identifier (state/territory) Health, Standard 01/03/2005

Establishment—outpatient clinic type Health, Standard 04/07/2007

Establishment—outpatient clinic type Health, Superseded 04/07/2007

Establishment—patients/clients in residence at year end Health, Standard 01/03/2005

Establishment—quality accreditation/certification standard indicator Health, Standard 01/03/2005

Establishment—recurrent expenditure Health, Standard 08/12/2004

Establishment—recurrent expenditure (administrative expenses) Health, Standard 01/03/2005

Establishment—recurrent expenditure (Department of Veterans' Affairs funded) Health, Standard 08/12/2004

Establishment—recurrent expenditure (depreciation) Health, Standard 01/03/2005

Establishment—recurrent expenditure (domestic services) Health, Standard 01/03/2005

Establishment—recurrent expenditure (drug supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (food supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (indirect health care) Health, Standard 01/03/2005

Establishment—recurrent expenditure (interest payments) Health, Standard 01/03/2005

Establishment—recurrent expenditure (medical and surgical supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (National Mental Health Strategy payments) Health, Standard 08/12/2004

Establishment—recurrent expenditure (non-salary operating costs) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other Commonwealth Government funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other patient revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other recurrent expenditure) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other state or territory funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (patient transport cost) Health, Standard 01/03/2005

Establishment—recurrent expenditure (recoveries funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (repairs and maintenance) Health, Standard 01/03/2005

Establishment—recurrent expenditure (salaries and wages) Health, Standard 01/03/2005

Establishment—recurrent expenditure (state or territory health authority funded) Health, Standard 08/12/2004

Establishment—recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Establishment—region identifier Health, Standard 01/03/2005

Establishment—revenue (other revenue) Health, Standard 05/12/2007

Establishment—revenue (other revenue) Health, Superseded 05/12/2007

Establishment—revenue (patient) Health, Superseded 05/12/2007

Establishment—revenue (patient) Health, Standard 05/12/2007

Establishment—revenue (recoveries) Health, Superseded 05/12/2007

Establishment—revenue (recoveries) Health, Standard 05/12/2007

Establishment—sector Health, Standard 01/03/2005

Establishment—specialised service indicator Health, Standard 01/03/2005

Establishment—teaching status (university affiliation) Health, Standard 01/03/2005

Female

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269000
Registration status:	Health, Standard 01/03/2005
Definition:	A human being of the sex which conceives and brings forth young.
Specialisation of:	Person (Sex)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd.

Relational attributes

Data Element Concepts implementing this Object Class:	Female (mother)—postpartum perineal status Health, Standard 01/03/2005
	Female (pregnant)—estimated gestational age Health, Standard 01/03/2005
	Female (pregnant)—maternal medical condition Health, Standard 01/03/2005
	Female— pregnancy indicator Health, Standard 21/09/2005
	Female—caesarean section indicator Health, Standard 29/11/2006
	Female—current pregnancy status Health, Superseded 21/09/2005
	Female—number of caesarean sections Health, Standard 29/11/2006
	Female—number of previous pregnancies Health, Standard 01/03/2005
	Female—parity Health, Standard 29/11/2006

Health industry relevant organisation

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	352194
Registration status:	Health, Standard 05/12/2007
Definition:	An organisation that provides health care goods and services to prevent or cure disease, care for illness, impairment, disability or handicap, or non-health care good and services to support these activities.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Data Element Concepts implementing this Object Class:	Health industry relevant organisation—main activity type Health, Standard 05/12/2007 Health industry relevant organisation—source of revenue Health, Standard 05/12/2007

Health professional

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268985
Registration status:	Health, Standard 01/03/2005
Definition:	A person whose primary employment role is to diagnose and treat physical and mental illnesses and conditions or recommend, administer, dispense and develop medications and treatment to promote or restore good health.
Specialisation of:	Individual service provider (Health professional status)

Collection and usage attributes

Guide for use:	Health professionals include medical practitioners, nursing professionals, dental practitioners, pharmacists, physiotherapists and podiatrists.

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare
Origin:	ABS (Australian Bureau of Statistics) 1997. Australian Standard Classification of Occupations, 2nd ed. Cat. no. 1220.0. Canberra: ABS

Relational attributes

Data Element Concepts implementing this Object Class:	Health professional—area of clinical practice (principal) Health, Standard 01/03/2005
	Health professional—establishment type (employment) Health, Standard 01/03/2005
	Health professional—hours worked Health, Standard 01/03/2005
	Health professional—labour force status Health, Standard 01/03/2005
	Health professional—occupation Health, Standard 01/03/2005
	Health professional—principal role Health, Standard 01/03/2005

Health service event

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268979
Registration status:	Health, Standard 01/03/2005
Definition:	An interaction between one or more health care providers with one or more persons for assessment, care, consultation and/or treatment.
Specialisation of:	Service/care event (Health service event status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Health service event—fasting indicator Health, Standard 01/03/2005 Health service event—presentation date Health, Standard 01/03/2005 Health service event—presentation time Health, Standard 01/03/2005 Health service event—referral to ophthalmologist status Health, Superseded 21/09/2005 Health service event—referral to rehabilitation service date Health, Standard 01/03/2005 Health service event—service commencement date Health, Superseded 07/12/2005 Health service event—service commencement time Health, Superseded 07/12/2005

Hospital

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268971
Registration status:	Health, Standard 01/03/2005
Definition:	A health care facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit, and authorised to provide treatment and/or care to patients.
Context:	Admitted patient care, admitted patient palliative care, admitted patient mental health care and public hospital establishments.
Specialisation of:	Establishment (Hospital status)

Collection and usage attributes

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Hospital, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.79 KB)
Data Element Concepts implementing this Object Class:	Hospital—contract role Health, Standard 01/03/2005 Hospital—contract type Health, Standard 01/03/2005

Hospital census

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269010
Registration status:	Health, Standard 01/03/2005
Definition:	A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.
Context:	Admitted patient care.
Specialisation of:	Service/care event (Hospital census status)

Relational attributes

Related metadata references:	Supersedes Hospital census, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.77 KB)
Data Element Concepts implementing this Object Class:	Hospital census (of elective surgery waitlist patients)—census date Health, Standard 01/03/2005

Hospital service

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269008
Registration status:	Health, Standard 01/03/2005
Definition:	A service provided within a hospital, characterised by only one care type.
Specialisation of:	Service/care event (Hospital service status)

Collection and usage attributes

Guide for use:	Includes hospital services provided to an admitted patient, to a **hospital boarder**, and to an organ donor who has been declared brain dead.

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Hospital service—care type Health, Standard 01/03/2005

Household

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268977
Registration status:	Community services, Superseded 27/04/2007 Housing assistance, Standard 01/03/2005
Definition:	A group of two or more related or unrelated people who usually reside in the same dwelling, and who make common provision for food or other essentials for living. Or a single person living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.
Context:	Together with family, household is considered one of the basic groups of social aggregation. Information on household numbers and composition aids in identifying groups within the population such as Indigenous households or the number of people living alone.
Specialisation of:	Group of persons (Household status)

Collection and usage attributes

Guide for use:	For the Commonwealth-State Housing Agreement (CSHA) data collections, the number of tenancy agreements is a practical proxy for calculating the number of households receiving housing assistance. The persons in the group may pool their incomes and have a common budget to a greater or lesser extent: they may be related or unrelated persons, or a combination of both. Only usual residents of the household are included as members of the household. Visitors to a household are, by definition, excluded from the household.

Source and reference attributes

Origin:	CSHA Public rental housing data manual 2001-02

Relational attributes

Related metadata references:	Supersedes Household, version 2, DEC, NHADD, NHDAMG, Superseded 01/03/2005.pdf (13.6 KB) Supersedes Household, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.72 KB)
Data Element Concepts implementing this Object Class:	Household—gross income Health, Standard 15/12/2005 Housing assistance, Retired 10/02/2006

Individual service provider

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269021
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	A person who provides a service and/or care.
Specialisation of:	Service/care provider (Organisation status)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Individual service provider—occupation (self-identified) Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Individual service provider—occupation end date Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Individual service provider—occupation start date Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Injury event

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268967
Registration status:	Health, Standard 01/03/2005
Definition:	An occurrence of injury, poisoning or other adverse effect inflicted on the person as the direct or indirect result of an environmental event, circumstance or condition.
Specialisation of:	Life event (Injury event status)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Injury event—activity type Health, Standard 01/03/2005 Injury event—external cause Health, Standard 01/03/2005 Injury event—human intent of injury Health, Standard 24/11/2005 Injury event—nature of main injury Health, Standard 01/03/2005 Injury event—place of occurrence Health, Standard 01/03/2005

Jurisdiction

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	352330
Registration status:	Health, Standard 05/12/2007
Definition:	The territory or area over which authority is exercised.

Relational attributes

Data Element Concepts implementing this Object Class:	Jurisdiction—Australian state/territory identifier Health, Standard 05/12/2007

Laboratory standard

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	310463
Registration status:	Health, Standard 27/10/2005
Definition:	The acknowledged measure of comparison of a laboratory test result for the specified laboratory. The measure of comparison can vary between laboratories.

Relational attributes

Data Element Concepts implementing this Object Class:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme Health, Standard 04/06/2004 Laboratory standard—upper limit of normal range for microalbumin Health, Standard 01/03/2005 Laboratory standard—upper limit of normal range of glycosylated haemoglobin Health, Standard 01/03/2005 Laboratory standard—upper limit of normal range of troponin assay Health, Standard 04/06/2004

Medical practitioner

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269005
Registration status:	Health, Standard 01/03/2005
Definition:	A person whose primary employment role is to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatment to promote or restore good health.
Specialisation of:	Health professional (Profession)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare
Origin:	ABS (Australian Bureau of Statistics) 1997. Australian Standard Classification of Occupations, 2nd ed. Cat. no. 1220.0. Canberra: ABS

Relational attributes

Data Element Concepts implementing this Object Class:	Medical practitioner—hours on-call Health, Standard 01/03/2005 Medical practitioner—hours worked Health, Standard 01/03/2005

Mental health service contact

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	286670
Registration status:	Health, Standard 08/12/2004
Definition:	The provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.
Specialisation of:	Service/care event (Service contact status)

Collection and usage attributes

Guide for use:

A service contact must involve at least two persons, one of whom must be a specialised mental health service provider.

Mobile and outreach services and consultation and liaison services are included as service contacts.

Service contacts are not restricted to in person communication but can include telephone, video link or other forms of direct communication.

Service contacts can either be with a patient/client, or with a third party such as a carer or family member, other professional or mental health worker or other service provider. Services involving only a service provider and a third party(ies) are included as service contacts, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.

There may be multiple service contacts on any one day for a patient/client or a third party(ies) and each service contact should be recorded separately.

A service contact should be recorded for each patient/client for which the service is provided, whether by phone or other electronic means or in person, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Service provision is only regarded as a service contact if it is relevant to the clinical condition of the patient/client. This means that it does not include services of an administrative nature (e.g. telephone contact to schedule an appointment) except where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.

There may however be instances where notes are made in the patient/client clinical record that have not been prompted by a service provision for a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as service contacts.

In instances where documenting the patient/client's service contact details is separated in time from the service provision, this is not counted as a separate service contact.

Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be

reported as a service contact.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:

Mental health service contact—mental health service contact duration Health, Standard 08/12/2004

Mental health service contact—patient/client participation indicator Health, Standard 08/12/2004

Mental health service contact—service contact date Health, Standard 08/12/2004

Mental health service contact—session type Health, Standard 08/12/2004

Non-admitted patient emergency department service episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268976
Registration status:	Health, Standard 01/03/2005
Definition:	The treatment or care between when a patient presents at an **emergency department** and when the non-admitted patient emergency department treatment or care ends.
Context:	Emergency department care.

Collection and usage attributes

Guide for use:	Includes patients who do not wait for treatment once registered or triaged, and those who are dead on arrival at the emergency department. Both a non-admitted patient emergency department service episode and an admitted patient episode of care should be recorded for patients who subsequently undergo a formal admission. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care, if applicable. A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.
Comments:	This metadata item has been defined to support the national minimum data set for Non-admitted patient emergency department care.

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references:	Supersedes Non-admitted patient emergency department service episode, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
Data Element Concepts implementing this Object Class:	Non admitted patient emergency department service episode - presenting problem Health, Standard 05/12/2007 Non-admitted patient emergency department service episode - principal diagnosis Health, Standard 05/12/2007 Non-admitted patient emergency department service episode — episode end date Health, Standard 24/03/2006 Non-admitted patient emergency department service episode — episode end status Health, Standard 24/03/2006 Non-admitted patient emergency department service episode — episode end time Health, Standard 24/03/2006 Non-admitted patient emergency department service episode — patient departure status Health, Superseded 24/03/2006 Non-admitted patient emergency department service episode —

service commencement date Health, Standard 07/12/2005

Non-admitted patient emergency department service episode—service commencement time Health, Standard 07/12/2005

Non-admitted patient emergency department service episode—service episode length Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—transport mode Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—triage category Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—triage date Health, Standard 07/12/2005

Non-admitted patient emergency department service episode—triage time Health, Standard 07/12/2005

Non-admitted patient emergency department service episode—type of visit to emergency department Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time (to hospital admission) Health, Standard 01/03/2005

Non-admitted patient service event

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268972
Registration status:	Health, Standard 01/03/2005
Definition:	An interaction between one or more health care professionals with one or more non-admitted patients, for assessment, consultation and/or treatment intended to be unbroken in time. A service event means that a dated entry is made in the patient/client's medical record.
Context:	Hospital non-admitted patient care: This definition applies to non-admitted hospital patients and is not intended to apply to community based services.
Specialisation of:	Service/care event (Non-admitted patient service event status)

Collection and usage attributes

Guide for use:

The period of interaction can be broken but still regarded as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons, for example, a clinician is called to assess another patient who requires more urgent care.

Service events can occur in an outpatient, emergency, radiology, pathology and/or pharmacy department or, by a hospital-based outreach service, in a location that is not part of the hospital campus.

Service events may or may not be pre-arranged (except for telephone calls).

Imaging, pathology and/or pharmacy services that are associated with a service event in an outpatient clinic, **emergency department** or outreach service are not regarded as service events themselves.

Imaging, pathology or pharmacy services provided independent of a service event in an outpatient clinic, emergency department or outreach service are regarded as individual service events.

Service events delivered via a telephone call are included if

- they are a substitute for a face-to-face service event, and
- they are pre-arranged, and
- a record of the service event is included in the patient's medical record.

Service events include when the patient is participating via a video link (telemedicine). A service event can be counted at each site participating via the video link.

If a carer/relative accompanies a patient during a service event, this is not considered to be a service event for the carer/relative, provided that the carer/relative is not a patient in their own right for the service contact.

Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

A service event is regarded as having occurred for each patient who attends a group session such as an antenatal class. Outpatient department services provided to admitted patients are not regarded as service events.

Work-related services provided in clinics for staff are not service events.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.02 KB)

Data Element Concepts implementing this Object Class:

Non-admitted patient service event—multi-disciplinary team status Health, Standard 01/03/2005

Non-admitted patient service event—new/repeat service event status Health, Standard 01/03/2005

Non-admitted patient service event—patient present status Health, Standard 01/03/2005

Non-admitted patient service event—service event type (clinical) Health, Standard 01/03/2005

Non-admitted patient service event—service mode Health, Standard 01/03/2005

Organisation

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	354505
Registration status:	Health, Standard 05/12/2007
Definition:	The smallest type of accounting unit within a management unit within a State or Territory of Australia which controls its productive activities and for which a specified range of detailed data is available, at least on an annual basis, thus enabling measures such as value added to be calculated.

Source and reference attributes

Reference documents:	Australian Bureau of Statistics 2002. Standard Economic Sector Classifications of Australia (SESCA). ABS cat. no. 1218.0. Canberra: ABS.

Relational attributes

Data Element Concepts implementing this Object Class:	Organisation—depreciation expenses Health, Standard 05/12/2007 Organisation—employee related expenses Health, Standard 05/12/2007 Organisation—expenses Health, Standard 05/12/2007 Organisation—purchase of goods and services Health, Standard 05/12/2007 Organisation—revenue Health, Standard 05/12/2007 Organisation—type of health or health related function Health, Standard 05/12/2007

Patient

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268959
Registration status:	Health, Standard 01/03/2005
Definition:	A person for whom a health service accepts responsibility for treatment and or care.
Specialisation of:	Person (Patient status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Patient, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.24 KB)
Data Element Concepts implementing this Object Class:	Patient—compensable status Health, Standard 01/03/2005 Patient—diagnosis date Health, Standard 01/03/2005 Patient—hospital insurance status Health, Standard 01/03/2005 Patient—initial visit since diagnosis indicator (diabetes mellitus) Health, Standard 21/09/2005 Patient—initial visit since diagnosis status (diabetes mellitus) Health, Superseded 21/09/2005 Patient—insulin start date Health, Standard 01/03/2005 Patient—number of psychiatric outpatient clinic/day program attendances Health, Standard 01/03/2005 Patient—previous specialised treatment Health, Standard 01/03/2005

Person

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268955
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	A human being, whether man, woman or child.
Specialisation of:	Person/group of persons (Group status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare
Origin:	Macquarie University 2003. *The Macquarie Dictionary 3rd ed*. Sydney: The Macquarie Library Pty. Ltd

Relational attributes

Data Element Concepts implementing this Object Class:	Person (address)—address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Person (address)—address type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Person (address)—Australian postcode Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Person (address)—building/complex sub-unit identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Person (address)—building/complex sub-unit type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Person (address)—building/property name Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Person (address)—country identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Person (address)—electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Person (address)—electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Person (address)—electronic communication usage code Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Person (address)—floor/level identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Person (address)—floor/level type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Person (address)—health address line Health, Superseded 04/05/2005

Person (address)—house/property identifier Health, Standard 01/03/2005

Person (address)—international postcode Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (address)—lot/section identifier Health, Standard 01/03/2005

Person (address)—non-Australian state/province Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (address)—postal delivery point identifier Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (address)—postal delivery service type identifier Health, Standard 01/03/2005

Person (address)—street name Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address)—street suffix Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address)—street type Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address)—suburb/town/locality name Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (identifier)—identifier type Health, Standard 01/03/2005

Person (male)—erectile dysfunction Health, Standard 01/03/2005

Person (name)—family name Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 28/07/2005

Person (name)—given name Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005

Person (name)—given name sequence number Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (name)—name conditional use flag Health, Standard 04/05/2005
Community services, Standard 25/08/2005

Person (name)—name context flag Health, Superseded 04/05/2005
Community services, Superseded 25/08/2005

Person (name)—name suffix Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (name)—name suffix sequence number Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (name)—name title Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (name)—name title sequence number Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (name)—name type Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (overseas born)—year of first arrival in Australia Health, Standard 04/05/2005

Community services, Standard 01/03/2005

Person (requiring care)—carer availability status Health, Superseded 04/07/2007
Community services, Superseded 02/05/2006

Person (telephone)—telephone number type Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person—accommodation type Health, Standard 01/03/2005

Person—activity and participation life area Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—acute coronary syndrome concurrent clinical condition Health, Standard 04/06/2004

Person—acute coronary syndrome procedure type Health, Standard 04/06/2004

Person—acute coronary syndrome risk stratum Health, Standard 04/06/2004

Person—age Health, Standard 04/05/2005
Community services, Standard 04/05/2005
Housing assistance, Standard 17/06/2005

Person—age range Health, Standard 04/05/2005
Community services, Standard 30/11/2007

Person—alcohol consumption amount Health, Standard 01/03/2005

Person—alcohol consumption frequency Health, Standard 01/03/2005

Person—angiotensin converting enzyme inhibitors therapy status Health, Standard 04/06/2004

Person—area of usual residence Health, Standard 01/03/2005

Person—aspirin therapy status Health, Standard 04/06/2004

Person—Australian state/territory identifier Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006

Person—beta-blocker therapy status Health, Standard 04/06/2004

Person—bleeding episode status Health, Standard 04/06/2004

Person—blindness Health, Standard 01/03/2005

Person—blood pressure (diastolic) Health, Standard 01/03/2005

Person—blood pressure (systolic) Health, Standard 01/03/2005

Person—bodily location of main injury Health, Standard 01/03/2005

Person—body function Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—body mass index (classification) Health, Standard 01/03/2005

Person—body structure Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—cardiovascular disease condition targeted by drug therapy Health, Standard 01/03/2005

Person—cardiovascular medication taken Health, Standard 01/03/2005

Person—cataract status Health, Standard 01/03/2005

Person—cerebral stroke due to vascular disease Health, Standard

01/03/2005

Person—chest pain pattern Health, Standard 04/06/2004

Person—cholesterol level Health, Standard 01/03/2005

Person—clinical evidence status (chronic lung disease) Health, Standard 04/06/2004

Person—clinical evidence status (heart failure) Health, Standard 13/06/2004

Person—clinical evidence status (peripheral arterial disease) Health, Standard 13/06/2004

Person—clinical evidence status (sleep apnoea syndrome) Health, Standard 13/06/2004

Person—clinical evidence status (stroke) Health, Standard 13/06/2004

Person—clinical procedure timing Health, Standard 04/06/2004

Person—clopidogrel therapy status Health, Standard 04/06/2004

Person—congenital malformation Health, Standard 01/03/2005

Person—coronary artery disease intervention Health, Standard 01/03/2005

Person—country of birth Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 27/07/2005

Person—creatine kinase myocardial band isoenzyme measured date Health, Standard 04/06/2004

Person—creatine kinase myocardial band isoenzyme measured time Health, Standard 04/06/2004

Person—creatine kinase-myocardial band isoenzyme level Health, Standard 04/06/2004

Person—creatinine serum level Health, Standard 01/03/2005

Person—date of birth Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 27/07/2005

Person—date of death Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person—dependency in activities of daily living Health, Standard 01/03/2005

Person—diabetes mellitus status Health, Standard 01/03/2005

Person—diabetes therapy type Health, Standard 01/03/2005

Person—dyslipidaemia treatment status (anti-lipid medication) Health, Superseded 22/09/2005

Person—dyslipidaemia treatment with anti-lipid medication indicator Health, Standard 21/09/2005

Person—electrocardiogram change location Health, Standard 04/06/2004

Person—electrocardiogram change type Health, Standard 04/06/2004

Person—eligibility status Health, Standard 04/01/2006
Community services, Standard 04/01/2006

Person—end-stage renal disease status Health, Standard 01/03/2005

Person—environmental factor Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—extent of environmental factor influence Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Person—extent of impairment of body function Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—extent of impairment of body structure Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—extent of participation in a life area Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—fibrinolytic drug administered Health, Standard 04/06/2004

Person—fibrinolytic therapy status Health, Standard 04/06/2004

Person—first angioplasty balloon inflation or stenting date Health, Standard 04/06/2004

Person—first angioplasty balloon inflation or stenting time Health, Standard 04/06/2004

Person—foot deformity indicator Health, Standard 01/03/2005

Person—foot lesion indicator Health, Standard 01/03/2005

Person—foot ulcer history status Health, Standard 01/03/2005

Person—foot ulcer indicator Health, Standard 21/09/2005

Person—foot ulcer status (current) Health, Superseded 21/09/2005

Person—formal community support access indicator Health, Standard 01/03/2005

Person—functional stress test element Health, Standard 04/06/2004

Person—functional stress test ischaemic result Health, Standard 04/06/2004

Person—glycoprotein IIb/IIIa receptor antagonist status Health, Standard 04/06/2004

Person—glycosylated haemoglobin level Health, Standard 01/03/2005

Person—government funding identifier Health, Standard 01/03/2005
Community services, Standard 31/08/2007

Person—health professionals attended for diabetes mellitus Health, Standard 01/03/2005

Person—heart rate Health, Standard 04/06/2004

Person—heart rhythm type Health, Standard 04/06/2004

Person—height Health, Standard 01/03/2005

Person—high-density lipoprotein cholesterol level Health, Standard 01/03/2005

Person—hip circumference Health, Standard 01/03/2005

Person—hypertension treatment status (antihypertensive medication) Health, Superseded 21/09/2005

Person—hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Person—Indigenous status Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005

Person—informal carer existence indicator Health, Standard 04/07/2007
Community services, Standard 02/05/2006

Person—interpreter service required Health, Standard 08/02/2006
Community services, Standard 10/04/2006

Person—interpreter service required status (health) Health, Superseded 08/02/2006

Person—intravenous fibrinolytic therapy date Health, Standard 04/06/2004

Person—intravenous fibrinolytic therapy time Health, Standard 04/06/2004

Person—Killip classification Health, Standard 04/06/2004

Person—labour force status Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005

Person—level of difficulty with activities in a life area Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—level of satisfaction with participation in a life area Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—lipid-lowering therapy status Health, Standard 04/06/2004

Person—living arrangement Health, Standard 19/04/2005
Community services, Standard 01/03/2005

Person—location of impairment of body structure Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—low-density lipoprotein cholesterol level Health, Standard 01/03/2005

Person—lower limb amputation due to vascular disease Health, Standard 01/03/2005

Person—main language other than English spoken at home Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006

Person—marital status Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006

Person—microalbumin level Health, Standard 01/03/2005

Person—mother's original family name Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person—myocardial infarction Health, Standard 01/03/2005

Person—nature of impairment of body structure Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—need for assistance with activities in a life area Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—number of cigarettes smoked Health, Standard 01/03/2005

Person—number of service contact dates Health, Standard 01/03/2005

Person—occupation (main) Health, Standard 04/07/2007
Community services, Standard 27/03/2007
Housing assistance, Standard 10/08/2007

Person—occupation (main) Health, Superseded 04/07/2007
Community services, Superseded 27/03/2007
Housing assistance, Superseded 10/08/2007

Person—ophthalmological assessment outcome Health, Standard 01/03/2005

Person—ophthalmoscopy performed indicator Health, Standard 21/09/2005

Person—ophthalmoscopy performed status Health, Superseded 21/09/2005

Person—period of residence in Australia Health, Standard 01/03/2005

Person—peripheral neuropathy indicator Health, Standard 01/03/2005

Person—peripheral vascular disease indicator (foot) Health, Standard 01/03/2005

Person—person identifier Health, Standard 04/05/2005
Community services, Standard 25/08/2005

Person—person identifier (within establishment/agency) Health, Superseded 04/05/2005
Community services, Superseded 25/08/2005

Person—physical activity sufficiency status Health, Standard 01/03/2005

Person—postal delivery service type Health, Standard 01/03/2005

Person—preferred language Health, Standard 01/03/2005
Community services, Standard 10/04/2006

Person—premature cardiovascular disease family history status Health, Standard 01/03/2005

Person—proficiency in spoken English Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006

Person—proteinuria status Health, Standard 01/03/2005

Person—reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004

Person—referral to ophthalmologist indicator Health, Standard 21/09/2005

Person—regular tobacco smoking indicator Health, Standard 21/09/2005

Person—renal disease therapy Health, Standard 01/03/2005

Person—severe hypoglycaemia history Health, Superseded 21/09/2005

Person—severe hypoglycaemia indicator Health, Standard 21/09/2005

Person—sex Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006

Person—technical nursing care requirement Health, Standard 13/10/2005

Person—telephone number Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person—time since quitting tobacco smoking Health, Standard 01/03/2005

Person—tobacco product smoked Health, Standard 01/03/2005

Person—tobacco smoking daily use status Health, Standard

01/03/2005

Person—tobacco smoking duration Health, Standard 01/03/2005

Person—tobacco smoking frequency Health, Standard 01/03/2005

Person—tobacco smoking quit age Health, Standard 01/03/2005

Person—tobacco smoking start age Health, Standard 01/03/2005

Person—tobacco smoking status Health, Standard 01/03/2005

Person—tobacco smoking status (last three months) Health, Superseded 21/09/2005

Person—triglyceride level Health, Standard 01/03/2005

Person—troponin assay type Health, Standard 04/06/2004

Person—troponin level Health, Standard 04/06/2004

Person—troponin level measured date Health, Standard 04/06/2004

Person—troponin level measured time Health, Standard 04/06/2004

Person—vascular condition status Health, Standard 01/03/2005

Person—vascular procedure Health, Standard 01/03/2005

Person—visual acuity Health, Standard 01/03/2005

Person—waist circumference Health, Standard 01/03/2005

Person—weight Health, Standard 01/03/2005

Person with cancer

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268990
Registration status:	Health, Standard 01/03/2005
Definition:	A person who has been diagnosed with a cancer.
Specialisation of:	Person (Health condition)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Person with cancer—degree of spread of a cancer Health, Standard 01/03/2005
	Person with cancer—distant metastasis status Health, Standard 13/06/2004
	Person with cancer—extent of primary cancer Health, Standard 04/06/2004
	Person with cancer—histopathological grade Health, Standard 04/06/2004
	Person with cancer—laterality of primary cancer Health, Standard 01/03/2005
	Person with cancer—melanoma thickness Health, Standard 01/03/2005
	Person with cancer—morphology of cancer Health, Standard 01/03/2005
	Person with cancer—most valid basis of diagnosis of a cancer Health, Standard 01/03/2005
	Person with cancer—number of positive regional lymph nodes Health, Standard 04/06/2004
	Person with cancer—number of regional lymph nodes examined Health, Standard 04/06/2004
	Person with cancer—oestrogen receptor assay results Health, Standard 04/06/2004
	Person with cancer—primary site of cancer Health, Standard 01/03/2005
	Person with cancer—primary tumour status Health, Standard 13/06/2004
	Person with cancer—progesterone receptor assay results Health, Standard 13/06/2004
	Person with cancer—region of first recurrence of cancer Health, Standard 04/06/2004
	Person with cancer—regional lymph node metastasis status Health, Standard 13/06/2004
	Person with cancer—solid tumour size Health, Standard 01/03/2005

Pregnancy

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268966
Registration status:	Health, Standard 01/03/2005
Definition:	The period during which a woman carries a developing fetus, normally in the uterus. Pregnancy lasts for approximately 266 days, from conception until the baby is born, or 280 days from the first day of the last menstrual period. During pregnancy menstruation is absent, there may be a great increase in appetite, and the breasts increase in size; the woman may also experience morning sickness. These and other changes brought about by a hormone (progesterone) produced at first day the ovary and later by the placenta. Definite evidence of pregnancy is provided by various pregnancy tests, by the detection of the heartbeat of the fetus, and by ultrasound.
Specialisation of:	Life event (Pregnancy event status)

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare
Origin:	University of Oxford 2002. Concise Colour Medical Dictionary 3rd ed. UK: Oxford University Press

Relational attributes

Data Element Concepts implementing this Object Class:	Pregnancy (current)—complication Health, Standard 01/03/2005 Pregnancy (last previous)—pregnancy completion date Health, Standard 01/03/2005 Pregnancy (last previous)—pregnancy outcome Health, Standard 01/03/2005 Pregnancy—first day of the last menstrual period Health, Standard 01/03/2005

Residential stay

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268960
Registration status:	Health, Standard 01/03/2005
Definition:	The period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. It may involve more than one reference period, that is, more than one episode of residential care.
Context:	Specialised mental health services (Residential mental health care).
Specialisation of:	Service/care (Residential stay status)

Relational attributes

Data Element Concepts implementing this Object Class:	Residential stay—episode start date Health, Standard 01/03/2005

Service contact

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268983
Registration status:	Health, Standard 01/03/2005
Definition:	A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.
Context:	Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services). A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (e.g. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record. Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.
Specialisation of:	Service/care event (Service contact status)

Collection and usage attributes

Comments:	The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in admitted patient care) and hospital separations. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not currently covered by this metadata item.

