National Health Data Dictionary Version 12

Volume 1

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

National Health Data Dictionary Version 12

Volume 1

National Health Data Committee

2003

Australian Institute of Health and Welfare Canberra

AIHW cat. no. HWI 43

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 ISBN Volume 1
 1 74024 268 8

 ISBN (set)
 1 74024 267 X

 ISSN
 1329-4555

Suggested citation

National Health Data Committee 2003. *National Health Data Dictionary*. Version 12. AIHW cat. no. HWI 43. Canberra: Australian Institute of Health and Welfare.

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Published by the Australian Institute of Health and Welfare Printed by Elect Printing

Foreword

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

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

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

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

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

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

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

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

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

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

Richard Madden Director Australian Institute of Health and Welfare

How to use this book

Format of publication

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

Volume 1

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

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

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

Volume 2

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

Contains a full description of all data set specifications for National Minimum Data Sets and other data set specifications.

- Appendixes
- Full Index for both volumes

Formatting conventions

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

Not all attributes have instances of information.

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Introduction

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

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

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

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

The objectives of the National Health Data Dictionary are to:

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

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

The National Health Data Committee

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

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

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

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

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

The National Health Data Committee comprises representatives of:

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

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

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

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

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

The Knowledgebase

The Knowledgebase – Australia's Health, Community Services and Housing Metadata Registry is an electronically accessible registry of national data definitions. The Knowledgebase was designed and created by the Australian Institute of Health and Welfare on behalf of the National Health Information Management Group. Organisations that may place data definitions into the Knowledgebase are given the status of 'Registration Authority'. The organisation authorised to register *National Health Data Dictionary* data definitions in the Knowledgebase is the National Health Information Management Group. The organisation authorised to register *National Community Services Data Dictionary* data definitions in the Knowledgebase is the National Community Services Information Management Group. The Knowledgebase is also a registry for other Registration Authorities that are approved by the relevant national information management groups. These other groups are allowed to have data definitions with 'DRAFT' status only. DRAFT definitions are not available in print form.

The Knowledgebase integrates and presents information about:

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

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

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

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

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

National Health Data Dictionary

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

National Health Data Dictionary, Version 12

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

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

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

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

Version 12 comprises:

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

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

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

Summary of changes

National Minimum Data Sets

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

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

Data elements

Modified in version 12

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

- one wording changes made to the definition and additional information has been included under Collection methods, Related data and Guide for use.
- Other drugs of concern:
 - similar changes were made as Principal drug of concern.
- Source of referral to alcohol and other drug treatment service:
 - the Data domain and the Guide for use were revised to more accurately capture the most common sources of referral and to make the categories mutually exclusive.
- Changes were made to the wording in the following data elements in order to reflect their inclusion in the new NMDS Non-admitted patient emergency department care and the new Data Set Specifications Cardiovascular disease (clinical), Diabetes (clinical) and Health care client identification:
 - Area of usual residence
 - Birth order
 - Birth plurality
 - Compensable status
 - Country of birth
 - Date of birth
 - Date patient presents
 - Department of Veterans' Affairs patient
 - Establishment identifier
 - Establishment sector
 - Estimated date flag

- Height-measured
- Person identifier
- Region code
- Service contact date
- Sex
- State/Territory identifier
- Time patient presents
- Triage category
- Type of visit to emergency department

New in version 12

- Address
- Address type
- Alcohol consumption concept
- Alcohol consumption frequency self-report
- Alcohol consumption in standard drinks per day – self-report
- Australian postcode
- Behaviour-related risk factor intervention
- Behaviour-related risk factor intervention purpose
- Blindness diabetes complication
- Blood pressure concept
- Blood pressure diastolic measured
- Blood pressure systolic measured
- Cardiovascular medication current
- *Cataract history*
- Centrelink customer reference number
- Cerebral stroke due to vascular disease history
- Cholesterol-total measured
- Cholesterol-HDL measured
- Cholesterol-LDL calculated
- Coronary artery disease history of intervention or procedure
- Creatinine serum measured
- CVD drug therapy condition
- Date of diagnosis
- Date of referral to rehabilitation
- Diabetes status
- Diabetes therapy type
- Division of General Practice number
- Dyslipidaemia treatment
- Emergency department public hospital
- Emergency department arrival mode-transport
- Erectile dysfunction
- Family name
- Fasting status
- Foot deformity
- Foot lesion active
- Foot ulcer current
- Foot ulcer history
- Formal community support access status
- Geographical location of service delivery outlet
- *Given name(s)*
- Glycosylated haemoglobin (HbA1c) measured
- Glycosylated haemoglobin (HbA1c) upper limit of normal range
- Health professionals attended diabetes mellitus

- Hypertension treatment
- Hypoglycaemia severe
- Initial visit diabetes mellitus
- Labour force status
- Length of non-admitted patient emergency department service episode
- Living arrangement
- Lower limb amputation due to vascular disease
- Microalbumin units
- Microalbumin upper limit of normal range
- Microalbumin/protein measured
- Mother's original family name
- *Myocardial infarction history*
- Name
- Name context flag
- Name suffix
- Name title
- Name type
- Non-admitted patient emergency department service episode
- Ophthalmological assessment outcome
- Ophthalmoscopy performed
- *Peripheral neuropathy status*
- *Peripheral vascular disease in feet status*
- Person identifier type health care
- *Physical activity sufficiency status*
- Postal delivery point identifier
- Pregnancy current status
- Premature cardiovascular disease family history – status
- Proteinuria status
- Referred to ophthalmologist diabetes mellitus
- Renal disease end stage, diabetes complication
- Renal disease therapy
- Service delivery outlet
- Suburb/town/locality
- Telephone number
- Telephone number type
- Tobacco smoking status diabetes mellitus
- Triglycerides measured
- Vascular history
- Vascular procedures
- Visual acuity
- Waist circumference risk indicator adults
- Year insulin started
- Year of diagnosis of diabetes mellitus