Source and reference attributes

Steward:	Australian Bureau of Statistics (ABS)

Relational attributes

Related metadata references:	Supersedes Service contact, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.57 KB)
Data Element Concepts implementing this Object Class:	Service contact—group session status Health, Standard 04/05/2005 Service contact—service contact date Health, Standard 01/03/2005

Service delivery outlet

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268970
Registration status:	Health, Standard 01/03/2005
Definition:	A site from which an organisation, or sub-unit of an organisation, delivers a health/community service.
Context:	Alcohol and other drug treatment services: Required to identify the agency sites that conduct treatment episodes, as distinguished from administration centres. Identification of sites from which health care or community services are delivered facilitates assessment of the accessibility of services to the population.
Specialisation of:	Service provider organisation (Service delivery outlet status)

Collection and usage attributes

Comments:	An organisation may have one or more service delivery outlets. An organisation with a devolved structure for service delivery may or may not devolve all functions to the service delivery outlet level. It is common for administrative functions, including personnel management, to be retained at a higher or central level of an organisation. The service delivery outlet is the lowest level of an organisation at which, or from which, services are delivered. The site from which a service is delivered relates to the physical location of the service and is to be clearly differentiated from the service delivery setting which refers to the type of physical setting in which a service is actually provided to a client (e.g. client's home, non-residential treatment facility etc). For example, where a service provider regularly delivers a service at a variety of clients' homes (e.g. home visits every Monday, Wednesday and Friday) or a mobile service delivers a service to a variety of different locations, then the service delivery outlet should be recorded as the location of the clinic in which the service provider is based. However, where a mobile unit regularly (e.g. every Monday) delivers a service from the same geographical location then this location will be recorded as the service delivery outlet.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs NMDS-WG

Relational attributes

Related metadata references:	Supersedes Service delivery outlet, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.75 KB)
Data Element Concepts implementing this Object Class:	Service delivery outlet—geographic location Health, Standard 01/03/2005

Service provider organisation

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269022
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	An organisation that provides services and/or care.
Specialisation of:	Service/care provider (Organisation status)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Service provider organisation (address)—address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—address type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—Australian postcode Health, Standard 04/05/2005 Community services, Standard 31/08/2005
	Service provider organisation (address)—building/complex sub-unit identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—building/complex sub-unit type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—building/property name Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—floor/level identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—floor/level type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—house/property identifier Health, Standard 04/05/2005
	Service provider organisation (address)—international postcode Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Service provider organisation (address)—lot/section identifier Health, Standard 04/05/2005

Service provider organisation (address)—non-Australian state/province Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation (address)—postal delivery point identifier Health, Standard 04/05/2005
Community services, Standard 31/08/2005

Service provider organisation (address)—street name Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation (address)—street suffix Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation (address)—street type Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation (address)—suburb/town/locality name Health, Standard 04/05/2005
Community services, Standard 31/08/2005

Service provider organisation (name)—name type Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation (name)—organisation name Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation—Australian state/territory identifier Health, Standard 04/05/2005
Community services, Standard 07/12/2005

Service provider organisation—coordinator of volunteers indicator Health, Standard 05/12/2007

Service provider organisation—feedback collection indicator Health, Standard 05/12/2007

Service provider organisation—feedback collection method Health, Standard 05/12/2007

Service provider organisation—level of service delivery Health, Standard 05/12/2007

Service provider organisation—most common service delivery setting Health, Standard 05/12/2007

Service provider organisation—organisation end date Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation—organisation start date Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Service provider organisation—partner organisation type Health, Standard 05/12/2007

Service provider organisation—service delivery setting Health, Standard 05/12/2007
Community services, Standard 29/04/2006

Service provider organisation—standards assessment indicator Health, Standard 05/12/2007

Service provider organisation—standards assessment level Health, Standard 05/12/2007

Service provider organisation—standards assessment method Health, Standard 05/12/2007

Service provider organisation—working partnership indicator

Specialised mental health service

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268984
Registration status:	Health, Standard 01/03/2005
Definition:	Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.
Context:	Hospitals and community mental health establishments and residential mental health establishments.
Specialisation of:	Health service provider (Specialised mental health service status)

Collection and usage attributes

Guide for use:	The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget. A service is not defined as a specialised mental health service solely because its clients include people affected by a mental disorder or psychiatric disability. The definition excludes specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability. These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc.).

Relational attributes

Data Element Concepts implementing this Object Class:	Specialised mental health service—admitted patient care program type Health, Standard 08/12/2004 Specialised mental health service—co-location with acute care hospital Health, Standard 08/12/2004 Specialised mental health service—number of hours staffed Health, Standard 08/12/2004 Specialised mental health service—number of supported public housing places Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (academic positions) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (education and training) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (insurance) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (mental health promotion) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (mental health research) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (other

indirect expenditure) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (patient transport services) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (program administration) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (property leasing costs) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (superannuation) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (support services) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (workers compensation) Health, Standard 08/12/2004

Specialised mental health service—service setting Health, Standard 01/03/2005

Specialised mental health service—specialised mental health service target population group Health, Standard 08/12/2004

Specialised mental health service organisation

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	286449
Registration status:	Health, Standard 08/12/2004
Definition:	A separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised mental health care.
Context:	Specialised mental health services.

Collection and usage attributes

Guide for use:

A specialised mental health service organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings. For example, a specialised mental health service organisation may consist of several hospitals or two or more community centres.

Where the specialised mental health service organisation consists of multiple service units, those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and
- share clinical records or, in the case where is more than one physical clinical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

For most states and territories, the Specialised mental health service organisation object class is equivalent to the Area/District Mental Health Service. These are usually organised to provide the full range of admitted patient, residential and ambulatory services to a given catchment population. However, the object class may also be used to refer to health care organisations which provide only one type of mental health service (e.g. acute admitted patient care) or which serve a specialised or state-wide function.

Source and reference attributes

Origin:

Department of Health and Ageing 2003. Mental Health National Outcomes and Casemix Collection. Technical specification of State and Territory reporting requirements for the outcomes and casemix components of 'Agreed Data', Version 1.50. Canberra: Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Object Class:

Specialised mental health service organisation—accommodation services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—advocacy services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation

arrangements status (carer consultants employed) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (formal participation policy) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (regular discussion groups) Health, Standard 08/12/2004

Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—consumer committee representation arrangements Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (formal participation policy) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (regular discussion groups) Health, Standard 08/12/2004

Specialised mental health service organisation—counselling services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—independent living skills support services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations Health, Standard 07/12/2005

Specialised mental health service organisation—other and unspecified services grants to non-government organisations Health, Superseded 07/12/2005

Specialised mental health service organisation—pre-vocational training services grants for non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—psychosocial support services grants for non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—recreation services grants to non-government organisations Health, Standard

08/12/2004

Specialised mental health service organisation—recurrent expenditure (residual mental health) Health, Standard 08/12/2004

Specialised mental health service organisation—respite services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—self-help support groups services grants for non-government organisations Health, Standard 08/12/2004

Specialised mental health service unit

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	287787
Registration status:	Health, Standard 08/12/2004
Definition:	A specialised mental health service unit.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Specialised mental health service unit—implementation of National standards for mental health services status Health, Standard 08/12/2004

State or Territory Government

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	301333
Registration status:	Health, Standard 07/12/2005 Community services, Standard 30/11/2007
Definition:	A separately constituted legal entity established by political processes which have legislative, judicial or executive authority over a specific state or territory and is responsible for the governance, administration and financial management of that state or territory.

Source and reference attributes

Reference documents:	Australian Bureau of Statistics 2002. Standard Economic Sector Classifications of Australia (SESCA). ABS Cat No. 1218.0. Canberra: ABS.

Relational attributes

Data Element Concepts implementing this Object Class:	State or Territory Government—mental health services grants to non-government organisations by non-health departments Health, Standard 07/12/2005

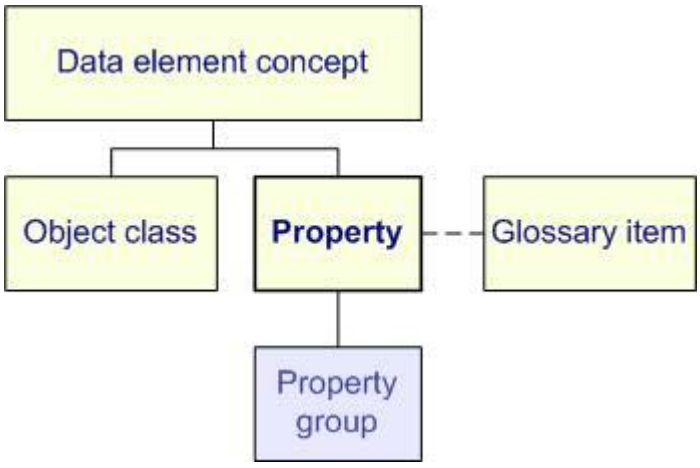
Properties

A property is a characteristic of an object class of interest. For example, the object class Person can have characteristics such as sex and date of birth. These characteristics are referred to as properties.

The union of a specific property with a specific object class creates a data element concept. The above mentioned examples create the data element concepts Person—sex and Person—date of birth.

Properties are assigned property groups which group similar properties such as Lifestyle characteristics and Financial characteristics. These property groups assist users in browsing and locating relevant properties.

Below is a graphical representation of the relationship between properties and related metadata item types.



Accommodation services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286596
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of accommodation services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—accommodation services grants to non-government organisations Health, Standard 08/12/2004

Accommodation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269143
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of accommodation.
Property group:	Accommodation/living characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—accommodation type Health, Standard 01/03/2005

Accrued mental health care days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286766
Registration status:	Health, Standard 08/12/2004
Definition:	Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—accrued mental health care days Health, Standard 08/12/2004

Accuracy indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	294414
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The level of detail to which recorded information is correct.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Date—accuracy indicator Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Activity and participation life area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	324432
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	Life areas in which individuals may participate or undertake activities.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—activity and participation life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Activity type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269042
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of activity.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Injury event—activity type Health, Standard 01/03/2005

Acute coronary syndrome concurrent clinical condition

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284875
Registration status:	Health, Standard 04/06/2004
Definition:	Concurrent medical conditions, which are pertinent to the risk stratification and treatment of acute coronary syndrome.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—acute coronary syndrome concurrent clinical condition Health, Standard 04/06/2004

Acute coronary syndrome procedure type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284640
Registration status:	Health, Standard 04/06/2004
Definition:	The type of procedure performed for the treatment of acute coronary syndrome.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—acute coronary syndrome procedure type Health, Standard 04/06/2004

Acute coronary syndrome risk stratum

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284646
Registration status:	Health, Standard 04/06/2004
Definition:	Risk stratum of clinical features consistent with an acute coronary syndrome.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—acute coronary syndrome risk stratum Health, Standard 04/06/2004

Additional diagnosis

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269371
Registration status:	Health, Standard 01/03/2005
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during a service event or episode.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—additional diagnosis Health, Standard 01/03/2005

Address line

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	292741
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A composite of one or more standard address components that describes a low level of geographical/physical description of a location.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Health address line Health, Superseded 04/05/2005
Data Element Concepts implementing this Property:	Person (address)—address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Address type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269037
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	A descriptor of the class of a geographical/physical location.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—address type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—address type Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Admission date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269247
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which an episode of admitted patient care commences.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—admission date Health, Standard 01/03/2005

Admission mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269028
Registration status:	Health, Standard 01/03/2005
Definition:	The method by which an episode of admitted patient care commences.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—admission mode Health, Standard 01/03/2005

Admission time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269046
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which an episode of admitted patient care commences
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—admission time Health, Standard 01/03/2005

Admission urgency status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269032
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the urgency status assigned to an **admission**.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—admission urgency status Health, Standard 01/03/2005

Admitted patient care program type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288881
Registration status:	Health, Standard 08/12/2004
Definition:	The type of admitted patient care program.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—admitted patient care program type Health, Standard 08/12/2004

Advocacy services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286876
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of advocacy services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—advocacy services grants to non-government organisations Health, Standard 08/12/2004

Age

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269152
Registration status:	Health, Standard 04/05/2005 Community services, Standard 04/05/2005 Housing assistance, Standard 01/03/2005
Definition:	The length of life or existence.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Person—age Health, Standard 04/05/2005 Community services, Standard 04/05/2005 Housing assistance, Standard 17/06/2005

Age range

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290491
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/11/2007
Definition:	A chronological grouping of age.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—age range Health, Standard 04/05/2005 Community services, Standard 30/11/2007

Alcohol consumption amount

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Alcohol consumption - concept; Ethanol consumption
METeOR identifier:	269217
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the amount of alcohol consumed.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Australian Alcohol Guidelines: Health Risks and Benefits, NH&MRC, October 2001

Relational attributes

Related metadata references:	Supersedes Alcohol consumption - concept, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.74 KB)
Data Element Concepts implementing this Property:	Person—alcohol consumption amount Health, Standard 01/03/2005

Alcohol consumption frequency

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269363
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of how frequently alcohol is consumed.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—alcohol consumption frequency Health, Standard 01/03/2005

Anaesthesia administered

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269079
Registration status:	Health, Standard 01/03/2005
Definition:	Drug or other medical intervention administered to cause inability to feel pain.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Birth event—anaesthesia administered Health, Superseded 07/12/2005
	Birth event—anaesthesia administered Health, Standard 07/12/2005

Analgesia administered

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269080
Registration status:	Health, Standard 01/03/2005
Definition:	An agent given to alleviate pain without causing loss of consciousness.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Birth event—analgesia administered Health, Superseded 07/12/2005
	Birth event—analgesia administered Health, Standard 07/12/2005

Angiotensin converting enzyme inhibitors therapy status

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	ACE inhibitors therapy status
METeOR identifier:	284728
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of angiotensin converting enzyme (ACE) inhibitors therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—angiotensin converting enzyme inhibitors therapy status Health, Standard 04/06/2004

Anticipated accommodation status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	319942
Registration status:	*No registration status*
Definition:	An indicator of whether a person has nominated to be treated as either a public or private patient. The anticipated accommodation status is not binding on the patient and may vary from the elected accommodation status.
Property group:	Funding characteristics

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—anticipated accommodation status Health, Standard 01/03/2005

Apgar score

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269035
Registration status:	Health, Standard 01/03/2005
Definition:	The score used to evaluate the fitness of a newborn infant, based on heart rate, respiration, muscle tone, cough reflex, and colour.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Birth—Apgar score Health, Superseded 07/12/2005 Birth—Apgar score Health, Standard 07/12/2005

Area of clinical practice

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269350
Registration status:	Health, Standard 01/03/2005
Definition:	A field of clinical activity or area of responsibility.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health professional—area of clinical practice (principal) Health, Standard 01/03/2005

Area of usual residence

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269104
Registration status:	Health, Standard 01/03/2005
Definition:	The geographical region in which a person or group of people usually reside.
Property group:	Location characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—area of usual residence Health, Standard 01/03/2005

Aspirin therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284754
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of aspirin therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—aspirin therapy status Health, Standard 04/06/2004

Australian postcode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269316
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place.
Context:	Postcode is an important part of a postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Standards Australia Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—Australian postcode Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Service provider organisation (address)—Australian postcode Health, Standard 04/05/2005 Community services, Standard 31/08/2005

Australian state/territory identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269056
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	An identifier of the Australian state or territory.
Context:	This is a **geographic indicator** which is used for analysis of the distribution of clients or patients, agencies or establishments and services.
Property group:	Location characteristics

Relational attributes

Data Element Concepts implementing this Property:	Establishment—Australian state/territory identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Jurisdiction—Australian state/territory identifier Health, Standard 05/12/2007 Person—Australian state/territory identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Service provider organisation—Australian state/territory identifier Health, Standard 04/05/2005 Community services, Standard 07/12/2005

Baby resuscitation method

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269026
Registration status:	Health, Standard 01/03/2005
Definition:	The action taken for a baby to revive from apparent death or unconsciousness.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Birth event—baby resuscitation method Health, Standard 01/03/2005

Behaviour-related risk factor intervention

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269285
Registration status:	Health, Standard 01/03/2005
Definition:	The action taken to address a behaviour-related risk factor.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—behaviour-related risk factor intervention Health, Standard 01/03/2005

Behaviour-related risk factor intervention purpose

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269286
Registration status:	Health, Standard 01/03/2005
Definition:	A lifestyle choice related risk factor associated with an intervention.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—behaviour-related risk factor intervention purpose Health, Standard 01/03/2005

Beta-blocker therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284791
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of beta-blocker therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—beta-blocker therapy status Health, Standard 04/06/2004

Birth method

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	337674
Registration status:	Health, Standard 06/09/2006
Definition:	The method of complete expulsion or extraction from its mother of a product of conception.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Delivery method Health, Superseded 06/09/2006
Data Element Concepts implementing this Property:	Birth event—birth method Health, Standard 06/09/2006

Birth order

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269038
Registration status:	Health, Standard 01/03/2005
Definition:	The sequence number in the multiple birth.
Context:	National Minimum Data Set (NMDS) Perinatal: Required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low **birthweight**, and a higher perinatal death rate. Data Set Specification (DSS) - Health care client identification: While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS5017 Health Care Client Identification

Relational attributes

Data Element Concepts implementing this Property:	Birth—birth order Health, Standard 01/03/2005

Birth plurality

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269039
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.
Context:	National Minimum Data Set (NMDS) Perinatal: Multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality. Data Set Specification (DSS) Health Care Client Identification: While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—birth plurality Health, Standard 01/03/2005

Birth presentation

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269062
Registration status:	Health, Standard 01/03/2005
Definition:	Presenting part of the fetus (at lower segment of uterus).
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—birth presentation Health, Standard 06/09/2006 Birth event—birth presentation Health, Superseded 06/09/2006

Birth status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269064
Registration status:	Health, Standard 01/03/2005
Definition:	Status of the baby at birth as an outcome of pregnancy.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth—birth status Health, Standard 01/03/2005

Birth weight

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269347
Registration status:	Health, Standard 01/03/2005
Definition:	The weight of a newborn as recorded at birth.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth—birth weight Health, Standard 01/03/2005

Bleeding episode status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284804
Registration status:	Health, Standard 04/06/2004
Definition:	An episode of bleeding as described by the Thrombolysis In Myocardial Infarction (TIMI) criteria.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—bleeding episode status Health, Standard 04/06/2004

Blindness

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269103
Registration status:	Health, Standard 01/03/2005
Definition:	Blindness is less than 6/60 vision in the better eye with glasses. Vision 6/60 is the ability to see only at 6 metres what the normal eye can see at 60 metres. An indicator of the presence or development of a visual impairment or inability to see.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—blindness Health, Standard 01/03/2005

Blood pressure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269105
Registration status:	Health, Standard 01/03/2005
Definition:	The pressure exerted by blood against the inner walls of the blood vessels
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Person—blood pressure (diastolic) Health, Standard 01/03/2005 Person—blood pressure (systolic) Health, Standard 01/03/2005

Bodily location of main injury

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Site
METeOR identifier:	269098
Registration status:	Health, Standard 01/03/2005
Definition:	The position on the body of the primary injury of concern.
Property group:	Crisis event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—bodily location of main injury Health, Standard 01/03/2005

Body function

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320237
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The physiological or psychological function of body system.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—body function Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Body mass index

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269114
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of body fat that gives an indication of nutritional status. Body mass index is the weight in kilograms divided by the square of the height in meters.
Property group:	Health and wellbeing

Source and reference attributes

Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Adult—body mass index Health, Standard 01/03/2005 Child—body mass index Health, Standard 01/03/2005 Person—body mass index (classification) Health, Standard 01/03/2005

Body structure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320249
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	An anatomical part of the body such as organs, limbs or their components.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Building/complex sub-unit identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269388
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The specification of the number or identifier of a building/complex, marina, etc. to clearly distinguish it from another.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—building/complex sub-unit identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—building/complex sub-unit identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Building/complex sub-unit type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269380
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The specification of the type of a separately identifiable portion within a building/complex, marina, etc. to clearly distinguish it from another.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee
Origin:	Australia Post Address Presentation Standard.

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—building/complex sub-unit type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—building/complex sub-unit type Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Building/property name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269387
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The full name used to identify the physical building or property as part of its location.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—building/property name Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—building/property name Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Caesarean section indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	302129
Registration status:	Health, Standard 29/11/2006
Definition:	Pregnancy resulting in a live birth or a stillbirth.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Data Element Concepts implementing this Property:	Female—caesarean section indicator Health, Standard 29/11/2006

Cancer staging scheme source

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	296984
Registration status:	Health, Standard 04/06/2004
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	UICC TNM Classification of Malignant Tumours (5th Edition) (1997)

Relational attributes

Data Element Concepts implementing this Property:	Cancer staging—cancer staging scheme source Health, Standard 04/06/2004

Cancer staging scheme source edition number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	297000
Registration status:	Health, Standard 04/06/2004
Definition:	The edition number of the reference used for the purposes of staging a cancer.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Cancer staging—cancer staging scheme source edition number Health, Standard 04/06/2004

Cancer treatment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288143
Registration status:	Health, Standard 04/06/2004
Definition:	The type of cancer treatment provided.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—cancer treatment type Health, Standard 04/06/2004

Cardiovascular disease condition targeted by drug therapy

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269329
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the cardiovascular disease condition for which a drug therapy is being used.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cardiovascular disease condition targeted by drug therapy Health, Standard 01/03/2005

Cardiovascular medication taken

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269391
Registration status:	Health, Standard 01/03/2005
Definition:	Medication taken for a cardiovascular condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cardiovascular medication taken Health, Standard 01/03/2005

Care type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269177
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the overall nature of a service provided.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Hospital service—care type Health, Standard 01/03/2005

Carer participation arrangements

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288821
Registration status:	Health, Standard 08/12/2004
Definition:	Mechanisms in place to promote the participation of mental health carers in the planning, delivery and evaluation of a service.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed) Health, Standard 08/12/2004
	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys) Health, Standard 08/12/2004
	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism) Health, Standard 08/12/2004
	Specialised mental health service organisation—carer participation arrangements status (formal participation policy) Health, Standard 08/12/2004
	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups) Health, Standard 08/12/2004

Cataract status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269230
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of previous experience with cataracts.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cataract status Health, Standard 01/03/2005

Category reassignment date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269115
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a clinical urgency category or patient listing status category is reassigned.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective care waiting list episode—category reassignment date Health, Standard 01/03/2005

Census date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269364
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a population is officially enumerated and characterised.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Hospital census (of elective surgery waitlist patients)—census date Health, Standard 01/03/2005

Cerebral stroke due to vascular disease

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269298
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of previous experience of a cerebral stroke due to vascular disease and the recency of the stroke.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cerebral stroke due to vascular disease Health, Standard 01/03/2005

Cessation reason

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269077
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for ending an event or process.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—cessation reason Health, Standard 01/03/2005

Chest pain pattern

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284815
Registration status:	Health, Standard 04/06/2004
Definition:	Identification of the frequency and severity of chest pain of myocardial ischaemic origin.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—chest pain pattern Health, Standard 04/06/2004

Cholesterol level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269323
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of cholesterol in the blood, usually indicated by a number within a range going from low to high, these numbers being correlated with the risk of coronary heart disease.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd.

Relational attributes

Data Element Concepts implementing this Property:	Person—cholesterol level Health, Standard 01/03/2005

Client type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269128
Registration status:	Health, Standard 01/03/2005
Definition:	Whether treatment is focused on the client's conditions and problems or on those of another person.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—client type Health, Standard 01/03/2005

Clinical evidence status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285279
Registration status:	Health, Standard 04/06/2004
Definition:	Indicator of the status of evidence of a pre-existing clinical condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Acute Coronary Syndrome Data Working Group

Relational attributes

Data Element Concepts implementing this Property:	Person—clinical evidence status (chronic lung disease) Health, Standard 04/06/2004 Person—clinical evidence status (heart failure) Health, Standard 13/06/2004 Person—clinical evidence status (peripheral arterial disease) Health, Standard 13/06/2004 Person—clinical evidence status (sleep apnoea syndrome) Health, Standard 13/06/2004 Person—clinical evidence status (stroke) Health, Standard 13/06/2004

Clinical procedure timing

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284841
Registration status:	Health, Standard 04/06/2004
Definition:	Identifies when a clinical procedure was performed.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—clinical procedure timing Health, Standard 04/06/2004

Clinical urgency

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269075
Registration status:	Health, Standard 01/03/2005
Definition:	A clinical assessment of the urgency with which care, treatment or assistance is required.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—clinical urgency Health, Standard 01/03/2005

Clopidogrel therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284865
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of clopidogrel therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—clopidogrel therapy status Health, Standard 04/06/2004

Co-location with acute care hospital

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286929
Registration status:	Health, Standard 08/12/2004
Definition:	The co-location of a service with an acute care hospital.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—co-location with acute care hospital Health, Standard 08/12/2004

Community awareness/health promotion services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287005
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of community awareness/health promotion services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations Health, Standard 08/12/2004

Compensable status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269123
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of an entitlement for compensation.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—compensable status Health, Standard 01/03/2005

Complication

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269096
Registration status:	Health, Standard 01/03/2005
Definition:	A disease or disorder concurrent with another disease, disorder or condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Birth event—complication Health, Standard 01/03/2005 Birth event—complication (postpartum) Health, Standard 01/03/2005 Pregnancy (current)—complication Health, Standard 01/03/2005

Condition onset flag

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	354805
Registration status:	Health, Standard 05/02/2008
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Diagnosis onset type Health, Superseded 05/02/2008
Data Element Concepts implementing this Property:	Episode of admitted patient care—condition onset flag Health, Standard 05/02/2008

Congenital malformation

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269324
Registration status:	Health, Standard 01/03/2005
Definition:	An anomaly that is present at birth.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—congenital malformation Health, Standard 01/03/2005

Consumer committee representation arrangements

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288847
Registration status:	Health, Standard 08/12/2004
Definition:	An indicator of the extent of formal committee mechanisms in place to promote the participation of mental health consumers.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare.

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—consumer committee representation arrangements Health, Standard 08/12/2004

Consumer participation arrangements

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288859
Registration status:	Health, Standard 08/12/2004
Definition:	An indicator of whether mechanisms are in place to promote the participation of mental health consumers.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed) Health, Standard 08/12/2004
	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys) Health, Standard 08/12/2004
	Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism) Health, Standard 08/12/2004
	Specialised mental health service organisation—consumer participation arrangements (formal participation policy) Health, Standard 08/12/2004
	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups) Health, Standard 08/12/2004

Contract role

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269131
Registration status:	Health, Standard 01/03/2005
Definition:	The assigned responsibility under a contractual arrangement.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Hospital—contract role Health, Standard 01/03/2005

Contract type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269174
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of a contractual agreement.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Hospital—contract type Health, Standard 01/03/2005

Contracted care commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269263
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care commenced.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Contracted hospital care—contracted care commencement date Health, Standard 01/03/2005

Contracted care completed date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269102
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care is completed.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Contracted hospital care—contracted care completed date Health, Standard 01/03/2005

Contracted procedure flag

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269345
Registration status:	Health, Standard 01/03/2005
Definition:	Indicator that a procedure was performed as a contracted service.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care (procedure)—contracted procedure flag Health, Standard 01/03/2005

Coordinator of volunteers indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352858
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether a person is designated to coordinate the volunteer labour force.
Property group:	Organisational characteristics

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—coordinator of volunteers indicator Health, Standard 05/12/2007

Coronary artery disease intervention

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269207
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether treatment has been received for a coronary artery condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—coronary artery disease intervention Health, Standard 01/03/2005

Counselling services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287013
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of counselling services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—counselling services grants to non-government organisations Health, Standard 08/12/2004

Country identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288063
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The country component of an address.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—country identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Country of birth

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269206
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	The country in which an individual was born.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—country of birth Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 27/07/2005

Creatine kinase myocardial band isoenzyme measured date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284969
Registration status:	Health, Standard 04/06/2004
Definition:	The date creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—creatine kinase myocardial band isoenzyme measured date Health, Standard 04/06/2004

Creatine kinase myocardial band isoenzyme measured time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285175
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which the creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Data Element Concepts implementing this Property:	Person—creatine kinase myocardial band isoenzyme measured time Health, Standard 04/06/2004

Creatine kinase-myocardial band isoenzyme level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284893
Registration status:	Health, Standard 04/06/2004
Definition:	The level of creatine kinase-myocardial band (CK-MB) isoenzyme.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—creatine kinase-myocardial band isoenzyme level Health, Standard 04/06/2004

Creatinine serum level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269319
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of creatinine in the blood.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—creatinine serum level Health, Standard 01/03/2005

Date of birth

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269318
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	The date on which an individual was born.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—date of birth Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 27/07/2005

Date of change to qualification status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269082
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a **newborn qualification status** changes.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care (newborn)—date of change to qualification status Health, Standard 01/03/2005

Date of death

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287292
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	Date on which an individual died.
Context:	
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—date of death Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Degree of spread of a cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269182
Registration status:	Health, Standard 01/03/2005
Definition:	The progression/extent of a cancer measured at a particular point in time.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—degree of spread of a cancer Health, Standard 01/03/2005

Dependency in activities of daily living

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269342
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the extent to which help is required for tasks of everyday life.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—dependency in activities of daily living Health, Standard 01/03/2005

Depreciation expenses

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	360155
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting of consumption of fixed capital (depreciation).
Property group:	Financial characteristics

Relational attributes

Data Element Concepts implementing this Property:	Organisation—depreciation expenses Health, Standard 05/12/2007

Diabetes mellitus status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269209
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a risk of developing diabetes mellitus or a diagnosis of diabetes mellitus.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—diabetes mellitus status Health, Standard 01/03/2005

Diabetes therapy type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269378
Registration status:	Health, Standard 01/03/2005
Definition:	The class of treatment received for diabetes.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National diabetes data working group

Relational attributes

Data Element Concepts implementing this Property:	Person—diabetes therapy type Health, Standard 01/03/2005

Diagnosis date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269392
Registration status:	Health, Standard 01/03/2005
Definition:	The date a disease or condition is diagnosed.
Context:	Health services and clinical setting: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities and conditions.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—diagnosis date Health, Standard 01/03/2005

Diagnosis related group

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269188
Registration status:	Health, Standard 01/03/2005
Definition:	A resource utilisation classification based on diagnosed conditions, usage of hospital resources, and demographic characteristics of the patient.
Context:	The development of Australian refined diagnosis related groups has created a descriptive framework for studying hospitalisation. Diagnosis related groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—diagnosis related group Health, Standard 01/03/2005

Distant metastasis status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	293228
Registration status:	Health, Standard 13/06/2004
Definition:	The absence or presence of distant metastasis.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—distant metastasis status Health, Standard 13/06/2004

Drug of concern

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269127
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the psychoactive substance that is of concern.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—drug of concern Health, Standard 01/03/2005
	Episode of treatment for alcohol and other drugs—drug of concern (principal) Health, Superseded 13/10/2005

Dyslipidaemia treatment with anti-lipid medication indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304483
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of the receipt of treatment for abnormal lipid levels using anti-lipid medication.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Dyslipidaemia treatment status Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—dyslipidaemia treatment with anti-lipid medication indicator Health, Standard 21/09/2005

Elective care type

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Waiting list category
METeOR identifier:	269040
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of elective hospital care.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Elective care waiting list episode—elective care type Health, Standard 01/03/2005

Electrocardiogram change location

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	ECG change location
METeOR identifier:	285065
Registration status:	Health, Standard 04/06/2004
Definition:	The area in which the change is located on a 12-lead electrocardiogram (ECG).
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—electrocardiogram change location Health, Standard 04/06/2004

Electrocardiogram change type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285301
Registration status:	Health, Standard 04/06/2004
Definition:	The type of change to the heart rhythm as seen on an electrocardiogram (ECG).
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—electrocardiogram change type Health, Standard 04/06/2004

Electronic communication address

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287451
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The characters used for the purpose of communication by electronic means.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Electronic communication medium

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287501
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of mechanism used for electronic communication.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Electronic communication usage code

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287523
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The manner of use of an electronic communication address.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—electronic communication usage code Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Eligibility status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304551
Registration status:	Health, Standard 05/01/2006 Community services, Standard 04/01/2006
Definition:	An indicator of eligibility for services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—eligibility status Health, Standard 04/01/2006 Community services, Standard 04/01/2006

Employee related expenses

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	360140
Registration status:	Health, Standard 05/12/2007
Definition:	The expenditure incurred for wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts.
Property group:	Financial characteristics

Relational attributes

Data Element Concepts implementing this Property:	Organisation—employee related expenses Health, Standard 05/12/2007

End-stage renal disease status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269307
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the development of end-stage renal disease.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—end-stage renal disease status Health, Standard 01/03/2005

Environmental factor

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320223
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	Environmental factors make up the physical, social and attitudinal environment in which individuals live and conduct their lives.
Property group:	Environmental characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—environmental factor Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Episode end date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269252
Registration status:	Health, Standard 01/03/2005 Community services, Standard 16/05/2006
Definition:	The date on which an episode is completed.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—episode end date Health, Standard 01/03/2005 Non-admitted patient emergency department service episode—episode end date Health, Standard 24/03/2006

Episode end mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269144
Registration status:	Health, Standard 01/03/2005
Definition:	The method by which an episode ends.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—episode end mode Health, Standard 01/03/2005

Episode end status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	322637
Registration status:	Health, Standard 24/03/2006
Definition:	The status of the patient at the end of the episode of care or service episode.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Patient departure status Health, Superseded 24/03/2006
Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—episode end status Health, Standard 24/03/2006

Episode end time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	322612
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which an episode is completed.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing.

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—episode end time Health, Standard 24/03/2006

Episode start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269253
Registration status:	Health, Standard 01/03/2005 Community services, Standard 16/05/2006
Definition:	The date on which an episode commenced.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—episode start date Health, Standard 01/03/2005 Residential stay—episode start date Health, Standard 01/03/2005

Episode start mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269106
Registration status:	Health, Standard 01/03/2005
Definition:	The method by which an episode begins.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—episode start mode Health, Standard 01/03/2005

Erectile dysfunction

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Impotence
METeOR identifier:	269149
Registration status:	Health, Standard 01/03/2005
Definition:	The inability to achieve or maintain an erection of sufficient rigidity to perform sexual intercourse successfully.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (male)—erectile dysfunction Health, Standard 01/03/2005

Establishment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269027
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of establishment.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—establishment type Health, Standard 01/03/2005 Health professional—establishment type (employment) Health, Standard 01/03/2005

Estimated gestational age

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269025
Registration status:	Health, Standard 01/03/2005
Definition:	The period of development of the fetus from the time of fertilisation until birth.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National perinatal data development committee

Relational attributes

Data Element Concepts implementing this Property:	Female (pregnant)—estimated gestational age Health, Standard 01/03/2005

Expenses

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356286
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses consisting mainly of wages, salaries and supplements, purchases of goods and services and consumption of fixed capital (depreciation).
Property group:	Financial characteristics

Collection and usage attributes

Collection methods:	Data are collected and nationally collated for the reporting period—the financial year ending in 30 June each year.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee
Reference documents:	Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS. Australian Accounting Standards Board 1049, September 2006, <www.asb.com.au>.

Relational attributes

Data Element Concepts implementing this Property:	Organisation—expenses Health, Standard 05/12/2007

Extended wait patient indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269074
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a patient who has experienced a prolonged wait for care.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—extended wait patient indicator Health, Standard 01/03/2005

Extent of environmental factor influence

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320232
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree to which specified environmental factors influence functioning and disability.
Property group:	Environmental characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of environmental factor influence Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Extent of impairment of body function

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320240
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree of impairment in a specified body function.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of impairment of body function Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Extent of impairment of body structure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320252
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree of impairment in a specified body structure.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of impairment of body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Extent of participation in a life area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	324449
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree of participation in a life area.
Property group:	Lifestyle characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of participation in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Extent of primary cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	296911
Registration status:	Health, Standard 04/06/2004
Definition:	Degree of spread of the primary cancer.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—extent of primary cancer Health, Standard 04/06/2004

External cause

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269034
Registration status:	Health, Standard 01/03/2005
Definition:	The circumstances in which an injury, poisoning or other adverse effect has occurred.
Property group:	Crisis event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2002) National Centre for Classification in Health, Sydney

Relational attributes

Data Element Concepts implementing this Property:	Injury event—external cause Health, Standard 01/03/2005

Family name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269355
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	A designation for a family.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—family name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 28/07/2005

Fasting indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269148
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of abstinence from all food and drink except water.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders.

Relational attributes

Data Element Concepts implementing this Property:	Health service event—fasting indicator Health, Standard 01/03/2005

Feedback collection indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290389
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether feedback relating to services and service delivery is actively and routinely collected.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—feedback collection indicator Health, Standard 05/12/2007

Feedback collection method

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356484
Registration status:	Health, Standard 05/12/2007
Definition:	The method employed to actively and routinely collect feedback.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—feedback collection method Health, Standard 05/12/2007

Fibrinolytic drug administered

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285073
Registration status:	Health, Standard 04/06/2004
Definition:	The type of fibrinolytic drug therapy used.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—fibrinolytic drug administered Health, Standard 04/06/2004

Fibrinolytic therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285081
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of fibrinolytic therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—fibrinolytic therapy status Health, Standard 04/06/2004

First angioplasty balloon inflation or stenting date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284975
Registration status:	Health, Standard 04/06/2004
Definition:	The date of the first angioplasty balloon inflation or stent placement.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—first angioplasty balloon inflation or stenting date Health, Standard 04/06/2004

First angioplasty balloon inflation or stenting time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285181
Registration status:	Health, Standard 04/06/2004
Definition:	The time of the first angioplasty balloon inflation or stent placement.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Data Element Concepts implementing this Property:	Person—first angioplasty balloon inflation or stenting time Health, Standard 04/06/2004

First contact date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269337
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which first contact between a service provider and a patient/client occurred.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—first contact date Health, Standard 01/03/2005

First day of the last menstrual period

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269086
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the first day of the last menstrual period (LMP).
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Pregnancy—first day of the last menstrual period Health, Standard 01/03/2005

First service delivery date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269359
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which service is delivered for the first time.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—first service delivery date (community setting) Health, Standard 01/03/2005

Floor/level identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269053
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	Descriptor used to identify the floor or level of a multi-storey building/complex.
Context:	Australian addresses
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—floor/level identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—floor/level identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Floor/level type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269379
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	Descriptor used to classify the type of floor or level of a multi-storey building/complex.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—floor/level type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—floor/level type Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Foot deformity indicator

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Foot malformation
METeOR identifier:	269160
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of a distortion of the normal shape or size of either foot.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	United States National Library of Medicine 2004. Medical Subject Headings (MESH) Browser. National Library of Medicine, Maryland. Viewed 21 June 2004,

Relational attributes

Data Element Concepts implementing this Property:	Person—foot deformity indicator Health, Standard 01/03/2005

Foot lesion indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269162
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of a foot lesion other than an ulcer on either foot.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—foot lesion indicator Health, Standard 01/03/2005

Foot ulcer indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269163
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of a lesion on the surface of the skin of either foot, produced by the sloughing of inflammatory necrotic tissue.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders United States National Library of Medicine 2004. Medical Subject Headings (MESH) Browser. National Library of Medicine, Maryland. Viewed 21 June 2004,

Relational attributes

Data Element Concepts implementing this Property:	Person—foot ulcer indicator Health, Standard 21/09/2005 Person—foot ulcer status (current) Health, Superseded 21/09/2005

Formal community support access indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269170
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the receipt of community-based assistance from paid workers or volunteers organised by formal services (including paid staff in funded group houses).
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—formal community support access indicator Health, Standard 01/03/2005

Full-time equivalent staff

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269172
Registration status:	Health, Standard 13/05/2005 Community services, Standard 01/03/2005
Definition:	Hours actually worked divided by the number of normal hours worked by a full-time staff member.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—full-time equivalent staff (paid) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (trainee/pupil

nurses) Health, Standard 01/03/2005

Functional stress test element

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285091
Registration status:	Health, Standard 04/06/2004
Definition:	The element included in an electrocardiogram stress test.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—functional stress test element Health, Standard 04/06/2004

Functional stress test ischaemic result

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285099
Registration status:	Health, Standard 04/06/2004
Definition:	The result of an electrocardiogram stress test in terms of ischaemic outcome.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—functional stress test ischaemic result Health, Standard 04/06/2004

Funding eligibility indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269120
Registration status:	Health, Standard 01/03/2005
Definition:	Whether eligible services are actually funded.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—funding eligibility indicator Health, Standard 01/03/2005

Geographic location

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269234
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Retired 10/02/2006
Definition:	A description of physical location.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—geographic location Health, Standard 01/03/2005 Service delivery outlet—geographic location Health, Standard 01/03/2005

Given name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269222
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	A designation for an individual within the family group or by which the individual is socially identified.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—given name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005

Given name sequence number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287587
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	An order of given name or initials.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—given name sequence number Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Glycoprotein IIb/IIIa receptor antagonist therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285107
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of glycoprotein IIb/IIIa receptor antagonist therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—glycoprotein IIb/IIIa receptor antagonist status Health, Standard 04/06/2004

Glycosylated haemoglobin level

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	HbA1c
METeOR identifier:	269273
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of blood glucose.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—glycosylated haemoglobin level Health, Standard 01/03/2005

Goal of care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269203
Registration status:	Health, Standard 01/03/2005
Definition:	The expected outcome of planned care.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—goal of care Health, Standard 01/03/2005

Government funding identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269238
Registration status:	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
Definition:	An identifier allocated by a government department for the purpose of identifying those eligible for specific services.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—government funding identifier Health, Standard 01/03/2005 Community services, Standard 31/08/2007

Gross capital expenditure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269024
Registration status:	Health, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
Definition:	Expenditure on the acquisition or enhancement of a **non-financial asset**.
Property group:	Financial characteristics

Collection and usage attributes

Guide for use:	National health data dictionary specific: Gross capital expenditure is capital expenditure as reported by the particular establishment having regard to state health authority and other authoritative guidelines as to the differentiation between capital and recurrent expenditure. (A concise indication of the basis on which capital and recurrent expenditure have been differentiated is to form part of national minimum data sets). National housing assistance data dictionary specific: Expenditure on the acquisition or enhancement of an asset (excluding financial assets). A non-financial asset is an entity functioning as a store of value, over which ownership may be derived over a period of time, and which is not a financial asset. Capital includes: acquisitions (purchase of properties); construction costs; redevelopment and improvement (of properties); land acquisitions and development; joint ventures.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:	Establishment—gross capital expenditure (accrual accounting) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005 Establishment—gross capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment—gross capital expenditure (computer equipment/installations) Health, Standard 01/03/2005

Establishment—gross capital expenditure (intangible assets) Health, Standard 01/03/2005

Establishment—gross capital expenditure (land and buildings) Health, Standard 01/03/2005

Establishment—gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (other capital expenditure) Health, Standard 01/03/2005

Establishment—gross capital expenditure (plant and other equipment) Health, Standard 01/03/2005

Gross income

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269270
Registration status:	Housing assistance, Standard 01/03/2005
Definition:	The total income before business and tax deductions are accounted for.
Property group:	Financial characteristics

Source and reference attributes

Origin:	Australian taxation office 2004. Definitions. Australian taxation office, Canberra. Viewed 22 October 2004

Relational attributes

Data Element Concepts implementing this Property:	Household—gross income Health, Standard 15/12/2005 Housing assistance, Retired 10/02/2006

Group session status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	294406
Registration status:	Health, Standard 17/05/2005
Definition:	An indicator of services, care or assistance simultaneously being provided to more than one person.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Service contact—group session status Health, Standard 04/05/2005

Health professionals attended for diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269315
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of health professional that has been consulted for diabetes mellitus.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—health professionals attended for diabetes mellitus Health, Standard 01/03/2005

Heart rate

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285117
Registration status:	Health, Standard 04/06/2004
Definition:	The number of heart beats per unit time, usually expressed as beats per minute.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—heart rate Health, Standard 04/06/2004

Heart rhythm type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285127
Registration status:	Health, Standard 04/06/2004
Definition:	The rhythm of a beating heart.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—heart rhythm type Health, Standard 04/06/2004

Height

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Stature
METeOR identifier:	269299
Registration status:	Health, Standard 01/03/2005
Definition:	The standing height or recumbent length of a body.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—height Health, Standard 01/03/2005

High-density lipoprotein cholesterol level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	310764
Registration status:	Health, Standard 27/10/2005
Definition:	The level of the serum cholesterol carried on high-density lipoproteins, approximately 20 to 30 percent of the total serum cholesterol.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Person—high-density lipoprotein cholesterol level Health, Standard 01/03/2005

Hip circumference

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269302
Registration status:	Health, Standard 01/03/2005
Definition:	The distance around the human body at the level of maximum posterior extension of the buttocks.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—hip circumference Health, Standard 01/03/2005

Histopathological grade

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288655
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of how a tumour resembles the normal tissue from which it arose.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—histopathological grade Health, Standard 04/06/2004

Hospital insurance status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269219
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of private insurance cover for hospital expenses.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—hospital insurance status Health, Standard 01/03/2005

Hours on-call

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269154
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of time devoted to being available to provide advice, respond to any emergencies etc. over a specified period.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical practitioner—hours on-call Health, Standard 01/03/2005

Hours worked

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269066
Registration status:	Community services, Standard 01/03/2005
Definition:	The amount of time devoted to a work activity over a specified period.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health professional—hours worked Health, Standard 01/03/2005 Medical practitioner—hours worked Health, Standard 01/03/2005

House/property identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269386
Registration status:	Health, Standard 01/03/2005
Definition:	The numeric or alphanumeric reference number of a house or property that is unique within a street name.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—house/property identifier Health, Standard 01/03/2005 Service provider organisation (address)—house/property identifier Health, Standard 04/05/2005

Human intent of injury

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313828
Registration status:	*No registration status*
Definition:	The human intent of an injury.

Relational attributes

Data Element Concepts implementing this Property:	Injury event—human intent of injury Health, Standard 24/11/2005

Hypertension treatment with antihypertensive medication indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304493
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of receipt of therapy for hypertension using antihypertensive medication.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National diabetes data working group

Relational attributes

Related metadata references:	Supersedes Hypertension treatment status Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Identifier type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269094
Registration status:	Health, Standard 01/03/2005
Definition:	The class of identifier based on the extent to which it applies across geographic or administrative boundaries.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (identifier)—identifier type Health, Standard 01/03/2005

Implementation of National standards for mental health services status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287789
Registration status:	Health, Standard 08/12/2004
Definition:	Indicator of National standards for mental health services implementation.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service unit—implementation of National standards for mental health services status Health, Standard 08/12/2004

Independent living skills support services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287744
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of independent living skills support.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations Health, Standard 08/12/2004

Indicator procedure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269365
Registration status:	Health, Standard 01/03/2005
Definition:	The type of procedure that is high volume and often associated with long waiting periods.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—indicator procedure Health, Standard 01/03/2005

Indigenous status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269161
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	An indicator of identification as an Aboriginal and/or Torres Strait Islander.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—Indigenous status Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005

Informal carer existence indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313244
Registration status:	Health, Standard 04/07/2007 Community services, Standard 02/05/2006
Definition:	An indicator of whether or not an informal carer exists.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Carer availability status Health, Superseded 04/07/2007, Community services, Superseded 02/05/2006
Data Element Concepts implementing this Property:	Person—informal carer existence indicator Health, Standard 04/07/2007 Community services, Standard 02/05/2006

Initial visit since diagnosis indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	303970
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of whether a visit to a health professional in relation to a specific condition is the first visit since diagnosis.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Initial visit since diagnosis Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Patient—initial visit since diagnosis indicator (diabetes mellitus) Health, Standard 21/09/2005

Injecting drug use status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269129
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the administration of psychoactive substances by injection.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Client—injecting drug use status Health, Standard 01/03/2005

Insulin start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269048
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which insulin injections commenced.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—insulin start date Health, Standard 01/03/2005

Intended length of hospital stay

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269327
Registration status:	Health, Standard 01/03/2005
Definition:	The expected duration of a stay in hospital.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005

Intention of treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288666
Registration status:	Health, Standard 04/06/2004
Definition:	Reason for which treatment is provided for a particular condition.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—intention of treatment Health, Standard 04/06/2004

Inter-hospital contracted patient status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269338
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator identifying a patient as being treated as part of a contracted hospital care agreement.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—inter-hospital contracted patient status Health, Standard 01/03/2005

International postcode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288969
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A descriptor for a postal delivery area, aligned with locality, suburb or place.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—international postcode Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—international postcode Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Interpreter service required status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269289
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Retired 10/02/2006
Definition:	An indicator of a need for a translation service.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—interpreter service required Health, Standard 08/02/2006 Community services, Standard 10/04/2006 Person—interpreter service required status (health) Health, Superseded 08/02/2006

Intravenous fibrinolytic therapy date

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	IV fibrinolytic therapy
METeOR identifier:	284981
Registration status:	Health, Standard 04/06/2004
Definition:	The date of intravenous (IV) fibrinolytic therapy.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—intravenous fibrinolytic therapy date Health, Standard 04/06/2004

Intravenous fibrinolytic therapy time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285193
Registration status:	Health, Standard 04/06/2004
Definition:	The time intravenous (IV) fibrinolytic therapy was first administered.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Data Element Concepts implementing this Property:	Person—intravenous fibrinolytic therapy time Health, Standard 04/06/2004

Killip classification

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285143
Registration status:	Health, Standard 04/06/2004
Definition:	Identifies the Killip class, as a measure of haemodynamic compromise.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—Killip classification Health, Standard 04/06/2004

Labour augmentation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269084
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the method used to assist progress of labour.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—labour augmentation type Health, Standard 01/03/2005

Labour force status

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Employment status
METeOR identifier:	269067
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	An indicator of participation in paid employment or economic inactivity.
Property group:	Labour characteristics

Relational attributes

Data Element Concepts implementing this Property:	Health professional—labour force status Health, Standard 01/03/2005 Person—labour force status Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005

Labour induction type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269085
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the method used to induce labour.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—labour induction type Health, Standard 01/03/2005

Labour onset type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269058
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the manner in which labour commences.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—labour onset type Health, Standard 01/03/2005

Last contact date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269344
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which last contact between a service provider and a patient/client occurred.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—last contact date Health, Standard 01/03/2005

Laterality of primary cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269179
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of which side of a paired organ is the origin of the primary cancer.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—laterality of primary cancer Health, Standard 01/03/2005

Length of stay

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269031
Registration status:	Health, Standard 01/03/2005
Definition:	The duration of an episode of care or service event that includes the provision of accommodation and/or residential care.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005 Episode of admitted patient care—length of stay (including leave days) Health, Standard 01/03/2005 Episode of admitted patient care—length of stay (special/neonatal intensive care) Health, Standard 01/03/2005

Level of difficulty with activities in a life area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320312
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	An expression of the ease of which tasks and actions in a life area are performed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—level of difficulty with activities in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Level of satisfaction with participation in a life area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	324441
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The level of satisfaction with participation in a life area, in relation to current life goals.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—level of satisfaction with participation in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Level of service delivery

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	334501
Registration status:	Health, Standard 05/12/2007
Definition:	Level of specialisation of a health service delivered within a defined speciality.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—level of service delivery Health, Standard 05/12/2007

Lipid-lowering therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285153
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of lipid-lowering therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—lipid-lowering therapy status Health, Standard 04/06/2004

Listing date for care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269112
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient/client is accepted onto a list for care/treatment.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective care waiting list episode—listing date for care Health, Standard 01/03/2005

Living arrangement

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269314
Registration status:	Health, Standard 19/04/2005 Community services, Standard 01/03/2005
Definition:	An arrangement of living alone or with others.
Property group:	Accommodation/living characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—living arrangement Health, Standard 19/04/2005 Community services, Standard 01/03/2005

Location of impairment of body structure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320262
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The site where a specified body structure differs from the accepted population standard.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—location of impairment of body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Lot/section identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269059
Registration status:	Health, Standard 01/03/2005
Definition:	The lot/section reference allocated to an address in the absence of street numbering.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—lot/section identifier Health, Standard 01/03/2005 Service provider organisation (address)—lot/section identifier Health, Standard 04/05/2005

Low-density lipoprotein cholesterol level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	310787
Registration status:	Health, Standard 27/10/2005
Definition:	The level of the serum cholesterol carried on low-density lipoproteins, approximately 60 to 70 percent of the total serum cholesterol.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Person—low-density lipoprotein cholesterol level Health, Standard 01/03/2005

Lower limb amputation due to vascular disease

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269165
Registration status:	Health, Standard 01/03/2005
Definition:	The removal of a toe, forefoot or leg (above or below knee), due to vascular disease.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—lower limb amputation due to vascular disease Health, Standard 01/03/2005

Main activity type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356578
Registration status:	Health, Standard 05/12/2007
Definition:	A descriptor of the main activity type of an organisation.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Data Element Concepts implementing this Property:	Health industry relevant organisation—main activity type Health, Standard 05/12/2007

Main language other than English spoken at home

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269176
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	The primary language spoken at home, excluding English.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—main language other than English spoken at home Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006

Major diagnostic category

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269328
Registration status:	Health, Standard 01/03/2005
Definition:	The classification of diagnoses (and Australian refined diagnosis related groups) by body system or aetiology.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—major diagnostic category Health, Standard 01/03/2005

Marital status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269101
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	An indicator of involvement in a couple relationship or marriage.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—marital status Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006

Maternal medical condition

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269069
Registration status:	Health, Standard 01/03/2005
Definition:	Pre-existing and concurrent conditions that affect a pregnancy or its outcome.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female (pregnant)—maternal medical condition Health, Standard 01/03/2005

Melanoma thickness

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269185
Registration status:	Health, Standard 01/03/2005
Definition:	The measured depth of penetration of tumour cells below the basal layer of the skin.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—melanoma thickness Health, Standard 01/03/2005

Mental health legal status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269297
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether care was provided under relevant state or territory mental health legislation compulsory treatment provisions.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—mental health legal status Health, Standard 01/03/2005

Mental health service duration

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285847
Registration status:	Health, Standard 08/12/2004
Definition:	The duration of a mental health service contact.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Mental health service contact—mental health service contact duration Health, Standard 08/12/2004

Mental health services grants to non-government organisations from non-health departments

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	298935
Registration status:	Health, Standard 07/12/2005
Definition:	Grants made to non-government organisations for the provision of mental health services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	State or Territory Government—mental health services grants to non-government organisations by non-health departments Health, Standard 07/12/2005

Method of drug use

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269130
Registration status:	Health, Standard 01/03/2005
Definition:	The manner in which a psychoactive substance is administered.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Client—method of drug use (principal drug of concern) Health, Standard 01/03/2005

Microalbumin level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269284
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of microalbumin detected in the urine.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—microalbumin level Health, Standard 01/03/2005

Morphology of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269181
Registration status:	Health, Standard 01/03/2005
Definition:	The histology and likely course of development of a tumour.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—morphology of cancer Health, Standard 01/03/2005

Most common service delivery setting

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	297675
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which most service delivery occurs.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—most common service delivery setting Health, Standard 05/12/2007

Most valid basis of diagnosis of a cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269183
Registration status:	Health, Standard 01/03/2005
Definition:	The most reliable basis of a cancer diagnosis.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—most valid basis of diagnosis of a cancer Health, Standard 01/03/2005

Mother's original family name

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Mother's maiden name
METeOR identifier:	269229
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The family name of an individual's mother before the mother's first marriage.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—mother's original family name Health, Standard 01/03/2005 Community services, Standard 01/03/2005

Multi-disciplinary team status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269126
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the involvement of providers from more than one profession or occupation.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient service event—multi-disciplinary team status Health, Standard 01/03/2005

Myocardial infarction

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269235
Registration status:	Health, Standard 01/03/2005
Definition:	Gross necrosis of the myocardium as a result of interruption of the blood supply to the area; it is almost always caused by atherosclerosis of the coronary arteries, upon which coronary thrombosis is usually superimposed.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Person—myocardial infarction Health, Standard 01/03/2005

Name conditional use flag

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287051
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	An indicator of specific conditions which should be applied to a recorded name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Name context flag Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Data Element Concepts implementing this Property:	Person (name)—name conditional use flag Health, Standard 04/05/2005 Community services, Standard 25/08/2005

Name suffix

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269224
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	An additional term following a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name suffix Health, Standard 01/03/2005 Community services, Standard 01/03/2005

Name suffix sequence number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288187
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	An order of additional terms at the conclusion of a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name suffix sequence number Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Name title

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269225
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	An honorific form of address commencing a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name title Health, Standard 01/03/2005 Community services, Standard 01/03/2005

Name title sequence number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288244
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numeric order of an honorific form of address commencing a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name title sequence number Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Name type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269227
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	A descriptor of the class of name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (name)—name type Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Nature of impairment of body structure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320276
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The qualitative or quantitative change to the characteristics of a specified body structure compared with accepted population standards.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—nature of impairment of body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Nature of main injury

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269100
Registration status:	Health, Standard 01/03/2005
Definition:	The nature of the injury chiefly responsible for the attendance at a health care facility.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Injury event—nature of main injury Health, Standard 01/03/2005

Need for assistance with activities in a life area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	324428
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The need for personal assistance and/or supervision to perform tasks and actions in a life area.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—need for assistance with activities in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Neonatal morbidity

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269087
Registration status:	Health, Standard 01/03/2005
Definition:	A diseased condition or state during first 28 days of life.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Admitted patient (neonate)—neonatal morbidity Health, Standard 01/03/2005

Net capital expenditure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269033
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure less trade-in values of replaced items and receipts from the sale of replaced or otherwise disposed items.
Property group:	Financial characteristics

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:	Establishment—net capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

New/repeat service event status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269292
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a service event involves a problem not previously addressed at the same clinical service.
Property group:	Service provision event

Collection and usage attributes

Guide for use:	Examples of clinical services are included in the Guide for use for Non-admitted patient service event—service event type (clinical), code N[N].

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient service event—new/repeat service event status Health, Standard 01/03/2005

Non-Australian state/province

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288616
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—non-Australian state/province Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—non-Australian state/province Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Non-surgical cancer treatment completion date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288113
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which non-surgical treatment for cancer was completed.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—non-surgical cancer treatment completion date Health, Standard 04/06/2004

Non-surgical cancer treatment start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288069
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which non-surgical treatment for cancer was started.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—non-surgical cancer treatment start date Health, Standard 04/06/2004

Number of available beds for admitted patients/residents

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269150
Registration status:	Health, Standard 01/03/2005
Definition:	A count of beds which are available for use by an admitted patient or resident.
Property group:	Material resource characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of available beds for admitted patients/residents Health, Standard 01/03/2005

Number of cigarettes smoked

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269281
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of cigarettes smoked during a specified period.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—number of cigarettes smoked Health, Standard 01/03/2005

Number of day centre attendances

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269214
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of patient/client visits to a day centre.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of day centre attendances Health, Standard 01/03/2005

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

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269242
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the days of **hospital-in-the-home care** received.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—number of days of hospital-in-the-home care Health, Standard 01/03/2005

Number of episodes of residential care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287923
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of episodes of completed residential care. This includes both formal and statistical episodes of residential care.
Context:	Specialised residential mental health services.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—number of episodes of residential care Health, Standard 08/12/2004

Number of group session occasions of service for non-admitted patients.

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269119
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the non-admitted occasions of service provided as a group session.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005

Number of group sessions

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269304
Registration status:	Health, Standard 01/03/2005
Definition:	A count of groups of patients/clients receiving services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of group sessions Health, Superseded 04/07/2007
	Establishment—number of group sessions Health, Standard 04/07/2007

Number of hours staffed

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288870
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of hours per day that appropriately trained staff are employed on-site.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—number of hours staffed Health, Standard 08/12/2004

Number of individual session occasions of service for non-admitted patients

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313837
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the non-admitted occasions of service provided as an individual session.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of individual session occasions of service for non-admitted patients Health, Standard 01/03/2005

Number of leave days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269218
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of days spent on leave from a health care service.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—number of leave days Health, Standard 01/03/2005 Episode of residential care—number of leave days Health, Standard 01/03/2005

Number of leave periods

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269097
Registration status:	Health, Standard 01/03/2005
Definition:	A count of discrete periods of formal absence during an episode of care.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—number of leave periods Health, Standard 01/03/2005

Number of non-admitted patient service events

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269288
Registration status:	Health, Standard 01/03/2005
Definition:	A count of service events provided to non-admitted patients.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of non-admitted patient service events Health, Standard 01/03/2005

Number of occasions of service

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	316229
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the occasions of service provided.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Establishment (residential aged care service)—number of occasions of service Health, Standard 01/03/2005 Establishment—number of occasions of service Health, Standard 04/05/2005

Number of patient days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269090
Registration status:	Health, Standard 01/03/2005
Definition:	A count of days of patient care.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Admitted patient hospital stay—number of patient days (of contracted care) Health, Standard 01/03/2005 Establishment—number of patient days Health, Standard 01/03/2005

Number of positive regional lymph nodes

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289189
Registration status:	Health, Standard 04/06/2004
Definition:	The number of regional lymph nodes examined by a pathologist and reported as containing tumour.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—number of positive regional lymph nodes Health, Standard 04/06/2004

Number of previous caesarean sections

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	298035
Registration status:	Health, Standard 29/11/2006
Definition:	A count of the number of previous caesarean sections.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Data Element Concepts implementing this Property:	Female—number of caesarean sections Health, Standard 29/11/2006

Number of previous pregnancies

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269051
Registration status:	Health, Standard 01/03/2005
Definition:	A count of previous pregnancies.
Context:	Perinatal statistics: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.
Property group:	Health and wellbeing

Collection and usage attributes

Guide for use:

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

A pregnancy resulting in multiple births should be counted as one pregnancy.

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female—number of previous pregnancies Health, Standard 01/03/2005

Number of psychiatric care days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269361
Registration status:	Health, Standard 01/03/2005
Definition:	A count of days of in which specialised psychiatric care was received.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—number of psychiatric care days Health, Standard 01/03/2005

Number of psychiatric outpatient clinic/day program attendances

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269353
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the days on which a psychiatric outpatient clinic or a day program was attended.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—number of psychiatric outpatient clinic/day program attendances Health, Standard 01/03/2005

Number of qualified days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269081
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the days within an episode of admitted patient care that are designated as having a **newborn qualification status**.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care (newborn)—number of qualified days Health, Standard 01/03/2005

Number of regional lymph nodes examined

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289159
Registration status:	Health, Standard 04/06/2004
Definition:	The total number of regional lymph nodes examined by a pathologist.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—number of regional lymph nodes examined Health, Standard 04/06/2004

Number of separations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269336
Registration status:	Health, Standard 01/03/2005
Definition:	A count of separations.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of separations Health, Standard 01/03/2005

Number of service contact dates

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269340
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the dates on which there is a service contact.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—number of service contact dates Health, Standard 01/03/2005

Number of service contacts

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269134
Registration status:	Health, Standard 01/03/2005
Definition:	A count of service contacts between a service recipient and a service provider.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—number of service contacts Health, Standard 01/03/2005

Nursing diagnosis

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269198
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing diagnosis most related to the reason for **admission**.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—nursing diagnosis Health, Standard 01/03/2005

Nursing intervention

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269201
Registration status:	Health, Standard 01/03/2005
Definition:	An action undertaken by a nurse in order to relieve or alter a person's responses to actual or potential health problems.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—nursing intervention Health, Standard 01/03/2005

Occupation

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269099
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	A descriptor of the class of job based on similarities in the tasks undertaken.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health professional—occupation Health, Standard 01/03/2005 Individual service provider—occupation (self-identified) Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Person—occupation (main) Health, Superseded 04/07/2007 Community services, Superseded 27/03/2007 Housing assistance, Superseded 10/08/2007 Person—occupation (main) Health, Standard 04/07/2007 Community services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007

Occupation end date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289049
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	When the class of job based on similarities in the tasks undertaken concludes.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Individual service provider—occupation end date Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Occupation start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289055
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	When the class of job based on similarities in the tasks undertaken commences.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Individual service provider—occupation start date Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Oestrogen receptor assay result

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291318
Registration status:	Health, Standard 04/06/2004
Definition:	The results of an oestrogen receptor test.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—oestrogen receptor assay results Health, Standard 04/06/2004

Operating theatre time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269294
Registration status:	Health, Standard 01/03/2005
Definition:	The length of time spent in an operating theatre.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Admitted patient hospital stay—operating theatre time Health, Standard 01/03/2005

Ophthalmological assessment outcome

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269301
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's ophthalmological assessment.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—ophthalmological assessment outcome Health, Standard 01/03/2005

Ophthalmoscopy performed indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	303979
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of whether an ophthalmoscopy has been undertaken.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Ophthalmoscopy performed Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—ophthalmoscopy performed indicator Health, Standard 21/09/2005

Organisation end date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288650
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which operations or practice were concluded.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—organisation end date Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Organisation identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269367
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	A sequence of characters which identify an organisation.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Contracted hospital care—organisation identifier Health, Standard 01/03/2005 Division of general practice—organisation identifier Health, Standard 01/03/2005 Establishment—organisation identifier Health, Standard 01/03/2005 Establishment—organisation identifier (state/territory) Health, Standard 01/03/2005

Organisation name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288901
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The appellation by which an establishment, agency or organisation is known or called.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation (name)—organisation name Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Organisation start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288941
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which operations or a service commenced.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—organisation start date Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Other and unspecified mental health services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	306256
Registration status:	Health, Standard 07/12/2005
Definition:	Grants made to non-government organisations for provision of mental health services not elsewhere classified and grants not allocatable to specific service types.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Other and unspecified services grants to non-government organisations Health, Superseded 07/12/2005
Data Element Concepts implementing this Property:	Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations Health, Standard 07/12/2005

Outcome of treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289298
Registration status:	Health, Standard 04/06/2004
Definition:	The outcome for which treatment is provided for a particular condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—outcome of treatment Health, Standard 04/06/2004

Outpatient clinic type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291073
Registration status:	Health, Standard 04/05/2005
Definition:	The nature of services which are provided by **outpatient clinic services**.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—outpatient clinic type Health, Superseded 04/07/2007
	Establishment—outpatient clinic type Health, Standard 04/07/2007

Overdue patient status

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Timeliness of care/service
METeOR identifier:	269076
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a patient whose wait for care exceeded the time determined as clinically desirable.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—overdue patient status Health, Standard 01/03/2005

Palliative care strategic plan indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288321
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of the existence of a written strategic plan for palliative care.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Administrative health region—palliative care strategic plan indicator Health, Standard 05/12/2007

Parity

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	302011
Registration status:	Health, Standard 29/11/2006
Definition:	A count of previous pregnancies resulting in a live birth or stillbirth.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Data Element Concepts implementing this Property:	Female—parity Health, Standard 29/11/2006

Partner organisation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290699
Registration status:	Health, Standard 05/12/2007
Definition:	The type of organisation with which an organisation has a formal working partnership in place.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—partner organisation type Health, Standard 05/12/2007

Patient election status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	339067
Registration status:	Health, Standard 28/11/2006
Definition:	An indicator of whether a person has elected to be treated as either a public or private patient.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Elected accommodation status Health, Superseded 28/11/2006
Data Element Concepts implementing this Property:	Episode of admitted patient care—patient election status Health, Standard 28/11/2006

Patient listing status

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Readiness for care
METeOR identifier:	269041
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator a person's readiness to commence an awaited procedure.
Property group:	Service/care urgency

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—patient listing status Health, Standard 01/03/2005

Patient present status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269111
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a patient's presence at a service event.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient service event—patient present status Health, Standard 01/03/2005

Patient/client participation indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286845
Registration status:	Health, Standard 08/12/2004
Definition:	An indication of participation in a service contact.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Mental health service contact—patient/client participation indicator Health, Standard 08/12/2004

Patients/clients in residence at year end

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269091
Registration status:	Health, Standard 01/03/2005
Definition:	A count of admitted patients/clients in residence at the end of the normal financial year.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—patients/clients in residence at year end Health, Standard 01/03/2005

Period of residence in Australia

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269092
Registration status:	Health, Standard 01/03/2005
Definition:	The length of time lived in Australia.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—period of residence in Australia Health, Standard 01/03/2005

Peripheral neuropathy indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269164
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of peripheral nerve disorders of any cause.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—peripheral neuropathy indicator Health, Standard 01/03/2005

Peripheral vascular disease indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269093
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of peripheral vascular disease.
Context:	Public health, health care and clinical settings.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—peripheral vascular disease indicator (foot) Health, Standard 01/03/2005

Person identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269369
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	A sequence of characters which identify a person.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:	Person—person identifier Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Person—person identifier (within establishment/agency) Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005

Physical activity sufficiency status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269095
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a level of activity is sufficiently vigorous to confer a health benefit.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—physical activity sufficiency status Health, Standard 01/03/2005

Physical departure date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	322593
Registration status:	Health, Standard 24/03/2006
Definition:	The date on which a patient or client physically departs a service or facility.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Property:	Emergency department stay—physical departure date Health, Standard 24/03/2006

Physical departure time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	322606
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which a patient or client physically departs a service or facility.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Property:	Emergency department stay—physical departure time Health, Standard 24/03/2006

Place of occurrence

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269393
Registration status:	Health, Standard 01/03/2005
Definition:	The physical location in which an event occurred.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Injury event—place of occurrence Health, Standard 01/03/2005

Postal delivery point identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269334
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	A sequence of assigned characters which uniquely identify a postal delivery point.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—postal delivery point identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Service provider organisation (address)—postal delivery point identifier Health, Standard 04/05/2005 Community services, Standard 31/08/2005

Postal delivery service type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269382
Registration status:	Health, Standard 01/03/2005
Definition:	The type of distribution service for mail and packages
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person—postal delivery service type Health, Standard 01/03/2005

Postal delivery service type identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269381
Registration status:	Health, Standard 01/03/2005
Definition:	The specification of the identification of a postal delivery service such as General Post Office Box, Community Mail Bag, etc. to clearly distinguish it from another when applicable.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—postal delivery service type identifier Health, Standard 01/03/2005

Postpartum perineal status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269054
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the condition of the perineum after birth.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female (mother)—postpartum perineal status Health, Standard 01/03/2005

Pre-vocational training services grants for non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288095
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of pre-vocational training services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—pre-vocational training services grants for non-government organisations Health, Standard 08/12/2004

Preferred language

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269244
Registration status:	Health, Standard 01/03/2005 Community services, Standard 10/04/2006
Definition:	The language most preferred for communication.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—preferred language Health, Standard 01/03/2005 Community services, Standard 10/04/2006

Pregnancy completion date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269257
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a pregnancy was completed.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Pregnancy (last previous)—pregnancy completion date Health, Standard 01/03/2005

Pregnancy indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	303950
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of a developing embryo or fetus within a body.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Related metadata references:	Supersedes Current pregnancy status Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Female— pregnancy indicator Health, Standard 21/09/2005

Pregnancy outcome

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269049
Registration status:	Health, Standard 01/03/2005
Definition:	The end result of a period of pregnancy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Pregnancy (last previous)—pregnancy outcome Health, Standard 01/03/2005

Premature cardiovascular disease family history status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269233
Registration status:	Health, Standard 01/03/2005
Definition:	Indicates whether there is a history of early cardiovascular conditions within the family.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—premature cardiovascular disease family history status Health, Standard 01/03/2005

Presentation date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269321
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the patient/client presented for the delivery of a service.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—presentation date Health, Standard 01/03/2005

Presentation time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269146
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which a person presents for the delivery of a service.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—presentation time Health, Standard 01/03/2005

Previous specialised treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269308
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the receipt of prior care in the same specialty as the current treatment.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—previous specialised treatment Health, Standard 01/03/2005

Primary site of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269180
Registration status:	Health, Standard 01/03/2005
Definition:	The anatomical position of origin of a tumour.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—primary site of cancer Health, Standard 01/03/2005

Primary tumour status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	293238
Registration status:	Health, Standard 13/06/2004
Definition:	The extent of the primary tumour.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—primary tumour status Health, Standard 13/06/2004

Principal diagnosis

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269186
Registration status:	Health, Standard 01/03/2005
Definition:	The diagnosis mainly responsible for occasioning a service event or episode.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—principal diagnosis Health, Standard 01/03/2005 Non-admitted patient emergency department service episode - principal diagnosis Health, Standard 05/12/2007

Principal role

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269351
Registration status:	Health, Standard 01/03/2005 Community services, Standard 15/09/2007
Definition:	A descriptor of the role to which the most time is devoted.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health professional—principal role Health, Standard 01/03/2005

Principal source of funding

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	339074
Registration status:	Health, Standard 29/11/2006
Definition:	The source from which the majority of funding is anticipated.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Expected principal source of funding Health, Superseded 29/11/2006
Data Element Concepts implementing this Property:	Episode of care—principal source of funding Health, Standard 29/11/2006

Procedure

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Clinical intervention; Surgical operation
METeOR identifier:	269052
Registration status:	Health, Standard 01/03/2005
Definition:	A series of steps performed by a healthcare professional through which a desired result is intended to be accomplished.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders.

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—procedure Health, Standard 01/03/2005

Procedure commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269251
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a procedure commenced.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care (procedure)—procedure commencement date Health, Standard 01/03/2005

Proficiency in spoken English

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269192
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	An indicator of the level of skill in speaking English.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—proficiency in spoken English Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006

Progesterone receptor assay results

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291334
Registration status:	Health, Standard 13/06/2004
Definition:	The results of a progesterone receptor test.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—progesterone receptor assay results Health, Standard 13/06/2004

Proteinuria status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269290
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of excessive protein in the urine.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—proteinuria status Health, Standard 01/03/2005

Psychosocial support services grants for non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288670
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of psychosocial support services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—psychosocial support services grants for non-government organisations Health, Standard 08/12/2004

Purchase of goods and services

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	360134
Registration status:	Health, Standard 05/12/2007
Definition:	Expenditure incurred for the purchase of goods and services.
Property group:	Financial characteristics

Collection and usage attributes

Collection methods:

Relational attributes

Data Element Concepts implementing this Property:	Organisation—purchase of goods and services Health, Standard 05/12/2007

Quality accreditation/certification standard indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269293
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a service provider is accredited or compliant with relevant industry quality standards.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—quality accreditation/certification standard indicator Health, Standard 01/03/2005

Radiation dose received

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291463
Registration status:	Health, Standard 13/06/2004
Definition:	The amount of radiation received.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—radiation dose received Health, Standard 13/06/2004

Radiotherapy treatment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291343
Registration status:	Health, Standard 13/06/2004
Definition:	The type of radiation therapy used for treatment.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—radiotherapy treatment type Health, Standard 13/06/2004

Reason for readmission following acute coronary syndrome episode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285161
Registration status:	Health, Standard 04/06/2004
Definition:	Identifies the main reason for the readmission, following a previous discharge from an acute coronary syndrome episode.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004

Reason for removal from a waiting list

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269071
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for removal of an entry from a waiting list.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—reason for removal from a waiting list Health, Standard 01/03/2005

Recreation services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288692
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of recreation services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—recreation services grants to non-government organisations Health, Standard 08/12/2004

Recurrent expenditure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269132
Registration status:	Health, Standard 13/05/2005 Housing assistance, Standard 01/03/2005
Definition:	Expenditure which does not result in the acquisition or enhancement of an asset.
Property group:	Financial characteristics

Collection and usage attributes

Guide for use:

National Housing Assistance Data Dictionary specific:

Recurrent expenditure on goods and services is expenditure, which does not result in the creation or acquisition of fixed assets (new or second-hand). It consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services and consumption of fixed capital (depreciation).

When fees charged for goods and services are offset against recurrent expenditure, the result equates to final consumption expenditure in the Australian Bureau of Statistics' national accounts framework.

Includes:

- Operating expenses
- Tenancy manager revenue and expense components.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0

Relational attributes

Data Element Concepts implementing this Property:

Establishment—recurrent expenditure Health, Standard 08/12/2004

Establishment—recurrent expenditure (administrative expenses) Health, Standard 01/03/2005

Establishment—recurrent expenditure (Department of Veterans' Affairs funded) Health, Standard 08/12/2004

Establishment—recurrent expenditure (depreciation) Health, Standard 01/03/2005

Establishment—recurrent expenditure (domestic services) Health, Standard 01/03/2005

Establishment—recurrent expenditure (drug supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (food supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (indirect health care) Health, Standard 01/03/2005

Establishment—recurrent expenditure (interest payments) Health, Standard 01/03/2005

Establishment—recurrent expenditure (medical and surgical

supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (National Mental Health Strategy payments) Health, Standard 08/12/2004

Establishment—recurrent expenditure (non-salary operating costs) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other Commonwealth Government funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other patient revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other recurrent expenditure) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other state or territory funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (patient transport cost) Health, Standard 01/03/2005

Establishment—recurrent expenditure (recoveries funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (repairs and maintenance) Health, Standard 01/03/2005

Establishment—recurrent expenditure (salaries and wages) Health, Standard 01/03/2005

Establishment—recurrent expenditure (state or territory health authority funded) Health, Standard 08/12/2004

Establishment—recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Specialised mental health service organisation—recurrent expenditure (residual mental health) Health, Standard 08/12/2004

Referral destination

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269147
Registration status:	Health, Standard 01/03/2005
Definition:	The service provider to which a referral is made.
Property group:	Referral event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—referral destination Health, Standard 01/03/2005 Episode of residential care—referral destination (mental health care) Health, Standard 01/03/2005

Referral source

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269061
Registration status:	Health, Standard 01/03/2005 Community services, Standard 02/06/2005
Definition:	A person or organisation from which a person or group of people is referred.
Property group:	Referral event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—referral source Health, Standard 01/03/2005 Episode of treatment for alcohol and other drugs—referral source Health, Standard 01/03/2005

Referral to ophthalmologist indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304006
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of whether there was a referral to an ophthalmologist.
Property group:	Referral event

Source and reference attributes

Submitting organisation:	National diabetes data working group

Relational attributes

Related metadata references:	Supersedes Referral to ophthalmologist Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—referral to ophthalmologist indicator Health, Standard 21/09/2005

Referral to rehabilitation service date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269357
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a referral to a rehabilitation service is made.
Property group:	Referral event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—referral to rehabilitation service date Health, Standard 01/03/2005

Region identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269057
Registration status:	Health, Standard 01/03/2005 Community services, Standard 15/09/2007
Definition:	An identifier for a defined geographic or administrative area.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—region identifier Health, Standard 01/03/2005

Region name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352846
Registration status:	Health, Standard 05/12/2007
Definition:	A name for a defined geographic or administrative area.
Property group:	Identifier characteristics

Relational attributes

Data Element Concepts implementing this Property:	Administrative health region—region name Health, Standard 05/12/2007

Region of first recurrence of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289045
Registration status:	Health, Standard 04/06/2004
Definition:	The region where there is a return or reappearance of the primary cancer after a disease free period intermission or remission.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—region of first recurrence of cancer Health, Standard 04/06/2004

Regional lymph node metastasis status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	293233
Registration status:	Health, Standard 13/06/2004
Definition:	The absence or presence and the extent of regional lymph node metastasis.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—regional lymph node metastasis status Health, Standard 13/06/2004

Regular tobacco smoking indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304521
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of current and/or past regular tobacco smoking.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—regular tobacco smoking indicator Health, Standard 21/09/2005

Renal disease therapy

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269373
Registration status:	Health, Standard 01/03/2005
Definition:	The class of treatment undertaken for renal disease.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Cardiovascular data working group

Relational attributes

Data Element Concepts implementing this Property:	Person—renal disease therapy Health, Standard 01/03/2005

Residual expenditure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	295450
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit).
Property group:	Financial characteristics

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—residual expenditure (academic positions) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (education and training) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (insurance) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (mental health promotion) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (mental health research) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (other indirect expenditure) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (patient transport services) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (program administration) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (property leasing costs) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (superannuation) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (support services) Health, Standard 08/12/2004 Specialised mental health service—residual expenditure (workers compensation) Health, Standard 08/12/2004

Respite services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288749
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of respite services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—respite services grants to non-government organisations Health, Standard 08/12/2004

Revenue

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	358088
Registration status:	Health, Standard 05/12/2007 Housing assistance, Standardisation pending 30/11/2007
Definition:	Revenue is income that arises in the course of ordinary activities of an entity and is referred to by a variety of names including sales, fees, interest, dividends and royalties.
Property group:	Financial characteristics

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee
Origin:	ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no. 5514.0.55.001) EMBARGO: 11:30 AM (CANBERRA TIME) 10/10/2003. Australian Accounting Standards Board 118, July 2007, <www.aasb.com.au>.

Relational attributes

Related metadata references:	Supersedes Revenue Health, Superseded 05/12/2007, Housing assistance, Standard 22/10/2005
Data Element Concepts implementing this Property:	Establishment—revenue (other revenue) Health, Standard 05/12/2007 Establishment—revenue (patient) Health, Standard 05/12/2007 Establishment—revenue (recoveries) Health, Standard 05/12/2007 Organisation—revenue Health, Standard 05/12/2007

Scheduled admission date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269029
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which an **admission** is planned.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Admitted patient care waiting list episode—scheduled admission date Health, Standard 01/03/2005

Sector

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269055
Registration status:	Health, Standard 01/03/2005 Community services, Standard 27/04/2007
Definition:	A categorisation of an organisation based on its funding, management and ownership arrangements.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—sector Health, Standard 01/03/2005

Self-help support groups services grants for non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288802
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of self-help services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations Health, Standard 08/12/2004

Separation date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269258
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which an episode of care ceases.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—separation date Health, Standard 01/03/2005

Separation mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269121
Registration status:	Health, Standard 01/03/2005
Definition:	The method by which **separation** is achieved.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—separation mode Health, Standard 01/03/2005

Separation time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269330
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which an episode of care ceases.
Context:	Admitted patient care.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—separation time Health, Standard 01/03/2005

Service commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313941
Registration status:	Health, Standard 07/12/2005
Definition:	The date on which a service event commences.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—service commencement date Health, Standard 07/12/2005

Service commencement time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269045
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which a service event starts.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—service commencement time Health, Superseded 07/12/2005 Non-admitted patient emergency department service episode—service commencement time Health, Standard 07/12/2005

Service contact date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269137
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which contact between a service provider and patient/client occurred.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Mental health service contact—service contact date Health, Standard 08/12/2004 Service contact—service contact date Health, Standard 01/03/2005

Service delivery setting

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269375
Registration status:	Health, Standard 01/03/2005 Community services, Standard 02/05/2006
Definition:	The setting in which assistance or services are provided.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—service delivery setting Health, Standard 01/03/2005 Service provider organisation—service delivery setting Health, Standard 05/12/2007 Community services, Standard 29/04/2006 Specialised mental health service—service setting Health, Standard 01/03/2005

Service episode length

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269331
Registration status:	Health, Standard 01/03/2005
Definition:	The length of time between patient presentation and service episode conclusion.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—service episode length Health, Standard 01/03/2005

Service event type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269245
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of treatment or care provided during a service event.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient service event—service event type (clinical) Health, Standard 01/03/2005

Service mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269348
Registration status:	Health, Standard 01/03/2005
Definition:	The relative physical location of a patient to their service provider.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient service event—service mode Health, Standard 01/03/2005

Session type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286780
Registration status:	Health, Standard 08/12/2004
Definition:	An indicator of whether a person or group of persons is provided with a service.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health of Welfare

Relational attributes

Data Element Concepts implementing this Property:	Mental health service contact—session type Health, Standard 08/12/2004

Setting of birth

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Birth setting
METeOR identifier:	269110
Registration status:	Health, Standard 01/03/2005
Definition:	The type of physical environment where the birth occurred.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—setting (intended) Health, Superseded 08/12/2005 Birth event—setting of birth Health, Standard 01/03/2005

Severe hypoglycaemia indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304017
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of hypoglycaemia requiring assistance from another party.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Severe hypoglycaemia history Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—severe hypoglycaemia indicator Health, Standard 21/09/2005

Sex

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269231
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
Definition:	The biological distinction between male and female.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables Demographic Variables, Sex

Relational attributes

Data Element Concepts implementing this Property:	Person—sex Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006

Solid tumour size

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269184
Registration status:	Health, Standard 01/03/2005
Definition:	The diameter of a solid tumour at the widest point.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—solid tumour size Health, Standard 01/03/2005

Source of revenue

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352332
Registration status:	Health, Standard 05/12/2007
Definition:	The origin from which revenue is received.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Data Element Concepts implementing this Property:	Health industry relevant organisation—source of revenue Health, Standard 05/12/2007

Specialised mental health service target population group

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288951
Registration status:	Health, Standard 08/12/2004
Definition:	The population group primarily targeted by a specialised mental health service.
Context:	Specialised mental health services.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—specialised mental health service target population group Health, Standard 08/12/2004

Specialised service indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269158
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the capacity to provide specialised service.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—specialised service indicator Health, Standard 01/03/2005

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269325
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator that identifies whether the criteria for specialist private sector rehabilitation care is met.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—specialist private sector rehabilitation care indicator Health, Standard 01/03/2005

Staging basis of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	296959
Registration status:	Health, Standard 04/06/2004
Definition:	The type of evidence that confirms a diagnosis of a malignant tumour.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Cancer staging—staging basis of cancer Health, Standard 04/06/2004

Standards assessment indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356459
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether routine assessment against defined industry standards occurs.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—standards assessment indicator Health, Standard 05/12/2007

Standards assessment level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359010
Registration status:	Health, Standard 05/12/2007
Definition:	The level of assessment undertaken or undergone by an organisation against defined industry standards
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—standards assessment level Health, Standard 05/12/2007

Standards assessment method

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287989
Registration status:	Health, Standard 05/12/2007
Definition:	The method used for standards assessment.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—standards assessment method Health, Standard 05/12/2007

State/territory of birth

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269339
Registration status:	Health, Standard 01/03/2005
Definition:	The state/territory in which the birth occurred.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—state/territory of birth Health, Standard 01/03/2005

Street name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269385
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—street name Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—street name Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Street suffix

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269384
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	Term used to qualify the street name used for directional references.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee
Origin:	AS4590 Interchange of client information, Australia Post Address Presentation Standard.

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—street suffix Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—street suffix Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Street type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269383
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	A code that identifies the type of public thoroughfare.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—street type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address)—street type Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Suburb/town/locality name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269335
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The full name of the general locality containing the specific address.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—suburb/town/locality name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Service provider organisation (address)—suburb/town/locality name Health, Standard 04/05/2005 Community services, Standard 31/08/2005

Supported public housing places

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288935
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of public housing places supported by specialised mental health services, targeted to people affected by mental illness or psychiatric disability.
Context:	People affected by mental illness or psychiatric disability.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—number of supported public housing places Health, Standard 08/12/2004

Surgical procedure date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288620
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the surgical procedure was performed.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—surgical procedure date Health, Standard 04/06/2004

Surgical procedure for cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288476
Registration status:	Health, Standard 04/06/2004
Definition:	The surgical procedure(s) used in the treatment of a cancer.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—surgical procedure for cancer Health, Standard 04/06/2004

Surgical specialty

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269155
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of an area of clinical expertise in surgery.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor) Health, Standard 01/03/2005

Systemic therapy agent name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288347
Registration status:	Health, Standard 04/06/2004
Definition:	The standard chemotherapeutic agent or anti-cancer drug used for treatment of a cancer.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—systemic therapy agent name (primary cancer) Health, Standard 04/06/2004

Target site for cancer treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	293145
Registration status:	Health, Standard 13/06/2004
Definition:	The site or region of the cancer that is being targeted at treatment.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—target site for cancer treatment Health, Standard 13/06/2004

Teaching status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269156
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of engagement in the implementation of an educational program.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—teaching status (university affiliation) Health, Standard 01/03/2005

Technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313225
Registration status:	Health, Standard 13/10/2005
Definition:	Procedures and tasks for which specific nursing education is required as well as knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions relating to each.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—technical nursing care requirement Health, Standard 13/10/2005

Telephone number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269232
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	A sequence of digits.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—telephone number Health, Standard 01/03/2005 Community services, Standard 01/03/2005

Telephone number type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269239
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The class of telephone number.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (telephone)—telephone number type Health, Standard 01/03/2005 Community services, Standard 01/03/2005

Time since quitting tobacco smoking

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269266
Registration status:	Health, Standard 01/03/2005
Definition:	The period of time since quitting tobacco smoking.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—time since quitting tobacco smoking Health, Standard 01/03/2005

Tobacco product smoked

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269276
Registration status:	Health, Standard 01/03/2005
Definition:	The type of tobacco smoked.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco product smoked Health, Standard 01/03/2005

Tobacco smoking daily use status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269279
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether tobacco has ever been smoked on a daily basis.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking daily use status Health, Standard 01/03/2005

Tobacco smoking duration

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269280
Registration status:	Health, Standard 01/03/2005
Definition:	The length of time tobacco has been smoked.
Property group:	Lifestyle characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking duration Health, Standard 01/03/2005

Tobacco smoking frequency

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269277
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of how frequently tobacco is smoked.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking frequency Health, Standard 01/03/2005

Tobacco smoking quit age

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269274
Registration status:	Health, Standard 01/03/2005
Definition:	The age at which tobacco smoking ceased.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking quit age Health, Standard 01/03/2005

Tobacco smoking start age

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269275
Registration status:	Health, Standard 01/03/2005
Definition:	The age at which tobacco smoking commenced.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking start age Health, Standard 01/03/2005

Tobacco smoking status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269267
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of current and/or past tobacco smoking.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking status Health, Standard 01/03/2005 Person—tobacco smoking status (last three months) Health, Superseded 21/09/2005

Transport mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269043
Registration status:	Health, Standard 01/03/2005
Definition:	The act or method of moving an object or person.
Property group:	Transport characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—transport mode Health, Standard 01/03/2005

Treatment cessation date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269254
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—treatment cessation date Health, Standard 01/03/2005

Treatment commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269255
Registration status:	Health, Standard 01/03/2005
Definition:	The date of the first service contact in which an assessment and/or treatment occurred, whichever occurred first.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—treatment commencement date Health, Standard 01/03/2005

Treatment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269107
Registration status:	Health, Standard 01/03/2005
Definition:	The category of health care intervention or therapy.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—treatment type Health, Standard 01/03/2005 Episode of treatment for alcohol and other drugs—treatment type (other) Health, Superseded 13/10/2005

Triage category

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269109
Registration status:	Health, Standard 01/03/2005
Definition:	The classification of a patient assigned according to the urgency of their need for medical and/or nursing care.
Context:	Emergency department care
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—triage category Health, Standard 01/03/2005

Triage date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269259
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient is assessed to determine the urgency of their problem and priority for care.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—triage date Health, Standard 07/12/2005 Triage—triage date Health, Superseded 07/12/2005

Triage time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269360
Registration status:	Health, Standard 01/03/2005
Definition:	The time on which a patient is assessed to determine the urgency of their problem and priority for care.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—triage time Health, Standard 07/12/2005 Triage—triage time Health, Superseded 07/12/2005

Triglyceride level

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	TG; Triacylglycerol
METeOR identifier:	269204
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of triglyceride in the blood.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—triglyceride level Health, Standard 01/03/2005

Troponin assay type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285213
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the type of troponin assay.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—troponin assay type Health, Standard 04/06/2004

Troponin level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285243
Registration status:	Health, Standard 04/06/2004
Definition:	The amount of troponin.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—troponin level Health, Standard 04/06/2004

Troponin level measured date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284987
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which troponin was measured.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—troponin level measured date Health, Standard 04/06/2004

Troponin level measured time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285205
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which troponin was measured.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—troponin level measured time Health, Standard 04/06/2004

Type of health or health related function

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352183
Registration status:	Health, Standard 05/12/2007
Definition:	Type of activity or program provided to prevent or cure disease, care for illness, impairment, disability or handicap, or to support this activity.
Property group:	Organisational characteristics

Relational attributes

Data Element Concepts implementing this Property:	Organisation—type of health or health related function Health, Standard 05/12/2007

Type of visit to emergency department

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269300
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the reason for arrival at an emergency department.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—type of visit to emergency department Health, Standard 01/03/2005

Upper limit of normal range for creatine kinase myocardial band isoenzyme

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284925
Registration status:	Health, Standard 04/06/2004
Definition:	The value of creatine kinase myocardial band (CK-MB) isoenzyme that is the upper boundary of the normal reference range.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Data Element Concepts implementing this Property:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme Health, Standard 04/06/2004

Upper limit of normal range for microalbumin

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269283
Registration status:	Health, Standard 01/03/2005
Definition:	The value of microalbumin that is the upper boundary of the normal reference range.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Laboratory standard—upper limit of normal range for microalbumin Health, Standard 01/03/2005

Upper limit of normal range of glycosylated haemoglobin

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269282
Registration status:	Health, Standard 01/03/2005
Definition:	The value of glycosylated haemoglobin (HbA1c) that is the upper boundary of the normal reference range.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Laboratory standard—upper limit of normal range of glycosylated haemoglobin Health, Standard 01/03/2005

Upper limit of normal range of troponin assay

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285227
Registration status:	Health, Standard 04/06/2004
Definition:	The value of `troponin T' or `troponin I' that is the upper boundary of the normal reference range.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Laboratory standard—upper limit of normal range of troponin assay Health, Standard 04/06/2004

Vascular condition status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269070
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of conditions of blood vessels of the body.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—vascular condition status Health, Standard 01/03/2005

Vascular procedure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269072
Registration status:	Health, Standard 01/03/2005
Definition:	Interventions pertaining to the vascular system
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—vascular procedure Health, Standard 01/03/2005

Visual acuity

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269073
Registration status:	Health, Standard 01/03/2005
Definition:	Sharpness or acuteness of vision.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Person—visual acuity Health, Standard 01/03/2005

Waist circumference

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269145
Registration status:	Health, Standard 01/03/2005
Definition:	The distance around the human body between the ribs and the hips.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—waist circumference Health, Standard 01/03/2005

Waist circumference risk indicator

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Abdominal obesity risk indicator
METeOR identifier:	269195
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of the risk of metabolic complications associated with excess abdominal adiposity.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Adult—waist circumference risk indicator Health, Standard 01/03/2005

Waist-to-hip ratio

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	WHR
METeOR identifier:	269196
Registration status:	Health, Standard 01/03/2005
Definition:	The division of waist circumference by hip circumference.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Adult—waist-to-hip ratio Health, Standard 01/03/2005

Waiting list removal date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269113
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a person is removed from a waiting list.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—waiting list removal date Health, Standard 01/03/2005

Waiting time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269063
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed between a service request and a subsequent administrative or service event.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—waiting time Health, Standard 01/03/2005 Non-admitted patient emergency department service episode—waiting time Health, Standard 01/03/2005 Non-admitted patient emergency department service episode—waiting time (to hospital admission) Health, Standard 01/03/2005

Weight

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269197
Registration status:	Health, Standard 01/03/2005
Definition:	A measurement of body mass.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Adult—weight Health, Superseded 14/07/2005 Person—weight Health, Standard 01/03/2005

Working partnership indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290692
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether an agency has formal working partnership(s) with other service provider(s) or organisation(s).
Property group:	Organisational characteristics

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—working partnership indicator Health, Standard 05/12/2007

Year of first arrival in Australia

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269050
Registration status:	Health, Standard 04/05/2005 Community services, Standard 01/03/2005
Definition:	The calendar year in which an individual first arrived in Australia.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (overseas born)—year of first arrival in Australia Health, Standard 04/05/2005 Community services, Standard 01/03/2005

Classification Schemes

A classification scheme is an official terminological system, recognised and endorsed by a national or international body, that is used to classify data.

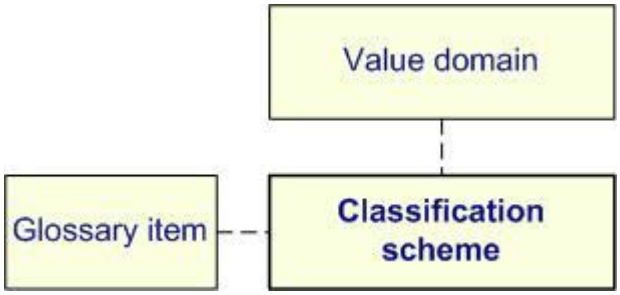
In METeOR examples of classification schemes include the:

Australian Standard Classification of Occupations (2nd edition)

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (3rd edition).

A classification scheme may be implemented by one or more value domains. For example, the Australian Standard Classification of Occupations (2nd edition) is implemented by the value domain Occupation code (ASCO 2nd edn) NNNN.

Below is a graphical representation of the relationship between classification schemes and related metadata item types.



Australian Classification of Health Interventions (ACHI) 5th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ACHI 5th edn
METeOR identifier:	335419
Registration status:	Health, Superseded 05/02/2008
Definition:	The National Centre for Classification in Health classification of health interventions.
Classification structure:	ACHI is comprised of: • Tabular List of Interventions - contains seven character code in the format xxxxx-xx. Generally, the first five characters represent the MBS item number and the last two characters are allocated for each procedural concept derived from the MBS item description. Two appendices are specified: Mapping table; and ACHI codes listed in numerical order. • Alphabetic Index of Interventions - is an alphabetic index to the ACHI Tabular List of Interventions that contains many more procedural terms than those appearing in the ACHI Tabular List.

Source and reference attributes

Origin:	National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.
Revision status:	ACHI 5th Ed supersedes the fourth edition of ACHI. ACHI was developed by the National Centre for Classification in Health (NCCH). During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia.

Relational attributes

Related metadata references:	Supersedes International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 4th edition Health, Superseded 07/12/2005
Value Domains based on this Classification Scheme:	Elective care type code N Health, Standard 07/12/2005 Indicator procedure code NN Health, Standard 01/03/2005 Procedure code (ACHI 5th edn) NNNNN-NN Health, Superseded 05/02/2008

Australian Classification of Health Interventions (ACHI) 6th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ACHI 6th edn
METeOR identifier:	361681
Registration status:	Health, Standard 05/02/2008
Definition:	The National Centre for Classification in Health classification of health interventions.
Classification structure:	ACHI is comprised of: • Tabular List of Interventions - contains seven character code in the format xxxxx-xx. Generally, the first five characters represent the MBS item number and the last two characters are allocated for each procedural concept derived from the MBS item description. Two appendices are specified: Mapping table; and ACHI codes listed in numerical order. • Alphabetic Index of Interventions - is an alphabetic index to the ACHI Tabular List of Interventions that contains many more procedural terms than those appearing in the ACHI Tabular List.

Source and reference attributes

Origin:	National Centre for Classification in Health (NCCH) 2007. The Australian Classification of Health Interventions (ACHI) – Sixth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.
Revision status:	ACHI was developed by the National Centre for Classification in Health (NCCH). During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia.

Relational attributes

Related metadata references:	Supersedes Australian Classification of Health Interventions (ACHI) 5th edition Health, Superseded 05/02/2008
Value Domains based on this Classification Scheme:	Procedure code (ACHI 6th edn) NNNNN-NN Health, Standard 05/02/2008

Australian Refined Diagnosis Related Groups version 5.1

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	AR-DRG v5.1
METeOR identifier:	270554
Registration status:	Health, Standard 01/03/2005
Definition:	The Commonwealth Department of Health and Ageing classification for the reasons for hospitalisation and the complexity of cases that a hospital treats.

Collection and usage attributes

Comments:	The Australian Refined Diagnosis Related Groups are derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM.

Relational attributes

Value Domains based on this Classification Scheme:	Diagnosis related group code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005 Major diagnostic category code (AR-DRG v5.1) NN Health, Standard 01/03/2005

Australian Standard Classification of Drugs of Concern 2000

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ASCDC 2000
METeOR identifier:	270550
Registration status:	Health, Standard 01/03/2005
Definition:	The Australian Bureau of Statistics' classification for data relating to drugs which are considered to be of concern in Australian society.
Classification structure:	The main classification of the ASCEDC has a three level hierarchical structure. It is essentially a classification of type of drug of concern based on the chemical structure, mechanism of action and effect on physiological activity of the drugs of concern.

Collection and usage attributes

Guide for use:	Indexes in alphabetical and numerical order are available, see the *Origin:* attribute.

Source and reference attributes

Steward:	Australian Bureau of Statistics (ABS)
Origin:	The Australian Standard Classification of Drugs of Concern (ASCDC). ABS Cat No. 1248.0 (2000).
Revision status:	Original 2000 - Standard.

Relational attributes

Value Domains based on this Classification Scheme:	Drug of concern (ASCDC 2000 extended) code NNNN Health, Standard 01/03/2005

Australian Standard Classification of Languages 2005

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ASCL 2005
METeOR identifier:	304118
Registration status:	Health, Standard 08/02/2006 Community services, Standard 30/09/2005 Housing assistance, Standard 10/02/2006
Definition:	The Australian Bureau of Statistics (ABS) classification for the languages spoken by Australians.
Classification structure:	The ASCL has a three-level hierarchical structure. Languages are grouped together into progressively broader categories on the basis of their evolution from a common ancestral language, and on the basis of geographic proximity of areas where a particular language originated.

Collection and usage attributes

Guide for use:	The ASCL is intended for use in the collection, aggregation and dissemination of data relating to the language use of the Australian population, or subsets of the population. Indexes in alphabetical and numerical order are available, see the *Origin:* attribute.

Source and reference attributes

Origin:	Australian Bureau of Statistics 2005. *Australian Standard Classification of Languages (ASCL) 2005*. Cat No. 1267.0. 2nd Edition, Canberra: ABS. Viewed 29 July 2005
Revision status:	If you require further information about this classification please email: social.classifications@abs.gov.au or telephone the Standards Support Hotline on (02) 6252 5736.

Relational attributes

Related metadata references:	Supersedes Australian Standard Classification of Languages 1997 Health, Superseded 08/02/2006, Community services, Superseded 30/09/2005
Value Domains based on this Classification Scheme:	Language code (ASCL 2005) NN{NN} Health, Standard 08/02/2006 Community services, Standard 30/09/2005 Housing assistance, Standard 10/02/2006

Australian Standard Geographical Classification 2007

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ASGC 2007
METeOR identifier:	362284
Registration status:	Health, Standard 05/02/2008 Community services, Standard 30/11/2007
Definition:	The Australian Bureau of Statistics classification for the classification of geographical locations.

Source and reference attributes

Origin:	Australian Bureau of Statistics 2006. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 28/09/2007

Relational attributes

Related metadata references:	Supersedes Australian Standard Geographical Classification 2006 Health, Superseded 05/02/2008, Community services, Superseded 30/11/2007
Value Domains based on this Classification Scheme:	Geographical location code (ASGC 2007) NNNNN Health, Standard 05/02/2008 Community services, Standard 30/11/2007

Australian and New Zealand Standard Classification of Occupations, First edition, 2006

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ANZSCO 1st edition
METeOR identifier:	350882
Registration status:	Health, Standard 04/07/2007 Community services, Standard 27/03/2007
Definition:	The Australian Bureau of Statistics (ABS) classification for occupations.
Classification structure:	The structure of ANZSCO has five hierarchical levels - major group, sub-major group, minor group, unit group and occupation. The categories at the most detailed level of the classification are termed 'occupations'. These are grouped together to form 'unit groups', which in turn are grouped into 'minor groups'. Minor groups are aggregated to form 'sub-major groups' which in turn are aggregated at the highest level to form 'major groups'. These are the same hierarchical levels that are used in ASCO Second Edition and NZSCO 1999. **Conceptual model** ANZSCO is a skill-based classification used to classify all occupations and jobs in the Australian and New Zealand labour markets. To do this, ANZSCO identifies a set of occupations covering all jobs in the Australian and New Zealand labour markets, defines these occupations according to their attributes and groups them on the basis of their similarity into successively broader categories for statistical and other types of analysis. The individual objects classified in ANZSCO are jobs. In ANZSCO, occupations are organised into progressively larger groups on the basis of their similarities in terms of both skill level and skill specialisation. The conceptual model adopted for ANZSCO uses a combination of skill level and skill specialisation as criteria to design major groups which are meaningful and useful for most purposes. The eight major groups are formed by grouping together sub-major groups using aspects of both skill level and skill specialisation. In designing the major groups, intuitive appeal and usefulness in both statistical and administrative applications were also important considerations. The skill level criterion is applied as rigorously as possible at the second level of the classification, the sub-major group level, together with a finer application of skill specialisation than that applied at the major group level. Each sub-major group is made up of a number of minor groups. Minor groups are distinguished from each other mainly on the basis of a finer application of skill specialisation than that applied at the sub-major group level. Within minor groups, unit groups are distinguished from each other on the basis of skill specialisation and, where necessary, skill level. Virtually all unit groups are at one skill level. There are only

eight unit groups which contain occupations at more than one skill level. In all but two of these unit groups, the vast majority of jobs classified to the unit group are at one skill level only. Data stored at unit group level can therefore be aggregated by skill level with a high degree of validity.

Within unit groups, the distinction between occupations amounts to differences between tasks performed in occupations. All occupations are at one skill level.

As a result, data classified at the major group level will provide only a broad indication of skill level. Data at the sub-major group level will provide a satisfactory indication of skill level for many analytical purposes. Data classified at the unit group level will provide an accurate indication of skill level. Unit groups can, therefore, be aggregated by skill level to provide an indicative measure of occupations classified by skill level.

Source and reference attributes

Origin: Australian Bureau of Statistics 2006. Australian and New Zealand Standard Classification of Occupations, First Edition, Cat no. 1220.0 Canberra: ABS. Viewed 13 March 2007.

Relational attributes

Related metadata references: Supersedes Australian Standard Classification of Occupations 2nd edition Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007, Housing assistance, Standard 01/03/2005

Value Domains based on this Classification Scheme: Occupation code (ANZSCO 1st edition) N[NNN]{NN} Health, Standard 04/07/2007
Community services, Standard 27/03/2007
Housing assistance, Standard 10/08/2007

British Paediatric Association Classification of Diseases 1979

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	BPA 1979
METeOR identifier:	270559
Registration status:	Health, Standard 01/03/2005
Definition:	The British Paediatric Association classification system for the classification of diseases.

Relational attributes

Value Domains based on this Classification Scheme:	Congenital malformations code (BPA 1979) ANN.N[N] Health, Standard 01/03/2005

International Classification of Diseases for Oncology 3rd edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ICDO-3
METeOR identifier:	270553
Registration status:	Health, Standard 01/03/2005
Definition:	The World Health Organization's classification for coding the topography and the morphology of the neoplasm.

Source and reference attributes

Origin:	International Classification of Diseases for Oncology, Third Edition

Relational attributes

Value Domains based on this Classification Scheme:	Morphology of cancer code (ICDO-3) NNNN/N Health, Standard 01/03/2005 Primary site of cancer code (ICDO-3) ANN{.N[N]} Health, Standard 01/03/2005 Topography code (ICD0-3) ANN Health, Standard 13/06/2004

International Classification of Functioning, Disability and Health 2001

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ICF 2001
METeOR identifier:	270548
Registration status:	Health, Standard 23/02/2005 Community services, Standard 01/12/2004
Definition:	The World Health Organization's (WHO) system for classifying functioning, disability and health.

Collection and usage attributes

Comments:	The International Classification of Functioning, Disability and Health (ICF) was endorsed by the World Health Assembly in 2001 and is a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

Source and reference attributes

Origin:	World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO
Reference documents:	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide Version 1.0 (AIHW 2003), at the following websites: • WHO ICF website: http://www.who.int/classifications/icf/en/ • Australian Collaborating Centre ICF website: http://www.aihw.gov.au/disability/icf/index.cfm

Relational attributes

Value Domains based on this Classification Scheme:	Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Activity need for assistance code N Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Body function code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Body structure code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Environmental factor code (ICF 2001) AN[NNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Impairment extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Impairment location code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Impairment nature code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ICD-10-AM 5th edn
METeOR identifier:	325389
Registration status:	Health, Superseded 05/02/2008
Definition:	The National Centre for Classification in Health classification for diseases and related health problems
Classification structure:	ICD-10-AM is comprised of: • Tabular List of Diseases - contains core three character codes with some expansion to four and five character codes. Two appendices are specified: Morphology of neoplasms; and Special tabulation lists for mortality and morbidity. • Alphabetic Index of Diseases - consists of three sections: Section I is the index of diseases, syndromes, pathological conditions, injuries, signs, symptoms, problems and other reasons for contact with health services. Section II is the index of external causes of injury. The terms included here are not medical diagnoses but descriptions of the circumstances in which the violence occurred. Section III is the index of drugs and other chemical substances giving rise to poisoning or other adverse effects (also known as the Table of drugs and chemicals).

Source and reference attributes

Origin:	National Centre for Classification in Health (NCCH) 2006. The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) – Fifth Edition - Tabular list of diseases and Alphabetic index of diseases. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.
Revision status:	ICD-10-AM 5th Ed supersedes the fourth edition of ICD-10-AM. ICD-10-AM was developed by the National Centre for Classification in Health (NCCH). During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia.

Relational attributes

Related metadata references:	Supersedes International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 4th edition Health, Superseded 07/12/2005
Value Domains based on this Classification Scheme:	Activity type code (ICD-10-AM 5th edn) ANNNN Health, Superseded 05/02/2008 Congenital malformations code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Standard 07/12/2005

Diagnosis code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

External cause code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Neonatal morbidity code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Place of occurrence (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Pregnancy/childbirth and puerperium code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Primary site of cancer code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ICD-10-AM 6th edn
METeOR identifier:	360927
Registration status:	Health, Standard 05/02/2008
Definition:	The National Centre for Classification in Health classification for diseases and related health problems
Classification structure:	ICD-10-AM is comprised of: • Tabular List of Diseases - contains core three character codes with some expansion to four and five character codes. Two appendices are specified: Morphology of neoplasms; and Special tabulation lists for mortality and morbidity. • Alphabetic Index of Diseases - consists of three sections: Section I is the index of diseases, syndromes, pathological conditions, injuries, signs, symptoms, problems and other reasons for contact with health services. Section II is the index of external causes of injury. The terms included here are not medical diagnoses but descriptions of the circumstances in which the violence occurred. Section III is the index of drugs and other chemical substances giving rise to poisoning or other adverse effects (also known as the Table of drugs and chemicals).

Source and reference attributes

Origin:	National Centre for Classification in Health (NCCH) 2008. The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) – Sixth Edition - Tabular list of diseases and Alphabetic index of diseases. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.
Revision status:	ICD-10-AM was developed by the National Centre for Classification in Health (NCCH). During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia.

Relational attributes

Related metadata references:	Supersedes International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition Health, Superseded 05/02/2008
Value Domains based on this Classification Scheme:	Activity type code (ICD-10-AM 6th edn) ANNNN Health, Standard 05/02/2008 Diagnosis code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Standard 05/02/2008 External cause code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Standard 05/02/2008

Neonatal morbidity code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Standard 05/02/2008

Place of occurrence (ICD-10-AM 6th edn) ANN{.N[N]} Health, Standard 05/02/2008

Pregnancy/childbirth and puerperium code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Standard 05/02/2008

Primary site of cancer code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Standard 05/02/2008

International Union against Cancer TNM Classification of Malignant Tumours 5th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	UICC TNM Classification of Malignant Tumours 5th ed
METeOR identifier:	293130
Registration status:	Health, Standard 13/06/2004
Definition:	The International Union Against Cancer classification for malignant tumours.

Relational attributes

Value Domains based on this Classification Scheme:	M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX Health, Standard 13/06/2004 N stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX Health, Standard 13/06/2004 T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X] Health, Standard 13/06/2004 TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Standard 04/06/2004

North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	NANDA 1997-98
METeOR identifier:	270555
Registration status:	Health, Standard 01/03/2005
Definition:	The North American Nursing Diagnosis Association's (NANDA) 1997-1998 classification for nursing diagnoses.

Source and reference attributes

Origin:	North American Nursing Diagnosis Association (NANDA) Nursing Diagnoses: Definitions and Classification 1997-1998. (1997) NANDA

Relational attributes

Value Domains based on this Classification Scheme:	Nursing diagnosis code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}] Health, Standard 01/03/2005

Postcode datafile

Identifying and definitional attributes

Metadata item type:	Classification Scheme
METeOR identifier:	270561
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.
Context:	Postcode is an important part of a persons or organisations postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location. Postcode may assist with uniquely identifying a person or organisation.

Collection and usage attributes

Guide for use:	The postcode book is updated more than once annually as postcodes are dynamic entities and are constantly changing.

Source and reference attributes

Origin:	Australia Post Postcode book. Reference through: http://www1.auspost.com.au/postcodes/

Relational attributes

Value Domains based on this Classification Scheme:	Australian postcode code (Postcode datafile) NNN[N] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Australian postcode code (Postcode datafile) {NNNN} Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006

Self-Instructional Manual for Tumour Registrars Book 8 Antineoplastic Drugs, 3rd edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
METeOR identifier:	291502
Registration status:	Health, Standard 13/06/2004
Definition:	The Surveillance, Epidemiology, and End Results (SEER) Program classification for antineoplastic drugs.

Collection and usage attributes

Comments:	This manual is being completely revised. The drugs listed in SEER Book 8 may not include any antineoplastic agents developed since 1993.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Value Domains based on this Classification Scheme:	Antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)] Health, Standard 13/06/2004

Standard Australian Classification of Countries 1998

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	SACC 1998
METeOR identifier:	270557
Registration status:	Health, Standard 01/03/2005 Community services, Superseded 02/06/2008 Housing assistance, Standard 20/06/2005
Definition:	The Australian Bureau of Statistics classification for countries.

Collection and usage attributes

Comments:	The Standard Australian Classification of Countries (SACC) supersedes the Australian Standard Classification of Countries for Social Statistics (ASCCSS).

Source and reference attributes

Origin:	Australian Bureau of Statistics 1998. Standard Australian Classification of Countries 1998 (SACC). Cat No. 1269.0. Canberra: ABS (last viewed 19 Feb 2007)

Relational attributes

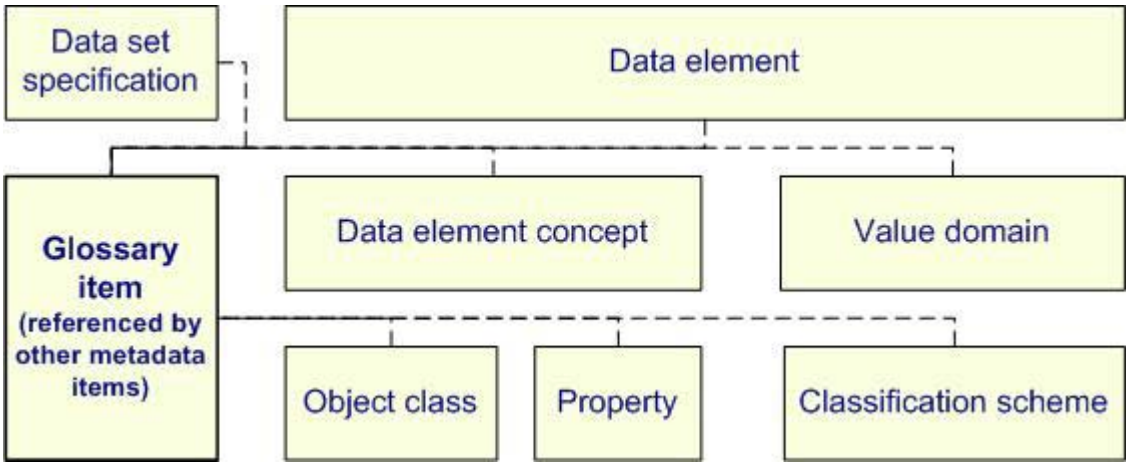
Value Domains based on this Classification Scheme:	Country code (SACC 1998) NNNN Health, Standard 01/03/2005 Community services, Superseded 02/06/2008 Housing assistance, Standard 20/06/2005

Glossary Items

A glossary item defines the meaning of a term within a specific context. Within METeOR examples of glossary items include Adoption and Family. These things of interest are not currently defined as object classes but their meaning must be understood for data to be collected.

For example, to collect data on whether a person has an information carer or not, we must understand the meaning of the term 'informal carer' to apply the appropriate counting rules for the data element, Person—informal carer existence indicator, code N.

A glossary item can be linked to by any other metadata item type. For example, the data element definition for Person—informal carer existence indicator, code N, links directly to the glossary item 'Informal carer'.



Activity—functioning, disability and health

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Activity
METeOR identifier:	327296
Registration status:	Health, Standard 29/11/2006 Community services, Standard 01/03/2005
Definition:	In the context of health, an activity is the execution of a task or action by an individual.
Context:	'Activities and participation' is one of three components that define the concept 'Disability', along with 'Body functions and structures' and 'Environmental factors'. 'Activities and participation' is also encompassed within the concept 'Functioning'. The concept 'Activity', as defined here and as measured in the metadata item Activity difficulty level code (ICF) N, may be relevant to people and human services not related to disability.

Collection and usage attributes

Comments:

Activity limitations are difficulties an individual has in the execution of an activity.

The performance of an activity is what the individual does in his or her current environment. The environment includes all aspects of the physical, social and attitudinal world. Activity limitation varies with the environment and is assessed in relation to a particular environment and in the absence or presence of assistance, including aids and equipment.

In time, a related and more generic data element may be developed. In the meantime, the addition of 'functioning, disability and health' to the concept of 'ability' indicates that the current concept is based on the concept and framework developed by World Health Organization to assist in the classification and description of functioning and disability, as contained in the ICF.

The ICF recognises two constructs that can be used with 'Activities and Participation': performance and capacity. 'Performance' is what the person does in their usual environment. 'Capacity' describes 'an individual's ability to execute a task or an action in a standardised environment, where a standardised environment may be:

- an actual environment commonly used for assessment in test settings; or
- in cases where this is not possible, an assumed environment which can be thought to have a uniform impact' (WHO 2001).

The standardised environment has not been generally operationalised. However, the recognition of these two constructs in the ICF underscores the importance of recording the environment in which activities are being performed.

This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed

by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).
The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en
• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:

Supersedes Activity - functioning, disability and health, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (17.9 KB)

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Disability Health, Standard 29/11/2006
Community services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005

Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Address

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327278
Registration status:	Health, Standard 01/03/2005 Community services, Standard 08/05/2006
Definition:	The referential description of a location where an entity is located or can be otherwise reached or found.

Collection and usage attributes

Comments:

Following are the attributes are commonly used in the formation of a full address:

- Address line; (address line is a composite data element containing many attributes of the specific location of a full address - see the current version of the Address line metadata item for further description and a list of its components for addresses located in Australia)
- Address type
- Australian state/territory identifier
- Country identifier
- Non-Australian State/province
- Postal delivery point identifier
- Postcode - Australian
- Postcode - international
- Suburb/town/locality

Some attributes of an address, located within Australia, also provide the elements to determine the **Statistical Local Are**a (SLA). This enables:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for facilities for planning purposes, and
- documentation of provision of services to clients who reside in other states or territories. The address is also a relevant element in the unambiguous identification of a Health Care Client and a Health Care Provider.

Source and reference attributes

Submitting organisation:	Health Data Standards Committee
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Address, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.31 KB)
Metadata items which use this glossary item:	Person (address)—address line, text [X(180)] Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Service provider organisation (address)—address line, text
[X(180)] Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327166
Registration status:	Health, Standard 01/03/2005
Definition:	Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category.

Relational attributes

Metadata items which use this glossary item:	Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Admission

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327206
Registration status:	Health, Standard 01/03/2005
Definition:	Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical. Formal admission: The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient. Statistical admission: The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.
Context:	Admitted patient care

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Admission, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.02 KB)
Metadata items which use this glossary item:	Accommodation type prior to admission code N Health, Standard 01/03/2005 Acute hospital and private psychiatric hospital admission labour force status code N Health, Standard 01/03/2005 Admission urgency status Health, Standard 01/03/2005 Admission urgency status code N Health, Standard 01/03/2005 Admitted patient Health, Standard 01/03/2005 Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Admitted patient hospital stay Health, Standard 01/03/2005 Clinical urgency code N Health, Standard 01/03/2005 Episode of admitted patient care—admission urgency status Health, Standard 01/03/2005

Episode of admitted patient care—admission urgency status, code N Health, Standard 01/03/2005

Episode of admitted patient care—elected accommodation status Health, Superseded 28/11/2006

Episode of admitted patient care—elected accommodation status, code N Health, Superseded 23/10/2006

Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005

Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Episode of admitted patient care—patient election status Health, Standard 28/11/2006

Episode of admitted patient care—patient election status, code N Health, Standard 23/10/2006

Episode of care—funding eligibility indicator (Department of Veterans Affairs), code N Health, Standard 01/03/2005

Establishment—specialised service indicator (geriatric assessment unit), yes/no code N Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard 05/12/2007

Non-admitted patient Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time (to hospital admission) Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Nursing diagnosis Health, Standard 01/03/2005

Patient—previous specialised treatment Health, Standard 01/03/2005

Patient—previous specialised treatment, code N Health, Standard 01/03/2005

Person—accommodation type (prior to admission), code N Health, Standard 01/03/2005

Person—labour force status, acute hospital and private psychiatric hospital admission code N Health, Standard 01/03/2005

Person—labour force status, public psychiatric hospital admission code N Health, Standard 01/03/2005

Person—reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004

Person—reason for readmission following acute coronary syndrome episode, code N[N] Health, Standard 04/06/2004

Previous specialised treatment code N Health, Standard 01/03/2005

Public psychiatric hospital admission labour force status code N Health, Standard 01/03/2005

Reason for readmission following acute coronary syndrome episode code N[N] Health, Standard 04/06/2004

Scheduled admission date Health, Standard 01/03/2005

Adoption

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327208
Registration status:	Community services, Standard 01/03/2005
Definition:	Adoption is the legal process by which a person legally becomes a child of the adoptive parents and legally ceases to be a child of his/her existing parents.
Context:	Children and family services.

Collection and usage attributes

Comments:	The adoption order severs the legal relationship between the biological parents and the child. A new birth certificate is issued to the child bearing the name(s) of his/her adoptive parent(s) as the natural parent(s) and the new name of the child, where a change has occurred.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)
Origin:	Adoptions Australia (AIHW). *Data collection standards, tables and counting rules*, 1998-99.

Relational attributes

Related metadata references:	Supersedes Adoption, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (12.33 KB)
Metadata items which use this glossary item:	Person (name)—family name, text X[X(39)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name)—family name, text X[X(39)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005

Ambulatory care

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	354366
Registration status:	Health, Standard 05/12/2007
Definition:	Care provided to hospital patients who are not admitted to the hospital, such as patients of **emergency departments** and **outpatient clinics**. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee
Origin:	AIHW 2007. Mental health services in Australia 2004–05. AIHW cat. no. HSE 47. Canberra: AIHW (Mental Health Series no. 9).

Relational attributes

Metadata items which use this glossary item:	Health industry relevant organisation type code NNN Health, Standard 05/12/2007 Health or health related function code NNN Health, Standard 05/12/2007

Assistance with activities and participation

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327298
Registration status:	Health, Standard 29/11/2006 Community services, Standard 01/03/2005
Definition:	The help that a person receives or needs from another person, because of their difficulty in performing an activity or in participating in an area of life.
Context:	'Assistance' is an important subset of Environmental factors that may facilitate (or hinder) the activities or participation of people with disability. Assistance is a key policy and service component in the disability and aged care services field in Australia. Further, it is recognised in the ICF as a crucial factor whose presence (or absence) must be noted when recording measures of functioning and disability. Recording measures of assistance needed or provided will provide further information about activity limitations.

Collection and usage attributes

Comments:	The concept can be used to describe aspects of the environment. Depending on which environment is present or being considered, the measure of assistance indicates what assistance is currently received (in the current or usual environment) and what would be needed (in an optimum environment). 'Need' more generally relates to environmental factors (including personal assistance, equipment and environmental modifications) that are present in an optimum environment but not in the person's current environment. That is, changes may be needed to environmental factors in order to improve a person's functioning and reduce their disability. While these ideas apply generally to 'Environmental Factors' and the related metadata item, Extent of environmental factors influence code [X]N, the concept of 'Assistance' focuses solely on the factor of personal assistance. Measures of assistance and need for assistance are under active development in a number of disciplines and service programs. Assistance may be measured in various ways, for instance in relation to duration, frequency and intensity of assistance. Related data elements are therefore likely to emerge in the future. This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for

example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website

http://www.who.int/classifications/icf/en

- Australian Collaborating Centre ICF website

http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:

Supersedes Assistance with activities and participation, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (17.39 KB)

Metadata items which use this glossary item:

Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Birthweight

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327212
Registration status:	Health, Standard 01/03/2005
Definition:	The first weight of the fetus or baby obtained after birth. The World Health Organization further defines the following categories: • extremely low birthweight: less than 1,000 grams (up to and including 999 grams), • very low birthweight: less than 1,500 grams (up to and including 1,499 grams), • low birthweight: less than 2,500 grams (up to and including 2,499 grams).
Context:	Perinatal

Collection and usage attributes

Comments:	The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low). For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 gram groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Relational attributes

Related metadata references:	Supersedes Birthweight, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.96 KB)
Metadata items which use this glossary item:	Birth Health, Standard 01/03/2005 Birth event—birth plurality, code N Health, Standard 01/03/2005 Birth order Health, Standard 01/03/2005 Birth status code N Health, Standard 01/03/2005 Birth—birth weight, total grams NNNN Health, Standard 01/03/2005 Female—number of previous pregnancies (spontaneous abortion), total NN Health, Standard 01/03/2005 Female—number of previous pregnancies (stillbirth), total N[N] Health, Standard 01/03/2005 Pregnancy (last previous)—pregnancy completion date, DDMMYYYY Health, Standard 01/03/2005

Blood pressure

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327210
Registration status:	Health, Standard 01/03/2005
Definition:	The pressure exerted by blood against the walls of the blood vessels - i.e. arteries, capillaries or veins.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases-Australian facts 2001. Canberra: AIHW. National Heart Foundation of Australia. National Stroke Foundation of Australia.

Relational attributes

Related metadata references:	Supersedes Blood pressure - concept, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (12.28 KB)
Metadata items which use this glossary item:	Adult—body mass index Health, Standard 01/03/2005 Person—blood pressure (diastolic) Health, Standard 01/03/2005 Person—blood pressure (diastolic) (measured), millimetres of mercury NN[N] Health, Standard 01/03/2005 Person—blood pressure (systolic) Health, Standard 01/03/2005 Person—blood pressure (systolic) (measured), millimetres of mercury NN[N] Health, Standard 01/03/2005 Person—hypertension treatment status (antihypertensive medication) Health, Superseded 21/09/2005 Person—hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Body functions

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327294
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	Body functions are the physiological functions of body systems (including psychological functions).

Collection and usage attributes

Guide for use:	Body functions are organised according to body systems. The term 'body' refers to the human organism as a whole and includes mental or psychological functions. Body functions are classified in neutral terms. To indicate that there is a problem with a body function requires the use of the impairment extent code to denote the extent or magnitude of the problem together with the body functions code
Comments:	This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of the ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin:	World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
Reference documents:	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites: • WHO ICF website http://www.who.int/classifications/icf/en/ • Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this	Body function code (ICF 2001) AN[NNNN] Health, Standard

glossary item:	29/11/2006 Community services, Standard 16/10/2006 Functioning and Disability DSS Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Body structures

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327300
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	Body structures are anatomical parts of the body such as organs, limbs and their components.

Collection and usage attributes

Guide for use:	Body structures are classified according to body systems. **Impairments of body structure** can involve anomaly, defect, loss and significant deviation. These are identified by use of the impairment extent, impairment location and impairment nature codes.
Comments:	This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin:	World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
Reference documents:	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites • WHO ICF website http://www.who.int/classifications/icf/en • Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this glossary item:	Functioning and Disability DSS Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Carer consultant

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327330
Registration status:	Health, Standard 08/12/2004
Definition:	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327302
Registration status:	Health, Standard 01/03/2005
Definition:	Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.
Context:	Alcohol and other drug treatment services

Collection and usage attributes

Guide for use:

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

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

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set working group
Origin:	

Relational attributes

Related metadata references:	Supersedes Cessation of treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.83 KB)
Metadata items which use this glossary item:	Episode of treatment for alcohol and other drugs—treatment cessation date, DDMMYYYY Health, Standard 01/03/2005

Clinical intervention

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327220
Registration status:	Health, Standard 01/03/2005
Definition:	An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.
Context:	Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Collection and usage attributes

Comments:	Clinical interventions include invasive and non-invasive procedures, and cognitive interventions. Invasive: (a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device); (b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration). Non-invasive: Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging). Cognitive: An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

Source and reference attributes

Submitting organisation:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Clinical intervention, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.88 KB)
Metadata items which use this glossary item:	Episode of admitted patient care—procedure Health, Standard 01/03/2005

Clinical review

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327214
Registration status:	Health, Standard 01/03/2005
Definition:	The examination of a patient by a clinician after the patient has been added to the elective care waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.
Context:	Admitted patient care.

Source and reference attributes

Submitting organisation:	Hospital Access Program Waiting List Working Group National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Clinical review, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.01 KB)
Metadata items which use this glossary item:	Elective care waiting list episode—category reassignment date Health, Standard 01/03/2005 Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005 Elective surgery waiting list episode—clinical urgency, code N Health, Standard 01/03/2005 Elective surgery waiting list episode—patient listing status, readiness for care code N Health, Standard 01/03/2005

Compensable patient

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327420
Registration status:	Health, Standard 01/03/2005
Definition:	A compensable patient is a person who: • is entitled to claim damages under Motor Vehicle Third Party insurance or • is entitled to claim damages under worker's compensation or • has an entitlement to claim under public liability or common law damages.

Relational attributes

Metadata items which use this glossary item:	Patient—compensable status, code N Health, Standard 01/03/2005

Consultant psychiatrist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327332
Registration status:	Health, Standard 08/12/2004
Definition:	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Consumer consultant

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327336
Registration status:	Health, Standard 08/12/2004
Definition:	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Diagnosis

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327224
Registration status:	Health, Standard 01/03/2005
Definition:	A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient or recipient of residential care (resident).
Context:	Health services: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Data Standards Committee
Origin:	

Relational attributes

Related metadata references:	Supersedes Diagnosis, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.65 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Person—visual acuity (left eye), code NN Health, Standard 01/03/2005 Person—visual acuity (right eye), code NN Health, Standard 01/03/2005

Diagnostic and health professional

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327164
Registration status:	Health, Standard 01/03/2005
Definition:	Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Disability

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327304
Registration status:	Health, Standard 29/11/2006 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multi-dimensional and complex concept and is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).

Collection and usage attributes

Comments:

Many different 'definitions' of disability are used in Australia, both in administrative data collections and in Acts of Parliament. The consistent identification of disability in national data collections has been recommended in a number of reports, for instance to enable:

- the monitoring of access to generic services by people with disability;
- the collection of more consistent data on disability support and related services, including data on service use by different groups;
- population data and service data to be related, thereby improving the nation's analytical capacity in relation to the need for and supply of services; and
- improved understanding of the relationship between disability, health conditions and other health outcomes.

Defining disability makes it possible to determine the number of people who are accessing services, both disability specific and generic, and also those with a disability in the general population with unmet need. Better definition of disability will aid better targeting of resources to those in need.

Disability arises from the interaction between health conditions and environmental and personal factors. A health condition may be a disease (acute or chronic), disorder, injury or trauma. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. Personal factors relate to the individual, such as age, sex and Indigenous status.

The concept 'Disability' can be described using a combination of related metadata items as building blocks.

The metadata items selected may vary depending on the definition of disability used. For example, in hospital rehabilitation, the focus may be on the impairment and **activity** dimensions and in community-based care the focus may be primarily on participation. Some applications may require a broad scope for inclusion (e.g. discrimination legislation). Data collections relating to services will select combinations of the data elements, which best reflect the eligibility criteria for the

service.

This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

• WHO ICF website
http://www.who.int/classifications/icf/en

• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Activity need for assistance code N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Body function code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Body structure code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Environmental factor code (ICF 2001) AN[NNN] Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Goal of care code NN Health, Standard 01/03/2005

Impairment extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Impairment location code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Impairment nature code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation satisfaction level code N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Domestic and other staff

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327168
Registration status:	Health, Standard 01/03/2005
Definition:	Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded. This category also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Elective surgery

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327226
Registration status:	Health, Standard 01/03/2005
Definition:	Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians.
Context:	Admitted patient care.

Source and reference attributes

Submitting organisation:	Hospital access program waiting list working group
Origin:	The National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Elective surgery, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.73 KB)
Metadata items which use this glossary item:	Coronary artery disease intervention code N Health, Standard 01/03/2005 Elective surgery code NN Health, Standard 01/03/2005

Emergency department

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327158
Registration status:	Health, Standard 01/03/2005
Definition:	An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Relational attributes

Metadata items which use this glossary item:	Emergency department visit type code N Health, Standard 01/03/2005 Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN] Health, Standard 01/03/2005 Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN] Health, Standard 01/03/2005 Health or health related function code NNN Health, Standard 05/12/2007 Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005 Health service event—presentation time, hhmm Health, Standard 01/03/2005 Health service event—service commencement date, DDMMYYYY Health, Superseded 07/12/2005 Non-admitted patient emergency department service episode Health, Standard 01/03/2005 Non-admitted patient service event Health, Standard 01/03/2005 Triage Health, Retired 07/12/2005 Triage Health, Standard 24/03/2006

Emergency department - public hospital

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327228
Registration status:	Health, Standard 01/03/2005
Definition:	The dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care. The emergency department must be part of a hospital and be licensed or otherwise recognised as an emergency department by the appropriate state or territory authority. An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition(s) and/or injury.
Context:	Emergency department care.

Collection and usage attributes

Comments:	This glossary term has been defined to support the National Minimum Data Set - Non-admitted patient emergency department care. It is not intended as a definitive statement of the role or purpose of an emergency department. The national definition of an emergency department and the care that is provided in an emergency department is characterised by jurisdictional and local differences. For example, there is no national agreement on the identification and classification of emergency department-related settings such as observation units, short stays units, or the use of 'admitted patient beds' located in an emergency department setting. Emergency department is therefore defined as a concept, and not necessarily as a physical premises, setting or site.

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001/02.

Relational attributes

Related metadata references:	Supersedes Emergency department - public hospital, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.06 KB)
Metadata items which use this glossary item:	Health or health related function code NNN Health, Standard 05/12/2007

Enrolled nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327160
Registration status:	Health, Standard 01/03/2005
Definition:	Enrolled nurses are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Environmental factors

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327286
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.
Context:	Environmental factors are external to the individual and can have a positive or negative influence on a person's participation as a member of society, on performance of activities, or on a person's body function or structure.

Collection and usage attributes

Guide for use:	In the ICF classification scheme Environmental factors are organised to focus on two different levels, individual and societal. Environmental factors interact with the Body structures/Body functions and Activities and participation components. A person's functioning and disability is conceived as the dynamic interaction between health conditions and environmental and personal factors.
Comments:	This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin:	World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
Reference documents:	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites • WHO ICF website http://www.who.int/classifications/icf/en • Australian Collaborating Centre ICF website

http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this glossary item:

Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person—extent of environmental factor influence, code (ICF 2001) [X]N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Episode of acute care

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Acute care episode for admitted patients
METeOR identifier:	327230
Registration status:	Health, Standard 01/03/2005
Definition:	An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following: • manage labour (obstetric), • cure illness or provide definitive treatment of injury, • perform surgery, • relieve symptoms of illness or injury (excluding palliative care), • reduce severity of illness or injury, • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, • perform diagnostic or therapeutic procedures.
Context:	Admitted patient care.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Acute care episode for admitted patients, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.22 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Episode of residential care end

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327194
Registration status:	Health, Standard 01/03/2005
Definition:	Episode of residential care end is the administrative process by which a residential care service either records: Formal episode of residential care end: • the formal end of residential care and accommodation of a resident, • the end of residential care and accommodation of a resident who has commenced leave where there is no intention that the resident returns to residential care within seven days, or; Statistical episode of residential care end: • the end of the reference period.
Context:	Specialised mental health services (Residential mental health care).

Relational attributes

Related metadata references:	Supersedes Episode of residential care end, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.99 KB)
Metadata items which use this glossary item:	Episode of residential care—episode end date Health, Standard 01/03/2005 Episode of residential care—episode end date, DDMMYYYY Health, Standard 01/03/2005 Episode of residential care—episode end mode Health, Standard 01/03/2005 Episode of residential care—episode end mode, code N Health, Standard 01/03/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008 Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Episode of residential care start

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327192
Registration status:	Health, Standard 01/03/2005
Definition:	The process whereby the residential care service accepts responsibility for the Resident's residential care and accommodation. Episode of residential care start is the administrative process by which a residential care service records either: Formal episode of residential care start: • the start of residential care and accommodation of a resident, and, • the unplanned return from leave of a resident (when there had been no intention of returning to overnight residential care within seven days); or Statistical episode of residential care start: • the start of a reference period for a resident continuing their residential care and accommodation, from the previous reference period.
Context:	Specialised mental health services (Residential mental health care).

Relational attributes

Related metadata references:	Supersedes Episode of residential care start, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.33 KB)
Metadata items which use this glossary item:	Episode of residential care—episode start date Health, Standard 01/03/2005 Episode of residential care—episode start date, DDMMYYYY Health, Standard 01/03/2005 Episode of residential care—episode start mode Health, Standard 01/03/2005 Episode of residential care—episode start mode, code N Health, Standard 01/03/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008 Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 Residential mental health care NMDS 2008-2009 Health,

Establishment based student nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327186
Registration status:	Health, Standard 01/03/2005
Definition:	Student nurses are persons employed by the establishment currently studying in years one to three of a three year certificate course. This includes any person commencing or undertaking a three year course of training leading to registration as a nurse by the state or territory registration board. This includes full time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post basic training courses.

Relational attributes

Metadata items which use this glossary item:	Establishment—recurrent expenditure (salaries and wages) (student nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Family

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	351499
Registration status:	Health, Standard 31/08/2007 Community services, Standard 31/08/2007
Definition:	Two or more people related by blood, marriage (registered or de facto), adoption, step or fostering who may or may not live together.

Source and reference attributes

Reference documents:	Australian Bureau of Statistics. Family, household and income unit variables. Cat No. 1286.0. Canberra: ABS. Viewed on 01/03/2007.

Relational attributes

Metadata items which use this glossary item:	Establishment—number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005 Informal carer Health, Standard 04/07/2007 Community services, Standard 03/05/2007 Person (name)—family name, text X[X(39)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name)—family name, text X[X(39)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005 Person (name)—given name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005 Person (name)—given name, text [X(40)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005 Person—informal carer existence indicator, code N Health, Standard 04/07/2007 Community services, Standard 29/04/2006

Functioning

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327292
Registration status:	Health, Standard 29/11/2006 Community services, Standard 01/03/2005
Definition:	Functioning is the umbrella term for any or all of: body functions, body structures, activities and participation. Functioning is a multidimensional concept denoting the neutral aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal factors.
Context:	An individual's functioning in a specific domain is an interaction or complex relationship between health conditions and environmental and personal factors. Functioning and disability are dual concepts in a broad framework, with disability focussing on the more negative aspects of this interaction.

Collection and usage attributes

Comments:	This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin:	World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
Reference documents:	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites • WHO ICF website http://www.who.int/classifications/icf/en • Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:	Supersedes Functioning, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.4 KB)
Metadata items which use this glossary item:	Functioning and Disability DSS Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Geographic indicator

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327306
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	A classification scheme that divides an area into mutually exclusive sub-areas based on geographic location. Some geographic indicators are: • Australian Standard Geographical Classification (ASGC, ABS Cat No. 1216.0), • administrative regions, • electorates, • Accessibility/Remoteness Index of Australia (ARIA), • Rural, Remote and Metropolitan Area Classification (RRMA), and • country.
Context:	To enable the analysis of data on a geographical basis. Facilitates analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.

Collection and usage attributes

Comments:	Person (address)—Australian postcode (Postcode datafile), code [NNNN] is not included in the above listing, as it is, strictly speaking, not a geographic indicator. Sometimes postcodes are used in the analysis of data on a geographical basis, which involves a conversion to Statistical Local Area (an Australian Bureau of Statistics geographical structure). This conversion results in some inaccuracy of information. However, in some data sets Person (address)—Australian postcode (Postcode datafile), code [NNNN]; is the only geographic identifier, therefore the use of other more accurate indicators (for example, conversion from address line to Statistical Local Area) is not always possible.

Source and reference attributes

Origin:	Australian Institute of Health and Welfare.

Relational attributes

Related metadata references:	Supersedes Geographic indicator, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.97 KB)
Metadata items which use this glossary item:	Australian state/territory identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005

Homeless

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327244
Registration status:	Community services, Standard 01/03/2005
Definition:	A person is homeless if he or she does not have access to safe, secure and stable housing. Hence even if a person has a physical home, they would be considered homeless if: • they were not safe at home, • they had no legal right to continued occupation of their home (security of tenure), or • the home lacked the amenities or resources necessary for living.
Context:	There is considerable concern over the number of homeless people in society and the assistance they require. Collecting information on homeless people is problematic, as the concept of 'homelessness' encompasses elements in addition to whether, someone resides in a dwelling or not.

Source and reference attributes

Submitting organisation:	SAAP National Data Collection Agency Australian Institute of Health and Welfare
Origin:	SAAP (Supported Accommodation Assistance Program) National Data Collection Agency 2001. *National Data Collection Data Dictionary*. Version 2. Unpublished

Relational attributes

Related metadata references:	Supersedes Homelessness, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13 KB)
Metadata items which use this glossary item:	Person (address)—suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005

Hospital boarder

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Boarder
METeOR identifier:	327242
Registration status:	Health, Standard 01/03/2005
Definition:	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Context:	Admitted patient care.

Collection and usage attributes

Guide for use:	A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.

Source and reference attributes

Submitting organisation:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Hospital boarder, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.13 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Hospital service Health, Standard 01/03/2005

Hospital-in-the-home care

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327308
Registration status:	Health, Standard 01/03/2005
Definition:	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
Context:	Admitted patient care.

Collection and usage attributes

Comments:

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

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

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

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

Source and reference attributes

Origin:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Hospital-in-the-home care, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.08 KB)
Metadata items which use this glossary item:	Admitted patient Health, Standard 01/03/2005 Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Episode of admitted patient care Health, Standard 01/03/2005

Episode of admitted patient care—number of days of hospital-in-the-home care Health, Standard 01/03/2005

Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]} Health, Standard 01/03/2005

Episode of care (community setting)—first service delivery date, DDMMYYYY Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard 05/12/2007

Number of days of hospital-in-the-home care Health, Standard 01/03/2005

Impairment of body structure

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327288
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.
Context:	Body structures are classified in ICF in neutral terms. To indicate that there is a problem with a body structure requires the use of the body structures code for the structure affected and the impairment extent code to denote the extent or magnitude of the problem. The impairment nature and impairment location codes can be used to expand the description of a problem with a body structure.

Source and reference attributes

Origin:	World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW **Comments** This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}. Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites • WHO ICF website http://www.who.int/classifications/icf/en • Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this	Body structures Health, Standard 29/11/2006

glossary item:	Community services, Standard 16/10/2006 Impairment nature code (ICF 2001) N Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Person—body structure, code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Informal carer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	353420
Registration status:	Health, Standard 04/07/2007 Community services, Standard 03/05/2007
Definition:	An informal carer includes any person, such as a **family** member, friend or neighbour, who is giving regular, ongoing assistance to another person.

Relational attributes

Metadata items which use this glossary item:	Person—informal carer existence indicator Health, Standard 04/07/2007 Community services, Standard 02/05/2006 Person—informal carer existence indicator, code N Health, Standard 04/07/2007 Community services, Standard 29/04/2006

Intensive care unit

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327234
Registration status:	Health, Standard 01/03/2005
Definition:	An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.
Context:	Admitted patient care.

Collection and usage attributes

Comments:

There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards (ACHS). The five types of ICU are briefly described below:

- Adult intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.
- Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines).
- Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for less than a 24-hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.
- Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care; and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular

monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.

- Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature. Definitions for high-dependency unit and coronary care unit are under development.

Source and reference attributes

Submitting organisation: National Intensive Care Working Group.

Relational attributes

Related metadata references: Supersedes Intensive care unit, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.93 KB)

Metadata items which use this glossary item:

Episode of admitted patient care—length of stay (special/neonatal intensive care), total days N[NN] Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Health establishment accrual accounting capital expenditure code N Health, Standard 01/03/2005

Leave period

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327156
Registration status:	Health, Standard 01/03/2005
Definition:	Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

Relational attributes

Metadata items which use this glossary item:	Episode of admitted patient care—number of leave periods Health, Standard 01/03/2005

Live birth

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327248
Registration status:	Health, Standard 01/03/2005
Definition:	A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.
Context:	Perinatal Source document: *International Classification of Diseases and Related Health Problems*, 10th Revision, Vol 1, World Health Organization, 1992.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee National Perinatal Data Advisory Committee.
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Live birth, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.82 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Birth event—birth plurality, code N Health, Standard 01/03/2005 Birth—birth weight, total grams NNNN Health, Standard 01/03/2005 Female—number of previous pregnancies (live birth), total NN Health, Standard 01/03/2005

Mental health-funded non-government organisation

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327446
Registration status:	Health, Standard 07/12/2005
Definition:	A private organisation that receives Australian Government and/or State/Territory funding specifically for the provision of community health and related support and information services for people with a mental disorder or psychiatric disability, their carers or the broader community. These include accommodation, advocacy, community awareness, health promotion, counselling, independent living skills, psychosocial, recreation, residential, respite and self-help services.

Collection and usage attributes

Comments:	Mental health funded non-government organisations may also provide other services that are not related to mental health programs or activities, and/or undertake mental health research. Mental health-funded non-government organisations are usually not-for-profit, but can include for-profit organisations.

Relational attributes

Metadata items which use this glossary item:	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Neonate

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327284
Registration status:	Health, Standard 01/03/2005
Definition:	A live birth who is less than 28 days old.
Context:	Perinatal.

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee National Perinatal Data Advisory Committee
Origin:	National Health Data Committee International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Relational attributes

Related metadata references:	Supersedes Neonate, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.06 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Newborn qualification status

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327254
Registration status:	Health, Standard 01/03/2005
Definition:	Qualification status indicates whether the patient day within a newborn episode of care is either qualified or unqualified.
Context:	Admitted patient care: To provide accurate information on care provided in newborn episodes of care through exclusion of unqualified patient days.

Collection and usage attributes

Guide for use:

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

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

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

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

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

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

Comments:

All babies born in hospital are admitted patients.

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

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

Relational attributes

Related metadata references:

Supersedes Newborn qualification status, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.11 KB)

Metadata items which use this glossary item:

Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Date of change to qualification status Health, Standard 01/03/2005

Episode of admitted patient care (newborn)—date of change to qualification status Health, Standard 01/03/2005

Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY Health, Standard 01/03/2005

Hospital care type code N[N].N Health, Standard 01/03/2005

Number of qualified days Health, Standard 01/03/2005

Non-financial asset

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327196
Registration status:	Health, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
Definition:	A non-financial asset is an entity functioning as a store of value, over which ownership may be derived over a period of time, and which is not a financial asset.

Relational attributes

Metadata items which use this glossary item:	Gross capital expenditure Health, Standard 01/03/2005 Housing assistance, Standard 10/02/2006

Occupational Therapist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327340
Registration status:	Health, Standard 08/12/2004
Definition:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (occupational therapists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Ophthalmologist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327364
Registration status:	Health, Standard 21/09/2005
Definition:	An ophthalmologist is a physician specialising in diagnosing and prescribing treatment for defects, injuries and diseases of the eye, and who is skilled at delicate eye surgery.

Relational attributes

Metadata items which use this glossary item:	Person—referral to ophthalmologist indicator Health, Standard 21/09/2005 Person—referral to ophthalmologist indicator (last 12 months), code N Health, Standard 21/09/2005

Organ procurement - posthumous

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327258
Registration status:	Health, Standard 01/03/2005
Definition:	Organ procurement - posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.
Context:	Hospital activity.

Collection and usage attributes

Comments:	This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian coding standards. Declarations of brain death are made in accordance with relevant state/territory legislation.

Relational attributes

Related metadata references:	Supersedes Organ procurement - posthumous, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.1 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Hospital service—care type Health, Standard 01/03/2005 Hospital service—care type, code N[N].N Health, Standard 01/03/2005

Other diagnostic and health professional

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327338
Registration status:	Health, Standard 08/12/2004
Definition:	Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (other diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Other medical officer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327342
Registration status:	Health, Standard 08/12/2004
Definition:	A person who is a medical officer employed or engaged by the organisation who is not registered as a psychiatrist within the state or territory nor is a formal trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (other medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Other personal care staff

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327162
Registration status:	Health, Standard 01/03/2005
Definition:	This category includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Outpatient clinic service

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	336980
Registration status:	Health, Standard 04/07/2007
Definition:	An examination, consultation, treatment or other service provided in an outpatient setting in a specialty unit or under an organisational arrangement administered by a hospital.
Context:	Non-admitted patient service activity, excluding emergency department. Does not include services provided through community health settings (such as community and child health centre).

Collection and usage attributes

Guide for use:	This glossary item relates to activity of a clinic. See the Outpatient care National Minimum Data Set Scope statement for observations about use of the term 'clinic' in hospitals.

Source and reference attributes

Submitting organisation:	Non-admitted patient NMDS Development Working Party, 2006
Origin:	NCCH consultants report to Outpatients NMDS Development Working Group, September 2004.

Relational attributes

Related metadata references:	Supersedes Outpatient clinic service Health, Superseded 04/07/2007
Metadata items which use this glossary item:	Health or health related function code NNN Health, Standard 05/12/2007 Outpatient care NMDS Health, Standard 04/07/2007 Outpatient clinic type Health, Standard 04/05/2005

Overnight-stay patient

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327256
Registration status:	Health, Standard 01/03/2005
Definition:	A patient who, following a clinical decision, receives hospital treatment for a minimum of one night, i.e. who is admitted to and separated from the hospital on different dates.
Context:	Admitted patient care

Collection and usage attributes

Comments:	An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital, unless they are receiving contracted care. If not under a hospital contract, a patient must be separated from one hospital and admitted to the other hospital on each occasion of transfer. An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) on a contracted basis is to be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for contracted hospital care. Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient is regarded as part of the overnight episode. A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care. Patients who leave of their own accord, die or are transferred on their first day in hospital are not overnight-stay patients.

Source and reference attributes

Origin:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Overnight-stay patient, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.12 KB)
Metadata items which use this glossary item:	Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005 Establishment—number of patient days, total N[N(7)] Health, Standard 01/03/2005

Palliative care agency

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	356474
Registration status:	Health, Standard 05/12/2007
Definition:	A palliative care agency is an organisation or organisational sub-unit that provides specialist palliative care and receives Australian or state/territory government funding (including Australian Health Care Agreement funding), or does not provide specialist palliative care but receives Australian Health Care Agreement funding to provide care incorporating a palliative approach or palliative care-related services.

Collection and usage attributes

Guide for use:	'Specialist palliative care' services work substantively in the area of palliative care they would usually provide consultative and ongoing care for people with a life-limiting illness and provide support for primary carers and family members, provide multi-disciplinary healthcare and employ healthcare professionals who have qualifications or experience in palliative care. Care may be provided in admitted patient and/or community settings. Community settings include outpatient facilities. A palliative care agency represents the level of an organisation that is responsible for the care provided to clients (i.e. care coordination) regardless of whether the agency provides this care directly or purchases the care on behalf of clients.

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Metadata items which use this glossary item:	Palliative care performance indicators DSS Health, Standard 05/12/2007 Service provider organisation—level of service delivery, palliative care code N Health, Standard 05/12/2007 Service provider organisation—service delivery setting, palliative care agency code N Health, Standard 05/12/2007

Participation - functioning, disability and health

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Participation
METeOR identifier:	327312
Registration status:	Health, Standard 29/11/2006 Community services, Standard 06/06/2005
Definition:	In the context of health, participation is involvement in a life situation.
Context:	Involvement refers to the lived experience of people in the actual context in which they live. This context includes 'Environmental Factors' - all aspects of the physical, social and attitudinal world. The individual's degree of involvement can be reflected by this glossary item when combined with Participation extent code (ICF 2001) X and Participation satisfaction level code X. 'Activities and participation' is one of three components that define the concept 'Disability', along with 'Body functions and structures' and 'Environmental factors'. 'Activities and participation' is also encompassed within the concept 'Functioning'. The concept 'Participation', as defined here and as measured in the metadata items Participation extent code (ICF 2001) X and Participation satisfaction level code X, may be relevant to people and human services not related to disability.

Collection and usage attributes

Comments:	Participation restrictions are problems an individual may experience in involvement in life situations. In time, a related and more generic data element may be developed. In the meantime, the addition of 'functioning, disability and health' to the name of this glossary item indicates that the current concept is based on the concept and framework developed by World Health Organization to assist in the classification and description of functioning and disability, as contained in the International Classification of Functioning, Disability and Health (ICF). This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO
Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en
• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:

Supersedes Participation - functioning, disability and health, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (17.19 KB)

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation satisfaction level code N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Psychiatrist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327334
Registration status:	Health, Standard 08/12/2004
Definition:	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Relational attributes

Metadata items which use this glossary item:	Establishment—recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Psychiatry registrar or trainee

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327344
Registration status:	Health, Standard 08/12/2004
Definition:	A medical officer who is a formal trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (psychiatry registrars and trainees)(financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Psychologist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327346
Registration status:	Health, Standard 08/12/2004
Definition:	A person who is registered to practice psychology with the relevant state and territory registration board.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (psychologists), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (psychologists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Public health

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Public health
METeOR identifier:	352234
Registration status:	Health, Standard 05/12/2007
Definition:	Organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions is the population as a whole, or population subgroups (NPHP 1998).
Context:	Public health functions

Collection and usage attributes

Guide for use:	To be used for collecting information on public health expenditure and activities.
Collection methods:	Collected through the National Public Health Expenditure Project and the Government Health Expenditure NMDS.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare.
Origin:	National Public Health Partnership 1998.
Reference documents:	(NPHP) National Public Health Partnership 1998. Public Health in Australia: the public health landscape: person, society, environment. Melbourne: NPHP.

Relational attributes

Metadata items which use this glossary item:	Health or health related function code NNN Health, Standard 05/12/2007

Record linkage

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327264
Registration status:	Community services, Standard 01/03/2005
Definition:	A process, technique or method that enables the bringing together of two or more records that are believed to belong to the same individual.
Context:	Record linkage may facilitate improved service provision, treatment or case management to individual clients.

Collection and usage attributes

Comments:	Linkage can occur across data systems or within data systems and may be done by using a range of identifiers. For statistical purposes, including planning, research or the measurement of service or program outcomes, record linkage facilitates separating multiple items clustered around individuals from total counts (for example, double counting of clients can be reduced when calculating total numbers of clients across several agencies). The proposed use of a linkage key in the Home and Community Care program (HACC) Minimum Data Set is intended to make it possible to count the number of HACC clients (without counting clients more than once) and the services which they receive. The Commonwealth-State Territory Disability Agreement National Minimum Data Set is using the statistical linkage key based on that for the HACC Minimum Data Set.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Commonwealth Department of Health and Family Services 1998 Home and Community Care (HACC) Data Dictionary Version 1.0 Canberra: DHFS

Relational attributes

Related metadata references:	Supersedes Record linkage, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.63 KB)
Metadata items which use this glossary item:	Person (name)—family name, text X[X(39)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name)—given name, text [X(40)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name)—given name, text [X(40)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005

Registered nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327182
Registration status:	Health, Standard 01/03/2005
Definition:	Registered nurses include persons with at least a three year training certificate and nurses holding post graduate qualifications. Registered nurses must be registered with the state/territory registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005 Non-admitted patient emergency department service episode—triage category, code N Health, Standard 01/03/2005

Resident

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327198
Registration status:	Health, Standard 01/03/2005
Definition:	A person who receives residential care intended to be for a minimum of one night.
Context:	Specialised mental health services (Residential mental health care).

Collection and usage attributes

Comments:	A resident in one residential mental health service cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Relational attributes

Related metadata references:	Supersedes Resident, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.92 KB)
Metadata items which use this glossary item:	Admitted patient mental health care NMDS Health, Superseded 23/10/2006 Admitted patient mental health care NMDS Health, Superseded 07/12/2005 Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008 Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 Episode of care—mental health legal status, code N Health, Standard 01/03/2005 Episode of care—number of psychiatric care days Health, Standard 01/03/2005 Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005 Episode of residential care Health, Standard 01/03/2005 Episode of residential care—episode end date Health, Standard 01/03/2005 Episode of residential care—episode end date, DDMMYYYY Health, Standard 01/03/2005 Episode of residential care—episode start date Health, Standard 01/03/2005 Episode of residential care—episode start date, DDMMYYYY Health, Standard 01/03/2005 Episode of residential care—number of leave days, total N[NN] Health, Standard 01/03/2005 Episode of residential care—referral destination (mental health care) Health, Standard 01/03/2005 Episode of residential care—referral destination (mental health care), code N Health, Standard 01/03/2005 Establishment—number of available beds for admitted

patients/residents Health, Standard 01/03/2005

Establishment—number of available beds for admitted patients/residents, average N[NNN] Health, Standard 01/03/2005

Health industry relevant organisation type code NNN Health, Standard 05/12/2007

Health or health related function code NNN Health, Standard 05/12/2007

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Residential stay—episode start date Health, Standard 01/03/2005

Residential stay—episode start date, DDMMYYYY Health, Standard 01/03/2005

Residential mental health care service

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327280

Registration status: Health, Standard 01/03/2005

Definition: A residential mental health service is a specialised mental health service that:

- employs mental health-trained staff on-site;
- provides rehabilitation, treatment or extended care:
  to residents provided with care intended to be on an overnight basis;
  in a domestic-like environment; and
- encourages the resident to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However all these services employ on-site mental health trained staff for some part of each day.

Context: Specialised residential mental health services.

Relational attributes

Related metadata references: Supersedes Residential mental health service, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.02 KB)

Metadata items which use this glossary item:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Episode of care—mental health legal status, code N Health, Standard 01/03/2005

Health industry relevant organisation type code NNN Health, Standard 05/12/2007

Health or health related function code NNN Health, Standard 05/12/2007

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Residential mental health care NMDS 2005-2006 Health,

Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Specialised mental health service setting code N Health, Superseded 08/12/2004

Specialised mental health service setting code N Health, Standard 08/12/2004

Revenue (other revenue)

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Other revenue
METeOR identifier:	357543
Registration status:	Health, Standard 05/12/2007
Definition:	All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from state or territory governments). This would include revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors. See text relating to offsetting practices. Gross revenue should be reported (except in relation to payments for inter-hospital transfers of goods and services).

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee
Origin:	Establishment—revenue (other revenue), METeOR Identification 269591, NHIG, Standard 01/03/2005

Relational attributes

Metadata items which use this glossary item:	Organisation—revenue Health, Standard 05/12/2007 Organisation—revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007

Revenue (patient)

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Patient revenue
METeOR identifier:	357539
Registration status:	Health, Standard 05/12/2007
Definition:	Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. All patient revenue is to be grouped together regardless of source of payment (Commonwealth, health fund, insurance company, direct from patient) or status of patient (whether inpatient or non-inpatient, private or compensable). Gross revenue should be reported.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee
Origin:	Establishment—revenue (patient) METeOR Identifier 269518 NHIG, Standard 01/03/2005

Relational attributes

Metadata items which use this glossary item:	Organisation—revenue Health, Standard 05/12/2007 Organisation—revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007

Revenue (recoveries)

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	357541
Registration status:	Health, Standard 05/12/2007
Definition:	All revenue received that is in the nature of a recovery of expenditure incurred. This would include: • income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors); • income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital; and • other recoveries such as those relating to inter-hospital services where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost. Generally, gross revenues should be reported but, where inter-hospital payments for transfers of goods and services are made, offsetting practices are acceptable to avoid double counting. Where a range of inter-hospital transfers of goods and services is involved and it is not possible to allocate the offsetting revenue against particular expenditure categories, then it is acceptable to bring that revenue in through recoveries.

Source and reference attributes

Origin:	Establishment—revenue (recoveries) METeOR Identifier 269417, NHIG, Standard 01/03/2005

Relational attributes

Metadata items which use this glossary item:	Organisation—revenue Health, Standard 05/12/2007 Organisation—revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007

Salaried medical officer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327188
Registration status:	Health, Standard 01/03/2005
Definition:	Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical offices engaged on an honorary, sessional or fee for service basis. This category includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent)

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005 Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Same-day patient

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327270

Registration status: Health, Standard 01/03/2005

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

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

Context: Admitted patient care.

Collection and usage attributes

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

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

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

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

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references: Supersedes Same-day patient, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.5 KB)

Metadata items which use this glossary item: Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded

05/02/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005

Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005

Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Standard 04/07/2007

Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Establishment—number of patient days, total N[N(7)] Health, Standard 01/03/2005

Separation

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327268
Registration status:	Health, Standard 01/03/2005
Definition:	Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical. Formal separation: The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient. Statistical separation: The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.
Context:	Admitted patient care.

Collection and usage attributes

Comments:	This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). While this concept is also applicable to non-Admitted patient care and welfare services, different terminology to 'separation' is often used in these other care settings.

Source and reference attributes

Submitting organisation:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Separation, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.42 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Admitted patient hospital stay Health, Standard 01/03/2005 Admitted patient mental health care NMDS Health, Superseded 07/12/2005 Admitted patient mental health care NMDS Health, Superseded 23/10/2006 Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008 Community mental health care NMDS 2005-2006 Health,

Superseded 07/12/2005

Episode of admitted patient care Health, Standard 01/03/2005

Episode of admitted patient care—number of leave days Health, Standard 01/03/2005

Episode of admitted patient care—number of leave periods, total N[N] Health, Standard 01/03/2005

Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Episode of admitted patient care—separation mode Health, Standard 01/03/2005

Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Episode of care—principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Episode of care—principal diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Standard 05/02/2008

Establishment—number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of separations Health, Standard 01/03/2005

Establishment—number of separations (financial year), total

N[NNNNN] Health, Standard 01/03/2005

Person—congenital malformation Health, Standard 01/03/2005

Person—congenital malformation, code (BPA 1979) ANN.N[N] Health, Standard 01/03/2005

Person—congenital malformation, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Person—congenital malformation, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Person—congenital malformation, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Standard 07/12/2005

Separation mode Health, Standard 01/03/2005

Separation mode code N Health, Standard 01/03/2005

Severe hypoglycaemia

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327322
Registration status:	Health, Standard 01/03/2005
Definition:	**Hypoglycaemia** requiring assistance from another party.

Relational attributes

Metadata items which use this glossary item:	Person—severe hypoglycaemia history Health, Superseded 21/09/2005 Person—severe hypoglycaemia indicator Health, Standard 21/09/2005 Person—severe hypoglycaemia indicator, code N Health, Standard 21/09/2005

Social Worker

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327348
Registration status:	Health, Standard 08/12/2004
Definition:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (social workers), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (social workers) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Student nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327328
Registration status:	Health, Standard 01/03/2005
Definition:	A person employed by a health establishment who is currently studying in years one to three of a three-year certificate course. This includes any person commencing or undertaking a three-year course of training leading to registration as a nurse by the State or Territory registration board. This includes full-time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post-basic training courses.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (student nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Trainee/pupil nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327190
Registration status:	Health, Standard 01/03/2005
Definition:	Trainee/pupil nurse includes any person commencing or undertaking a 1-year course of training leading to registration as an enrolled nurse on the state/territory registration board (includes all trainee nurses).

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (trainee/pupil nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (trainee/pupil nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Triage

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	334003
Registration status:	Health, Standard 24/03/2006
Definition:	Process by which a patient is briefly assessed upon arrival in the **emergency department** to determine the urgency of their problem and priority for care.
Context:	Emergency department care

Source and reference attributes

Reference documents:	Hospital Demand Management Group, Metropolitan Health and Aged Care Services Division, State Government Department of Human Services, Victoria. http://www.health.vic.gov.au/hdms/triage.htm

Relational attributes

Metadata items which use this glossary item:	Non-admitted patient emergency department service episode—triage date, DDMMYYYY Health, Standard 07/12/2005 Non-admitted patient emergency department service episode—triage time, hhmm Health, Standard 07/12/2005 Triage category code N Health, Standard 01/03/2005

Visiting medical officer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327170
Registration status:	Health, Standard 01/03/2005
Definition:	A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian Standard Classification of Occupations codes as the salaried medical officers category.

Relational attributes

Metadata items which use this glossary item:	Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005 Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

National health data dictionary
Summary of updates since version 13

The Australian Institute of Health and Welfare is Australia's national health and welfare statistics and information agency. The Institute's mission is *better information and statistics for better health and wellbeing.*

Please note that as with all statistical reports there is the potential for minor revisions of data in this report over its life. Please refer to the online version at <www.aihw.gov.au>.

Contents

Summary of updates since version 13 of the National health data dictionary (NHDD)

The purpose of this document is to inform users of updates to the NHDD version 14 posted on METeOR in June 2008. This reflects changes to national health data standards between July 2006 and June 2008. One national minimum data set (NMDS), two data set specifications, thirty eight data elements and seventeen glossary items have been added to the NHDD since July 2006. Other changes include the revision of thirty-nine data elements, twenty-one national minimum data sets, three data set specifications, five classifications and one glossary item. As a result of standards being revised thirty-nine data elements, twenty-one national minimum data sets, three data set specifications, one glossary item and five classifications have been superseded. No national standards have been retired since version 13 of the NHDD was published.

These new standards have been agreed to by the members of the Health Data Standards Committee (HDSC), Statistical Information Management Committee (SIMC) and endorsed by the Health Data Standards Committee (NHDC) and the National Electronic Health Information Principal Committee (NEHIPC).

Table 1: Summary table of updates to the NHDD since version 13

Registration status	National Minimum Data Sets	Data Set Specifications	Data elements	Classifications	Glossary items
Standards (new)	1	2	38	Nil	17
Standards (revised)	21	3	39	5	1
Superseded	21	3	39	5	1
Retired	Nil	Nil	Nil	Nil	Nil

Table 2: Revised national minimum data sets (NMDS)

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
Admitted patient care NMDS 2008–2009	Revised scope statement which provides information about the purpose of the NMDS. Revision to seven data elements and the addition of one data element.	Activity when injured Additional diagnosis Area of usual residence External cause (admitted patient) Place of occurrence of external cause of injury (ICD-10-AM) Principal diagnosis Procedure	Condition onset flag	Nil
Admitted patient mental health care NMDS 2008–2009	Revisions to three data elements.	Additional diagnosis Area of usual residence Principal diagnosis	Nil	Nil

(continued)

Table 2 (continued): Revised national minimum data sets (NMDS)

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
Admitted patient care NMDS 2007–2008	Revision to three data elements and the removal of one data element from the NMDS.	Area of usual residence Funding source for hospital patient Admitted patient election status	Nil	Medicare eligibility status
Admitted patient mental health care NMDS 2007–2008	Revision to one data element in the NMDS.	Area of usual residence	Nil	Nil
Admitted patient palliative care NMDS 2007–08	Revision to two data elements in the NMDS.	Funding source for hospital patient Area of usual residence	Nil	Nil
Admitted patient palliative care NMDS 2008–09	Revisions to three data elements.	Additional diagnosis Area of usual residence Principal diagnosis	Nil	Nil
Alcohol and other drug treatment services NMDS 2007–2008	Revision to one data element in the NMDS.	Geographical location of service delivery outlet	Nil	Nil
Alcohol and other drug treatment services NMDS 2008–2009	Revision to one data element.	Area of usual residence	Nil	Nil
Community mental health care NMDS 2007–2008	Revision to one data element in the NMDS.	Area of usual residence	Nil	Nil
Community mental health care NMDS 2008–2009	Revisions to two data elements.	Area of usual residence Principal diagnosis	Nil	Nil
Mental health establishments NMDS 2007–2008	Revision to one data element in the NMDS.	Geographical location of establishment	Nil	Nil
Mental health establishments NMDS 2008–2009	Revision to one data element.	Geographical location of establishment	Nil	Nil
Non-admitted patient emergency department care NMDS 2008–2009	Revision to one data element.	Area of usual residence	Nil	Nil
Outpatient Care NMDS 2007–2008	Revision to the scope statement and three data elements in the NMDS.	Number of group sessions Number of occasions of service Outpatient clinic type	Nil	Nil
Perinatal NMDS 2008–2009	Revision to one data element.	Area of usual residence	Nil	Nil
Public hospital establishments NMDS 2008–2009	Revision to one data element.	Geographical location of establishment	Nil	Nil
Residential mental health care NMDS 2008–2009	Revisions to three data elements.	Additional diagnosis Area of usual residence Principal diagnosis	Nil	Nil

(continued)

Table 2 (continued): Revised national minimum data sets (NMDS)

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
Non-admitted patient emergency department care NMDS 2007–2008	Revision to one data element in the NMDS	Area of usual residence	Nil	Nil
Perinatal NMDS 2007–2008	Revision of NMDS description that broadens the scope. Revisions of two data elements and the addition of one data element to the NMDS.	Method of birth Presentation at birth	Area of usual residence	Nil
Public hospital establishments NMDS 2007–2008	Revision to one data element in the NMDS.	Geographical location of establishment	Nil	Nil
Residential mental health care NMDS 2007–2008	Revision to one data element in the NMDS.	Area of usual residence	Nil	Nil

Table 3: New national minimum data sets (NMDS)

Name	Description
Government health expenditure NMDS 2008–2009	The scope of this dataset is direct government and government-funded expenditure on health and health—related goods and services.

Table 4: Revised data set specifications (DSS)

DSS	Description of change	Data elements revised	Data elements added	Data elements removed
Cardiovascular disease (clinical) DSS	Revision to one data element in the NMDS.	Informal carer existence indicator	Nil	Nil
Health care provider identification DSS	Revision to one data element in the NMDS.	Provider occupation category (self-identified)	Nil	Nil
Injury surveillance DSS	Revisions to three data elements.	Activity when injured External cause (admitted patient) Place of occurrence of external cause of injury	Nil	Nil

Table 5: New data set specifications (DSS)

Name	Description
Functioning and disability DSS	The Functioning and disability DSS is new to the NHDD. Its aim is to ensure national consistency in relation to defining and measuring human functioning and disability. This DSS has been developed to be consistent with the International Classification of Functioning, Disability and Health (ICF).
Palliative care performance indicator DSS	This data set specification collects information about all government-funded palliative care agencies. It specifies information for collection about all administrative health regions, and whether they have developed strategic plans which incorporate specified palliative care elements.

Table 6: Revised data elements

Short name	Technical name	Description of change
Activity when injured	Injury event—activity type, code (ICD-10-AM 6th edition) ANNNN	Revisions are a result of the release of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition (ICD-10-AM 6th edition)
Additional diagnosis	Episode of care—additional diagnosis, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Admitted patient election status	Episode of admitted patient care—patient election status, code N	Technical name changed from Episode of admitted patient care—elected accommodation status, code N. Additional information provided in the guide for use field and text deleted from the collection methods field.
Area of usual residence	Person—area of usual residence, geographical location code (ASGC 2006) NNNNN	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2006.
Area of usual residence	Person—area of usual residence, geographical location code (ASGC 2007) NNNNN	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2007.
Cancer treatment—target site (ICD-10-AM)	Cancer treatment—target site for cancer treatment, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Complication of labour and delivery	Birth event—complication, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Condition onset flag	Episode of admitted patient care—condition onset flag, code N	Technical name changed from Episode of admitted patient care—diagnosis onset type, code N and Short name changed from Diagnosis onset type. Definition changed to clarify its meaning. Changes to the Value domain and guide for use and comments made to clarify the use of this data element.
Department of Veterans' Affairs file number	Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNNA	Representation and guide for use revised to clarify the representation of a file number for a DVA dependent.
External cause (admitted patient)	Injury event—external cause, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Funding source for hospital patient	Episode of care—principal source of funding, hospital code NN	Technical name and definition changed to remove the word and meaning of 'Expected' from the data element. Additional information provided in the guide for use field. New code 13 *No charge raised* added to value domain.
Geographical location of establishment	Establishment—geographical location, code (ASGC 2006) NNNNN	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2006.
Geographical location of establishment	Establishment—geographical location, code (ASGC 2007) NNNNN	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2007.
Geographical location of service delivery outlet	Service delivery outlet—geographic location, code (ASGC 2006) NNNNN	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2006.

(continued)

Table 6 (continued): Revised data elements

Short name	Technical name	Description of change
Geographical location of service delivery outlet	Service delivery outlet—geographic location, code (ASGC 2007) NNNNN	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2007.
Informal carer existence indicator	Person—informal carer existence indicator, code N	Revisions to technical name, short name, definition, value domain, guide for use and collection methods. The intent of revisions is to better reflect whether a person has an informal carer.
Length of stay (including leave days)	Episode of admitted patient care—length of stay (including leave days), total N[NN]	Revisions to guide for use and correction to formula for calculating length of stay.
Length of stay (including leave days) (antenatal)	Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN]	Revisions to definition, guide for use and correction to formula for calculating antenatal length of stay.
Length of stay (including leave days) (postnatal)	Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN]	Revisions to definition, guide for use and correction to formula for calculating postnatal length of stay.
Main occupation of person	Person—occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}	Revisions to technical name to include Australian and New Zealand Standard Classification of Occupations (ANZSCO) 1st edition and to guide for use.
Maternal medical conditions	Female (pregnant)—maternal medical condition, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Medicare eligibility status	Person—eligibility status, Medicare code N	Revisions to guide for use to clarify how to determine the Medicare eligibility of a newborn baby. Additional information provided in the guide for use field and context removed from this data element.
Method of birth	Birth event—birth method, code N	Technical name changed from Birth event—delivery method, code N. Additional information provided in the guide for use field.
Neonatal morbidity	Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Number of group sessions	Establishment—number of group sessions, total N[NNNNN]	Revisions to definition, guide for use and collection methods to strengthen the description of group session.
Number of occasions of service	Establishment—number of occasions of service, total N[NNNNNN]	Revisions to definition, guide for use and collection methods to strengthen the description of occasions of service.
Outpatient clinic type	Establishment—outpatient clinic type, code N[N]	Revisions to definition, value domain and guide for use to better describe outpatient clinics.
Place of occurrence of external cause of injury (ICD-10-AM)	Injury event—place of occurrence, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Postpartum complication	Birth event—complication (postpartum), code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Presentation at birth	Birth event—birth presentation, code N	Revisions have been made to the definition, guide for use and comments fields.

(continued)

Table 6 (continued): Revised data elements

Short name	Technical name	Description of change
Primary site of cancer (ICD-10-AM code)	Person with cancer—primary site of cancer, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Principal diagnosis	Episode of care—principal diagnosis, code (ICD-10-AM 6th edition) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM 6th edition.
Procedure	Episode of admitted patient care—procedure, code (ACHI 6th edition) NNNNN-NN	Revisions are a result of the release of the Australian Classification of Health Interventions (ACHI) 6th edition
Provider occupation category (self-identified)	Individual service provider—occupation (self-identified), code (ANZSCO 1st edition) N[NNN]{NN}	Revisions to technical name to include ANZSCO 1st edition and to guide for use updating commonly used Australian Standard Classification of Occupation (ASCO) codes with Australian and New Zealand Standard Classification of Occupation (ANZSCO) codes.
Revenue—other	Establishment—revenue (other revenue) (financial year), total Australian currency N[N(8)]	Revisions are to the definition of property for consistency with the Australian Accounting Standards Board 118 (2007) definition for revenue.
Revenue—patient	Establishment—revenue (patient) (financial year), total Australian currency N[N(8)]	Revisions are to the definition of property for consistency with the Australian Accounting Standards Board 118 (2007) definition for revenue.
Revenue—recoveries	Establishment—revenue (recoveries) (financial year), total Australian currency N[N(8)]	Revisions are to the definition of property for consistency with the Australian Accounting Standards Board 118 (2007) definition for revenue.
Surgical treatment procedure for cancer	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 6th edition) NNNNN-NN	Revisions are a result of the release of the ICD-10-AM 6th edition.

Table 7: New data elements

Short name	Technical name
Activity and participation life area	Person—activity and participation life area, code (ICF 2001) AN[NNN]
Administrative health region name	Administrative health region—region name, text [A(80)]
Administrative health region palliative care strategic plan indicator	Administrative health region—palliative care strategic plan indicator, yes/no code N
Assistance with activities	Person—need for assistance with activities in a life area, code N
Australian State/Territory identifier (jurisdiction)	Jurisdiction—Australian State/Territory identifier, code N
Body function	Person—body function, code (ICF 2001) AN[NNNN]
Body structure	Person—body structure, code (ICF 2001) AN[NNNN]
Caesarean section indicator, last previous birth	Female—caesarean section indicator (last previous birth) code N
Change to body structure	Person—nature of impairment of body structure, code (ICF 2001) N
Coordinator of volunteers indicator	Service provider organisation—coordinator of volunteers indicator, yes/no code N
Depreciation expenses	Organisation—depreciation expenses, total Australian currency NNNNN.N
Difficulty with activities	Person—level of difficulty with activities in life areas, code (ICF 2001) N

(continued)

Table 7 (continued): New data elements

Short name	Technical name
Employee expenses	Organisation—employee related expenses, total Australian currency NNNNN.N
Environmental factor	Person—environmental factor, code (ICF 2001) AN[NNN]
Extent of participation	Person—extent of participation in a life area, code (ICF 2001) N
Feedback collection indicator	Service provider organisation—feedback collection indicator, yes/no code N
Feedback collection method	Service provider organisation—feedback collection method, code N
Health industry relevant organisation type	Health industry relevant organisation—main activity type, code NNN
Impairment of body function	Person—extent of impairment of body function, code (ICF 2001) N
Impairment of body structure	Person—extent of impairment of body structure, code (ICF 2001) N
Influence of environmental factor	Person—extent of environmental factor influence, code (ICF 2001) [X]N
Level of palliative care service	Service provider organisation—level of service delivery, palliative care code N
Location of impairment	Person—location of impairment of body structure, code (ICF 2001) N
Most common service delivery setting	Service provider organisation—most common service delivery setting, code N
Number of caesarean sections	Female—number of caesarean sections, total count N[N]
Organisation expenses, total Australian currency	Organisation—expenses, total Australian currency NNNNN.N
Organisation revenues	Organisation—revenue, total Australian currency NNNNN.N
Palliative care agency service delivery setting	Service provider organisation—service delivery setting, palliative care agency code N
Parity	Female—parity, total N[N]
Partner organisation type	Service provider organisation—partner organisation type, palliative care code N[N]
Purchase of goods and services	Organisation—purchase of goods and services, total Australian currency NNNNN.N
Satisfaction with participation	Person—level of satisfaction with participation in a life area, code N
Source of public and private revenue	Health industry relevant organisation—source of revenue, public and private code NNN
Standards assessment indicator	Service provider organisation—standards assessment indicator, yes/no code N
Standards assessment level	Service provider organisation—standards assessment level, code N
Standards assessment method	Service provider organisation—standards assessment method, code N
Type of health or health related function	Organisation—type of health or health related function, code NNN
Working partnership indicator	Service provider organisation—working partnership indicator, yes/no code N

Table 8: Revised classification schemes

Name	Description of change
Australian and New Zealand Standard Classification of Occupations, First edition, 2006	Revisions are a result of the release of the Australia and New Zealand Standard Classification of Occupations (ANZSCO) 2006.
Australian Classification of Health Interventions (ACHI) 6th edition	Revisions are a result of the release of the Australian Classification of Health Interventions (ACHI) 6th edition

(continued)

Table 8 (continued): Revised classification schemes

Name	Description of change
Australian Standard Geographical Classification 2006	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2006.
Australian Standard Geographical Classification 2007	Revisions are a result of the release of the Australian Standard Geographical Classification (ASGC) 2007.
International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition	Revisions are a result of the release of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition (ICD-10-AM 6th edition)

Table 9: New glossary items

Name	Description
Activity (functioning, disability and health)	In the context of health, an activity is the execution of a task or action by an individual.
Ambulatory care	Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. Used in the Government health expenditure NMDS.
Assistance with activities and participation	The help that a person receives or needs from another person, because of their difficulty in performing an activity or in participating in an area of life.
Body functions	Body functions are the physiological functions of body systems (including psychological functions).
Body structures	Body structures are anatomical parts of the body such as organs, limbs and their components.
Disability	Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation.
	Disability is a multi-dimensional and complex concept and is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).
Environmental factors	Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.
Functioning	Functioning is the umbrella term for any or all of: body functions, body structures, activities and participation. Functioning is a multidimensional concept denoting the neutral aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal factors.
Impairment of body function	Impairments of body function are problems in body function such as a loss or significant departure from population standards or averages.
Impairment of body structure	Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.
Informal carer	This item was created to support the definitional changes to the data element *'Informal carer existence indicator'*.
	An informal carer includes any person, such as a family member, friend or neighbour, who is giving regular, ongoing assistance to another person.
Palliative care agency	A palliative care agency is an organisation or organisational sub-unit that provides specialist palliative care and receives Australian or state/territory government funding. Used in the Palliative care performance indicator DSS.
Public health	Organised response by society to protect and promote health, and to prevent illness, injury and disability. Used in the Government health expenditure NMDS.
Revenue (other revenue)	All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from state or territory governments). Used in the Government health expenditure NMDS
Revenue (patient)	Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. Used in the Government health expenditure NMDS.
Revenue (recoveries)	All revenue received that is in the nature of a recovery of expenditure incurred. Used in the Government health expenditure NMDS.

Table 10: Revised glossary items

Name	Description
Outpatient clinic service	Revisions are made to the description of outpatient clinic services and to the submitting organisation as the Non-admitted patient NMDS Development Working Party 2006.

Data elements included in National health minimum data sets—short name order

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Accrued mental health care days										✓					
Activity when injured	✓														
Actual place of birth													✓		
Additional diagnosis	✓	✓	✓												✓
Admission date	✓	✓	✓												
Admitted patient election status	✓														
Apgar score at 5 minutes													✓		
Area of usual residence	✓	✓	✓		✓						✓		✓		✓
Australian State/Territory identifier (establishment)	✓				✓					✓					✓
Australian State/Territory identifier (jurisdiction)								✓							

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Birth order													✓		
Birth plurality													✓		
Care type	✓	✓	✓												
Carer participation arrangements—carer consultants employed										✓					
Carer participation arrangements—carer satisfaction surveys										✓					
Carer participation arrangements—formal complaints mechanism										✓					
Carer participation arrangements—formal participation policy										✓					
Carer participation arrangements—regular discussion groups										✓					
Census date						✓									
Classification of health labour force job									✓						
Client type (alcohol and other drug treatment services)				✓											
Clinical urgency						✓	✓								
Co-location status of mental health service										✓					
Compensable status											✓				
Condition onset flag	✓														

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Consumer committee representation arrangements										✓					
Consumer participation arrangements—consumer consultants employed										✓					
Consumer participation arrangements—consumer satisfaction surveys										✓					
Consumer participation arrangements—formal complaints mechanism										✓					
Consumer participation arrangements—formal participation policy										✓					
Consumer participation arrangements—regular discussion groups										✓					
Country of birth	✓	✓	✓	✓	✓						✓		✓		✓
Date of birth	✓	✓	✓	✓	✓				✓		✓		✓		✓
Date of cessation of treatment episode for alcohol and other drugs				✓											
Date of commencement of treatment episode for alcohol and other drugs				✓											
Date of triage											✓				
Date patient presents											✓				
Department of Veterans' Affairs patient											✓				
Depreciation expenses								✓							
Diagnosis related group	✓	✓													

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Emergency department arrival mode - transport											✓				
Emergency department date of commencement of service event											✓				
Emergency department departure date											✓				
Emergency department departure time											✓				
Emergency department episode end date											✓				
Emergency department episode end time											✓				
Emergency department service episode end status											✓				
Emergency department time of commencement of service event											✓				
Employee expenses								✓							
Employment status—admitted patient		✓													
Employment status—public psychiatric hospital admissions		✓													
Episode of residential care end date															✓
Episode of residential care end mode															✓
Episode of residential care start date															✓
Episode of residential care start mode															✓

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Establishment identifier		✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓
Establishment number	✓				✓					✓					✓
Establishment sector	✓				✓					✓					✓
Establishment type														✓	
Extended wait patient						✓	✓								
External cause (admitted patient)	✓														
Full-time equivalent staff (mental health) – all staff										✓					
Full-time equivalent staff—administrative and clerical staff										✓				✓	
Full-time equivalent staff—carer consultants										✓					
Full-time equivalent staff—consultant psychiatrists and psychiatrists										✓					
Full-time equivalent staff—consumer consultants										✓					
Full-time equivalent staff—diagnostic and health professionals										✓				✓	
Full-time equivalent staff—domestic and other staff										✓				✓	
Full-time equivalent staff—enrolled nurses										✓				✓	
Full-time equivalent staff—occupational therapists										✓					

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Full-time equivalent staff—other diagnostic and health professionals										✓					
Full-time equivalent staff—other medical officers										✓					
Full-time equivalent staff—other personal care staff										✓				✓	
Full-time equivalent staff—psychiatry registrars and trainees										✓					
Full-time equivalent staff—psychologists										✓					
Full-time equivalent staff—registered nurses										✓				✓	
Full-time equivalent staff—salaried medical officers										✓				✓	
Full-time equivalent staff—social workers										✓					
Full-time equivalent staff—student nurses														✓	
Full-time equivalent staff—trainee/pupil nurses														✓	
Funding source for hospital patient	✓		✓												
Geographical location of establishment										✓				✓	
Geographical location of service delivery outlet				✓											
Gestational age													✓		
Grants to non-government organisations—accommodation services										✓					

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Grants to non-government organisations—advocacy services										✓					
Grants to non-government organisations—community awareness/health promotion services										✓					
Grants to non-government organisations—counselling services										✓					
Grants to non-government organisations—independent living skills support services										✓					
Grants to non-government organisations—other and unspecified mental health services										✓					
Grants to non-government organisations—pre-vocational training services										✓					
Grants to non-government organisations—psychosocial support services										✓					
Grants to non-government organisations—recreation services										✓					
Grants to non-government organisations—respite services										✓					
Grants to non-government organisations—self-help support groups services										✓					
Mental health services grants to non-government organisations by non-health departments										✓					
Gross capital expenditure (accrual accounting)—buildings and building services														✓	
Gross capital expenditure (accrual accounting)—constructions														✓	
Gross capital expenditure (accrual accounting)—equipment														✓	
Gross capital expenditure (accrual accounting)—information technology														✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Gross capital expenditure (accrual accounting)—intangible assets														✓	
Gross capital expenditure (accrual accounting)—land														✓	
Gross capital expenditure (accrual accounting)—major medical equipment														✓	
Gross capital expenditure (accrual accounting)—other equipment														✓	
Gross capital expenditure (accrual accounting)—transport														✓	
Gross capital expenditure—computer equipment/installations														✓	
Gross capital expenditure—intangible assets														✓	
Gross capital expenditure—land and buildings														✓	
Gross capital expenditure—major medical equipment														✓	
Gross capital expenditure—other														✓	
Gross capital expenditure—plant and other equipment														✓	
Group sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient														✓	
Group sessions (public psychiatric, alcohol and drug hospital)—outreach and community														✓	
Group sessions—alcohol and other drug														✓	
Group sessions—allied health services														✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Group sessions—community health services														✓	
Group sessions—dental														✓	
Group sessions—dialysis														✓	
Group sessions—district nursing services														✓	
Group sessions—emergency services														✓	
Group sessions—endoscopy and related procedures														✓	
Group sessions—mental health														✓	
Group sessions—other medical/surgical/diagnostic														✓	
Group sessions—other outreach services														✓	
Group sessions—pathology														✓	
Group sessions—pharmacy														✓	
Group sessions—radiology and organ imaging														✓	
Health industry relevant organisation type								✓							
Hospital insurance status	✓														
Hours on-call (not worked) by medical practitioner									✓						

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Hours worked by health professional									✓						
Hours worked by medical practitioner in direct patient care									✓						
Indicator procedure						✓	✓								
Indigenous status	✓	✓	✓	✓	✓						✓		✓		✓
Individual sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient														✓	
Individual sessions (public psychiatric, alcohol and drug hospital)—outreach and community														✓	
Individual sessions—alcohol and drug														✓	
Individual sessions—allied health services														✓	
Individual sessions—community health services														✓	
Individual sessions—dental														✓	
Individual sessions—dialysis														✓	
Individual sessions—district nursing services														✓	
Individual sessions—emergency services														✓	
Individual sessions—endoscopy and related procedures														✓	
Individual sessions—mental health														✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Individual sessions—other medical/surgical/diagnostic														✓	
Individual sessions—other outreach services														✓	
Individual sessions—pathology														✓	
Individual sessions—pharmacy														✓	
Individual sessions—radiology and organ imaging														✓	
Infant weight, neonate, stillborn													✓		
Injecting drug use status				✓											
Intended length of hospital stay	✓														
Inter-hospital contracted patient	✓														
Leave days from residential care															✓
Length of non-admitted patient emergency department service episode											✓				
Listing date for care						✓	✓								
Main treatment type for alcohol and other drugs				✓											
Major diagnostic category	✓	✓													
Marital status		✓			✓										✓

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Mental health legal status	✓	✓			✓										✓
Mental health service contact date					✓										
Mental health service contact duration					✓										
Mental health service contact—patient/client participation indicator					✓										
Mental health service contact—session type					✓										
Method of birth													✓		
Method of use for principal drug of concern				✓											
Mode of admission	✓		✓												
Mode of separation	✓	✓	✓												
National standards for mental health services review status										✓					
Net capital expenditure (accrual accounting)—buildings and building services														✓	
Net capital expenditure (accrual accounting)—constructions														✓	
Net capital expenditure (accrual accounting)—equipment														✓	
Net capital expenditure (accrual accounting)—information technology														✓	
Net capital expenditure (accrual accounting)—intangible assets														✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Net capital expenditure (accrual accounting)—land														✓	
Net capital expenditure (accrual accounting)—major medical equipment														✓	
Net capital expenditure (accrual accounting)—other equipment														✓	
Net capital expenditure (accrual accounting)—transport														✓	
Number of available beds for admitted patients										✓				✓	
Number of days of hospital-in-the-home care	✓		✓												
Number of episodes of residential care										✓					
Number of group sessions												✓			
Number of occasions of service												✓			
Number of qualified days for newborns	✓														
Onset of labour													✓		
Organisation expenses, total Australian currency								✓							
Organisation revenues								✓							
Other drug of concern				✓											
Other treatment type for alcohol and other drugs				✓											

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Outpatient clinic type												✓			
Overdue patient						✓	✓								
Person identifier	✓	✓	✓	✓	✓						✓		✓		✓
Place of occurrence of external cause of injury (ICD-10-AM)	✓														
Preferred language				✓											
Presentation at birth													✓		
Previous specialised treatment		✓	✓												
Principal area of clinical practice									✓						
Principal diagnosis	✓	✓	✓		✓										✓
Principal drug of concern				✓											
Principal role of health professional									✓						
Procedure	✓														
Profession labour force status of health professional									✓						
Purchase of goods and services								✓							
Reason for cessation of treatment episode for alcohol and other drugs				✓											

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Reason for removal from elective surgery waiting list							✓								
Recurrent expenditure (indirect health care)—central administrations														✓	
Recurrent expenditure (indirect health care)—central and statewide support services														✓	
Recurrent expenditure (indirect health care)—other														✓	
Recurrent expenditure (indirect health care)—patient transport services														✓	
Recurrent expenditure (indirect health care)—public health and monitoring services														✓	
Recurrent expenditure (mental health)—non-salary operating costs										✓					
Recurrent expenditure (mental health)—salaries and wages										✓					
Recurrent expenditure (salaries and wages)—administrative and clerical staff										✓				✓	
Recurrent expenditure (salaries and wages)—carer consultants										✓					
Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists										✓					
Recurrent expenditure (salaries and wages)—consumer consultants										✓					
Recurrent expenditure (salaries and wages)—diagnostic and health professionals										✓				✓	
Recurrent expenditure (salaries and wages)—domestic and other staff										✓				✓	
Recurrent expenditure (salaries and wages)—enrolled nurses										✓				✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Recurrent expenditure (salaries and wages)—occupational therapists										✓					
Recurrent expenditure (salaries and wages)—other diagnostic and health professionals										✓					
Recurrent expenditure (salaries and wages)—other medical officers										✓					
Recurrent expenditure (salaries and wages)—other personal care staff										✓				✓	
Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees										✓					
Recurrent expenditure (salaries and wages)—psychologists										✓					
Recurrent expenditure (salaries and wages)—registered nurses										✓				✓	
Recurrent expenditure (salaries and wages)—salaried medical officers										✓				✓	
Recurrent expenditure (salaries and wages)—social workers										✓					
Recurrent expenditure (salaries and wages)—student nurses														✓	
Recurrent expenditure (salaries and wages)—total														✓	
Recurrent expenditure (salaries and wages)—trainee/pupil nurses														✓	
Recurrent expenditure—administrative expenses										✓				✓	
Recurrent expenditure—Department of Veterans' Affairs funded										✓					
Recurrent expenditure—depreciation										✓				✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Recurrent expenditure—domestic services										✓				✓	
Recurrent expenditure—drug supplies										✓				✓	
Recurrent expenditure—food supplies										✓				✓	
Recurrent expenditure—interest payments										✓				✓	
Recurrent expenditure—medical and surgical supplies										✓				✓	
Recurrent expenditure—National Mental Health Strategy funded expenditure										✓					
Recurrent expenditure—other Commonwealth Government funded expenditure										✓					
Recurrent expenditure—other patient revenue funded										✓					
Recurrent expenditure—other recurrent expenditure										✓				✓	
Recurrent expenditure—other revenue funded										✓					
Recurrent expenditure—other State or Territory funded										✓					
Recurrent expenditure—patient transport										✓				✓	
Recurrent expenditure—payments to visiting medical officers										✓				✓	
Recurrent expenditure—recoveries funded										✓					
Recurrent expenditure—repairs and maintenance										✓				✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Recurrent expenditure—State or Territory health authority funded										✓					
Recurrent expenditure—superannuation employer contributions										✓				✓	
Recurrent expenditure—total										✓					
Referral destination to further care (from specialised mental health residential care)															✓
Referral destination to further care (psychiatric patients)		✓													
Region code	✓				✓					✓					✓
Removal date							✓								
Residential stay start date															✓
Residual expenditure (mental health)—academic positions										✓					
Residual expenditure (mental health)—education and training										✓					
Residual expenditure (mental health)—insurance										✓					
Residual expenditure (mental health)—mental health promotion										✓					
Residual expenditure (mental health)—mental health research										✓					
Residual expenditure (mental health)—other indirect expenditure										✓					
Residual expenditure (mental health)—patient transport services										✓					

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Residual expenditure (mental health)—program administration										✓					
Residual expenditure (mental health)—property leasing costs										✓					
Residual expenditure (mental health)—superannuation										✓					
Residual expenditure (mental health)—support services										✓					
Residual expenditure (mental health)—workers compensation										✓					
Revenue—other														✓	
Revenue—patient														✓	
Revenue—recoveries														✓	
Separation date	✓	✓	✓										✓		
Separations										✓					
Sex	✓	✓	✓	✓	✓						✓		✓		✓
Source of public and private revenue								✓							
Source of referral to alcohol and other drug treatment service				✓											
Source of referral to public psychiatric hospital	✓	✓													
Specialised mental health service—hours staffed										✓					

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Specialised mental health service—program type										✓					
Specialised mental health service—setting										✓					
Specialised mental health service—supported public housing places										✓					
Specialised mental health service—target population										✓					
Specialised service indicators—acquired immune deficiency syndrome unit														✓	
Specialised service indicators—acute renal dialysis unit														✓	
Specialised service indicators—acute spinal cord injury unit														✓	
Specialised service indicators—alcohol and drug unit														✓	
Specialised service indicators—bone marrow transplantation unit														✓	
Specialised service indicators—burns unit (level III)														✓	
Specialised service indicators—cardiac surgery unit														✓	
Specialised service indicators—clinical genetics unit														✓	
Specialised service indicators—comprehensive epilepsy centre														✓	
Specialised service indicators—coronary care unit														✓	
Specialised service indicators—diabetes unit														✓	

Data element name	National minimum data set														
	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Elective surgery waiting times (census data)	Elective surgery waiting times (removals data)	Government health expenditure	Health labour force	Mental health establishments	Non admitted patient emergency dept care	Outpatient care	Perinatal	Public hospital establishments	Residential mental health care
Specialised service indicators—domiciliary care service														✓	
Specialised service indicators—geriatric assessment unit														✓	
Specialised service indicators—heart, lung transplantation unit														✓	
Specialised service indicators—hospice care unit														✓	
Specialised service indicators—infectious diseases unit														✓	
Specialised service indicators—intensive care unit (level III)														✓	
Specialised service indicators—in-vitro fertilisation unit														✓	
Specialised service indicators—liver transplantation unit														✓	
Specialised service indicators—maintenance renal dialysis centre														✓	
Specialised service indicators—major plastic/reconstructive surgery unit														✓	
Specialised service indicators—neonatal intensive care unit (level III)														✓	
Specialised service indicators—neuro surgical unit														✓	
Specialised service indicators—nursing home care unit														✓	
Specialised service indicators—obstetric/maternity														✓	
Specialised service indicators—oncology unit, cancer treatment														✓	

Data element name	National minimum data set														
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Specialised service indicators—pancreas transplantation unit														✓	
Specialised service indicators—psychiatric unit/ward														✓	
Specialised service indicators—rehabilitation unit														✓	
Specialised service indicators—renal transplantation unit														✓	
Specialised service indicators—sleep centre														✓	
Specialised service indicators—specialist paediatric														✓	
State/Territory of birth													✓		
Status of the baby													✓		
Surgical specialty						✓	✓								
Teaching status														✓	
Time of triage											✓				
Time patient presents											✓				
Total hours worked by a medical practitioner									✓						
Total leave days	✓	✓													
Total psychiatric care days	✓	✓													

Data element name	National minimum data set														
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Treatment delivery setting for alcohol and other drugs				✓											
Triage category											✓				
Type and sector of employment establishment									✓						
Type of accommodation		✓													
Type of health or health related function								✓							
Type of usual accommodation		✓													
Type of visit to emergency department											✓				
Urgency of admission	✓														
Waiting time at a census date						✓									
Waiting time at removal from elective surgery waiting list							✓								
Weight in grams (measured)	✓														

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Australian Government

Australian Institute of Health and Welfare

National data dictionaries

Explanatory booklet 2008

NATIONAL HEALTH DATA DICTIONARY

Version 14

NATIONAL COMMUNITY SERVICES DATA DICTIONARY

Version 5

Home Quit

Community and Disability Services Ministers' Advisory Council

Australian Health Ministers' Advisory Council

The Australian Institute of Health and Welfare is Australia's national health and welfare statistics and information agency. The Institute's mission is *better information and statistics for better health and wellbeing*.

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Contents

The fourteenth version of the National Health Data Dictionary (NHDD V14) and the fifth version of the National Community Services Data Dictionary (V5) are stored on two separate CD-ROMs. Each CD-ROM contains all of the existing, new and modified nationally endorsed data standards in a format based on the international standard ISO/IEC 11179 edition 2.[1].

1 ISO/IEC 11179-3:2003(E), Information technology—Metadata registries (MDR)—Registry metamodel and basic attributes, Geneva: International Standards Organisation

The content of the CD-ROMs

Each CD-ROM contains:

- an introductory page and a table of contents
- the data dictionary containing all standard metadata items including data elements, classifications and glossary items
- a summary of the changes to the dictionary since its last publication
- details of the data collections such as the data set specifications and National Minimum Data Sets that use these standards
- this explanatory booklet.

How to use the CD-ROMs

To use a CD-ROM:

- Insert the CD-ROM into your computer. It should automatically open to a Start page.
- Choose a document by clicking on the buttons.
- The documents are in PDF format and can be navigated using the Adobe functions.

The majority of hyperlinks within the document link internally to other parts of the document; however, some hyperlinks may take you to pages outside the document itself and into METeOR, the online metadata registry, in which case a new web browser window will open. This will occur where references are made to metadata items that have been superseded and/or links to other websites such as the Australian Bureau of Statistics, to view a specific classification scheme. To return to the data dictionary, just close the new window.

What are the national data dictionaries?

The national data dictionaries contain standard data definitions and data elements for use in any Australian health or community services data collection. They are the authoritative source of information about endorsed national data standards and provide the basis for consistent national collection and reporting. National data standards are approved by the Australian Government and all state and territory relevant health and communities services departments as well as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW). This work is funded under the Australian Health Ministerial Advisory Council (AHMAC) and the Community Services and Disability Ministerial Advisory Council (CSDMAC).

Where possible, data standards in the dictionaries are consistent with other national standard classifications to ensure overall comparability of national data. The ABS is the source of many key socioeconomic classifications used in data collections, such as the Australian Standard Classification of Languages (ASCL), Australian Standard Geographic Classification (ASGC), and the Australian and New Zealand Standard Classifications of Occupations (ANZSCO).

The data dictionaries have been downloaded from METeOR, which is an online metadata registry for development, registration and dissemination of metadata based on the second edition of the international standard ISO/IEC 11179 Information technology—Metadata registries (MDR) in 2003. For more information about METeOR see the 'METeOR' section on page 24. The data dictionaries are also available online at meteor.aihw.gov.au.

Governance

The national data dictionaries are an initiative under the National Health Information Agreement and the National Community Services Information Agreement. These are auspiced by the respective Australian Health Ministers' Advisory Council (AHMAC) and the Community Services Disability Ministers' Advisory Council (CSDMAC).

Under these Agreements, all parties agree to ensure that the collection, compilation and interpretation of national information are appropriate and are carried out efficiently. This will require agreement on definitions, standards and rules of collection of information and on guidelines for the coordination of access, interpretation and publication of national health and community services information.

These data standards are endorsed and approved for use by all relevant health and community services state, territory and Commonwealth departments, the ABS and the AIHW.

Why use data standards?

Making data count

Data standards promote the quality, accuracy, interpretability, reliability, relevance, inter-changeability, transparency, currency, accessibility, coherence and comparability of data and information.

Without data standards there is the potential for data to be of poor quality. Data may fail to measure what it is supposed to measure, or not be comparable across collections or over time. Decisions based on poor quality data affect us all—whether it is hospital services, or delivery of services in the community.

Data standards enable consistent and comparable reporting of information about services and people, including describing what services are available, where services are located, to whom they are delivered, by whom are they delivered and when, how much they cost and what happened as a result of delivering services.

By making endorsed data standards readily available, users are assured that they can use these standards with confidence and that they will enable the maximum re-use of their data for future research: 'create once, use often'.

How are data standards developed?

Identifying the need for data standards

Data standards are developed when a clear need for standards is identified from the sector, subject experts, program managers or policy makers. For example, a national cancer centre and the Australian Association of Cancer Registries conducted a review of data items used in cancer registries, and found many inconsistencies among registries in coverage and data collection comparability for a number of data items. This resulted in collaboration between a national cancer centre and the Australian Association of Cancer Registries, clinical specialists, government and non-government organisations to revise the items and to develop a preliminary NMDS. This resulted in agreement on a NMDS of 17 data items recommended as essential for long-term breast cancer control monitoring, evaluation and planning.

Data standards development process

The data standards development process is outlined below.

1. **Proposal stage**

   A submission is made to the relevant data committee, which includes:

   - origins (or background material)
   - the rationale for the proposal
   - a business case for adoption
   - details of national consultation (including details of experts and/or others involved or consulted during development).

continued overleaf

2. Development stage

The development process is based on a number of data development principles and a methodology. [2]

3. Assessment stage

An assessment is conducted on the degree of compliance with accepted data development standards (adherence to 11179/ METeOR business rules), the degree of overlap with, or the confounding of, existing data standards, the degree to which the data elements impact on existing metadata, systems and collections, and the clarity of the content.

4. Data committee approval

Once an initial assessment has been conducted, the metadata is submitted to the relevant data committee for comment and approval.

5. Registration authority endorsement

If a submission is approved by the data committee, the metadata items are then forwarded to the relevant registration authority for final endorsement as a national standard.

2 Australian Institute of Health and Welfare (AIHW) 2007. A guide to data development. AIHW Cat. No. HWI 94. Canberra: AIHW.

Registration status progression

The registration status is the value assigned to a metadata item as it progresses through the data standards development process.

The registration statuses in METeOR are:	
Proposed	A developer has submitted this item for consideration by the registrar.
Recorded	The registrar has determined that the item meets basic quality criteria and is ready for consideration by the relevant data committee.
Candidate	The item has been reviewed by a data committee and has been accepted onto their work program.
Standardisation pending	A data committee has recommended the item to a registration authority for approval as a standard.
Standard	The item has been endorsed by a registration authority as a national data standard.
Superseded	A registration authority has superseded this item with another standard.
Retired	The item has been nominated by registration authority as retired.
Not progressed	The item will no longer be considered by the registrar, a data committee or a registration authority.

Who benefits from using data standards?

Information managers—use standard format and definitions to support receipt, transfer, storage, and management of data.

Program managers—use data standards as the basis of describing information requests (that is, data required under formal service/funding agreements, and contracts), measuring service activity, client flows, client characteristics, service usage, understanding demand, better planning of services, describing unmet need (need comparability of population and survey data) , and understanding ways to integrated service delivery resulting in better targeting and usage of services and ultimately cost savings.

Researchers—use data standards as the common language to support ad hoc survey work, as well as integrating data from other sources.

Policy makers—need aggregated information for future policy, management and funding decisions: that is, information to support comparisons across jurisdictions, programs and sectors.

Statisticians—use data standards for interpreting data and analysis of results, linking data sets for statistical purposes, time series analysis (over a period of time) and longitudinal studies (over a period of time within groups).

Metadata structure

The data standards are based on the 2003 version of the ISO/IEC 11179 international standard for metadata registries. Part three of the standard is a model for a metadata registry and the formulation of metadata items.

There are six types of metadata defined by 11179 that apply to METeOR and the data dictionaries:

- object class
- property
- data element concept
- data element
- value domain
- classification scheme.

The structure underlying a data element is illustrated in Figure 1 (differences from the ISO/IEC standard are shown with dashed lines).

Types of metadata

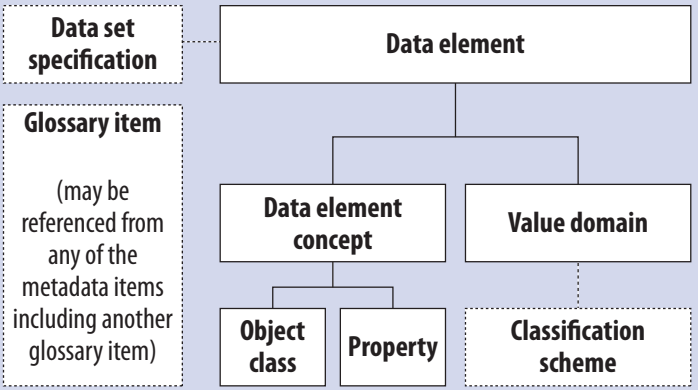

Figure 1: The 11179 model of metadata representation.

Components of data elements

The 'things' that we want to know about include ideas (knowledge), persons, organisations, the environment and events. These things are termed object classes. Some examples of object classes are 'Person', 'Dwelling' and 'Service Provider Organisation'. A characteristic of the object class that all instances of the object class have in common is known as a property. A property is normally the item of interest. For example, the object class 'Person' can have properties such as 'Sex' and 'Date of birth'.

A data element concept is defined as a concept created by the union of an object class and a property. Only one object class and one property can be joined for each data element concept; for example, the data element concept: 'Person—date of birth'.

As can be seen from the diagram, a data element is formed when a data element concept is represented in the real world by a set of values (a value domain).

A value domain specifies how something is to be represented. A value domain can specify:

- the range of permitted values; for example, a measure of weight in grams represented by 3 numeric characters
- all permissible values as a set of codes; for example, 'Code 1 Female', 'Code 2 Male'
- the values referenced from a nationally or internationally endorsed classification, such as all codes in the Australian Standard Classification of Languages (ASCL) 2005, or all activity codes listed in the International statistical classification of diseases and related health problems, Tenth revision, Australian modification, 5th edition.

A glossary item defines the meaning of a term within a specific context. Within METeOR examples of glossary items include 'Adoption' and 'Family'. These things of interest are not currently defined as object classes, but their meaning must be understood for data to be collected.

Data set specifications

A collection of these data elements that describe things about which we want to know has been termed a data set specification (DSS). A DSS specifies a group of data elements and the conditions under which this group is collected. A DSS can define the sequence in which data elements are included, whether they are mandatory, what verification rules should be employed and the characteristics of the collection (such as its scope).

National Minimum Data Set

A National Minimum Data Set (NMDS) is a special type of DSS. An NMDS is a minimum set of data elements agreed by the National Health or Community Services information groups for mandatory collection and reporting at a national level. Data elements may appear in more than one National Minimum Data Set.

The Data Dictionaries support data elements from a variety of national data sets, For example, the Commonwealth State Territory Disability Agreement (CSTDA) NMDS, Community Mental Health Care NMDS, and Admitted Patient Care NMDS. A full list is available on the CDs.

Non-mandatory data set specification

All data set specifications that are not mandated for collection are metadata sets recommended for collection as best practice. It is recommended that, if collecting data for the purposes of primary patient care, planning or analysis, the entire DSS be collected.

Integration of data elements in data dictionaries

The national health and community services data dictionaries contain 92 integrated data items that can be used consistently across the health and community services sectors. This is especially important for services that cross the sector boundaries such as aged care, mental health, drug and alcohol services and services for people with a disability. Examples of integrated data items include:

Address data items

Address line, text [X(180)]

Australian postcode, code (Postcode datafile) {NNNN}

Australian state/territory identifier, code N

Street name, text [A(30)]

Suburb/town/locality name, text [A(50)]

Personal and demographic data items

Activity and participation life area, code (ICF 2001) AN[NNN]

Age, total years N[NN]

Country of birth, code (SACC 2008) NNNN

Date of birth, DDMMYYYY

Family name, text X[X(39)]

Given name, text [X(40)]

Indigenous status, code N

Informal carer existence indicator, code N

Interpreter service required, yes/no code N

Labour force status, code N

Main language other than English spoken at home, code (ASCL 2005) NN{NN}

Marital status, code N

Mother's original family name, text [X(40)]

Occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}

Person identifier, XXXXXX[X(14)]

Preferred language, code (ASCL 2005) NN{NN}

Proficiency in spoken English, code N

Sex, code N

Year of first arrival in Australia, date YYYY

Service provider organisation data items

Organisation end date, DDMMYYYY

Organisation name, text [X(200)]

Organisation start date, DDMMYYYY

Quick reference guide

Formulation of good data standards

1. **A metadata item must have, at least, a name and a definition.**
2. **A metadata item can have an explicitly stated context within which the definition has meaning.**
3. **The name of the standard version of the metadata item must follow certain criteria:**
   a. the name must be unique within the context of the metadata item
   b. the name must be stated in the singular
   c. the name must reflect the concept being defined
   d. the name must avoid the use of abbreviations or acronyms other than those widely accepted (such as radar, laser or pH)
   e. the name should avoid the use of words that imply a pre-selected single instance.
4. **Definition rules and guidelines**

   A definition must:
   a. be stated in the singular
   b. state what the concept is, not only what it is not
   c. be stated as a descriptive phrase or sentence(s)
   d. contain only commonly understood abbreviations

continued

Quick reference guide (continued)

e. be expressed without embedding definitions of other data or underlying concepts.

A data definition should:

f. be expressed without embedding rationale, functional usage, domain information or procedural information

g. state the essential meaning of the concept

h. be precise and unambiguous

i. be concise

j. be able to stand alone

k. avoid circular reasoning

l. use the same terminology and consistent logical structure for related definitions

m. contain information appropriate for the type of metadata item being defined

n. use a preferred term to represent the definition of a concept specified elsewhere in the document

o. pass the substitution test.

5. Context should be closely linked to definition.

continued

Quick reference guide (continued)

6. Information must be included in a metadata item attribute only if it is appropriate for that attribute or metadata item.

a. Context

i. Metadata can exist within a specific context.

ii. Only information that is relevant to the environment or framework within which the definition for the metadata item is valid must be included in the Context attribute.

iii. The contexts of two metadata items must be compatible when the definition of one metadata item references a term defined in another.

b. Guide for use

Guide-for-use information must be included in any metadata item only if it is intended to provide advice or interpretation on how to use the particular metadata item or data collected using the metadata item.

i. In metadata items other than data elements, guide-for-use information should be about how to use the item itself and not about any data that can be collected or used.

ii. Data elements can also include information about how to use or interpret the data in the Guide for use.

c. Collection methods

The 'Collection methods' attribute must only include information about how data is to be collected. The following

continued

Quick reference guide (continued)

metadata items must not have a metadata attribute of 'Collection methods':

- object class
- property
- data element concept
- value domain
- glossary item.

d. Permissible values in a Value domain must:

i. be exhaustive within the set

ii. made into an exhaustive set of values by adding an 'Other' value to aggregate all other possibilities not covered by the stated set of values.

iii. be mutually exclusive within the set

iv. be a true representation of the concept defined in the data element.

e. Allocation of code values should

i. avoid the use of a code value for 'Other' that is contiguous with the last code in the sequence of permissible values or that, in any other way, does not provide for inclusions in the future.

ii. wherever possible, avoid the use of a coded value for 'Other' that may be commonly used as a supplementary value.

continued

Quick reference guide (continued)

f. Supplementary values

i. Supplementary values must not be included in a value domain.

ii. Do not include valid permissible values in the supplementary values attribute of a value domain.

iii. Avoid the use of values that are contiguous with the last code in the permissible value sequence.

iv. To limit variations in the meaning within a specific data collection, use a default supplementary value meaning of 'Not stated/inadequately described'.

v. When using more than one supplementary value, use a logical set.

vi. It is appropriate that the Supplementary value field size is the same number of characters as the permissible value.

vii. Consistent use of supplementary codes/values across the data elements in a data set should be applied.

viii. In non-enumerated Value domains (that is those without defined value meanings such as in a measurement) the supplementary value used should not be a valid permissible value.

7. Always use a standard format for referencing publications and not a mixture of referencing methods

METeOR

METeOR is the Australian Institute of Health and Welfare's online metadata registry.

METeOR currently integrates and presents information about:

- the National Community Services Data Dictionary
- the National Health Data Dictionary
- the National Housing Assistance Data Dictionary
- National Minimum Data Sets
- data set specifications.

METeOR includes the following tools:

- data search and browse tools allowing navigation of data standards of varying levels of endorsement and across the health, community services and housing assistance sectors
- data view, collation and download tools
- data development tools including areas in which multiple data developers may collaborate on the development of data standards
- data submission tools that enable data developers to submit draft data standards for consideration as a national standards
- data management tools that allow the registrar to change the registration status of data standards under authorisation of one or more registration authority
- comprehensive guidelines to assist metadata development and review.

METeOR is based on the 2003 version of the ISO/IEC 11179, titled Information technology—Metadata registries (MDR). This standard was applied to provide a detailed registry architecture in which data standards can be better defined, navigated and managed throughout the data development life-cycle. METeOR is an Internet-based application accessible through the following Internet address:

meteor.aihw.gov.au

Feedback and contact details

The development of the data dictionaries is an ongoing process, which is reliant on the support and input of a range of data development groups to expand its scope and utility.

The data committees welcome feedback on existing data standards in the data dictionaries, and also submissions (either for new data items, modifications to existing items or information on your data development activities).

Feedback

Please feel free to contact the Institute by any of the means listed below.

National Data Development and Standards Unit

For further information about the data dictionaries and for any comments and suggestions about national standards development processes, please contact the National Data Development and Standards Unit at the Australian Institute of Health and Welfare.

Phone: (02) 6244 1000
Fax: (02) 6244 1299
datadevelopment@aihw.gov.au

Data Development Hotline

Phone: (02) 6244 1222

Secretariat

For further information about the national data committees and their processes, please look up the Committees page on the AIHW website.

http://www.aihw.gov.au/committees/ncsdc/index.cfm

http://www.aihw.gov.au/committees/hdsc/index.cfm

Home

Open dictionary

Searching help

The *National health data dictionary version 14* is searchable. With the Dictionary open, the search feature in Adobe Reader® can be accessed by clicking Edit > Search.

Once you have entered your search term and clicked 'search', a list of results will be displayed. Clicking on any one of these results will take you to the page where the search term occurs.

Quit

Home

Open dictionary

Navigation tips

Bookmarks

A list of bookmarks is provided on the left-hand side of the screen. Clicking on a bookmark will take you to the corresponding page in the Dictionary.

Links

Links are provided in the *List of metadata items* and *Data Element Technical Names*.

Opening a specific page

You can go to a specific page in the Dictionary by:

- clicking on View > Go To > Page…
- pressing Shift+Ctrl+N (Windows) or ⇧⌘N (Mac OS X)
- typing the page number into the status bar at the bottom of the page and pressing the enter key

Quit