Retired from version 12

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

Knowledgebase

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

Feedback

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

Contacts

National Data Development Unit

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National Health Information Model, Version 2

Background information

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

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

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

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

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

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

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

The Model diagram

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

This page is to be replaced with NHIM diagram A3

Model entity index of data elements

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Activity when injured

Identifying and Definitional Attributes

Knowledgebase ID:	000002	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	The type of activity being	undertaken by the person when injured.
Context:	Injury surveillance:	
	for injury control. Necessa injury costing and identify	njury and poisoning according to factors important iry for defining and monitoring injury control targets, ving cases for in-depth research. This item is the basis ed and sport-related injuries.

Relational and Representational Attributes

Datatype:	Nun	neric	
Representational form:	Code		
Representational layout:	NN		
Minimum size:	1		
Maximum size:	2		
Data domain:	0	Sports activity	
	00	Football, rugby	
	01	Football, Australian	
	02	Football, soccer	
	03	Hockey	
	04	Squash	
	05	Basketball	
	06	Netball	
	07	Cricket	
	08	Roller blading	
	09	Other and unspecified sporting activity	
	1	Leisure activity (excluding sporting activity)	
	2	Working for income	
	3	Other types of work	
	4	Resting, sleeping, eating or engaging in other vital activities	
	5	Other specified activities	
	6	Unspecified activities	
Guide for use:	Adm	nitted patients:	
·	Use	the appropriate codes as fourth and fifth characters to Y93 when using the	
		-10-AM 3rd edition. Used with ICD-10-AM external cause codes V01 – Y34 assigned according to the Australian Coding Standards.	
		-admitted patients:	
		e used for injury surveillance purposes for non-admitted patients when it is	
		possible to use ICD-10-AM codes. Select the code which best characterises	
		ype of activity being undertaken by the person when injured, on the basis	
	of th	e information available at the time it is recorded. If two or more categories	

	are judged to be equally appropriate, select th list.	ne one that comes f	irst in the code	
Verification rules:	Admitted patients:			
	To be used with ICD-10-AM external cause co	odes V01 – Y34 onl	у.	
Collection methods:				
Related metadata:	supersedes previous data element Activity w	hen injured vers 1		
	is used in conjunction with Bodily location of	main injury vers 1	-	
	relates to the data element Diagnosis onset ty	pe vers 1		
	is used in conjunction with External cause - h	numan intent vers	1	
	is used in conjunction with External cause - non-admitted patient vers 4			
	is a qualifier of Narrative description of injury event vers 1			
	is used in conjunction with Nature of main injury – non-admitted patient vers 1			
Administrative Attrib	utes			
Source document:	ICD-10-AM 3rd edition			
Source organisation:	National Centre for Classification in Health			
Source organisation	National Injury Surveillance Unit			
Information model link:	, ,			
NHIM Injury event				
Data Set Specifications:		Start date	End date	
NMDS - Admitted patient ca	re	01/07/2000		
NMDS - Injury surveillance		01/07/2000		

Actual place of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000003	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	The actual place where th	e birth occurred.
Context:	Perinatal statistics:	
	deliveries occur within ho other settings. It is import	actors and outcomes by place of birth. While most spitals, an increasing number of births now occur in ant to monitor the births occurring outside hospitals or not the actual place of delivery was planned.

Relational and Representational Attributes

Datatype:	Nu	meric
Representational form:	Coc	le
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1	Hospital
	2	Birth centre, attached to hospital
	3	Birth centre, free-standing
	4	Home
	8	Other
	9	Not stated
Guide for use:	This	is to be recorded for each baby the mother delivers from this pregnancy.
Verification rules:		
Collection methods:		
Related metadata:	is a d	qualifier of Intended place of birth vers 1
		1 F F

Administrative Attributes

Source document:	
Source organisation:	National Perinatal Data Development Committee
Information model link:	
NHIM Other setting	
Data Set Specifications:	Start date End date
NMDS - Perinatal	01/07/1997
Comments:	The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and

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Territories.

Acute care episode for admitted patients

Identifying and Definitional Attributes				
Knowledgebase ID:	000004	Version No: 1		
Metadata type:	Data Element Concept			
Admin. status:	Current			
	01/07/95			
Definition:	An episode of acute care clinical intent is to do one	-		h the principal
	 manage labour (ob 	ostetric)		
	 cure illness or prov 	vide definitive treat	tment of injury	
	 perform surgery 			
	 relieve symptoms 	of illness or injury	(excluding palliativ	re care)
	 reduce severity of 	illness or injury		
	1 0	cerbation and/or c l threaten life or no	1	llness and/or
	 perform diagnostic 	c or therapeutic pro	ocedures.	
Context:	Admitted patient care.			
Relational and Rep	resentational Attrib	utes		
Datatype:				
Representational form:				
Representational layout:				
Minimum size:				
Maximum size:				
Data domain:				
Guide for use:				
Verification rules:				
Collection methods:				
Related metadata:	relates to the data elemen	t Care type vers 4		
Administrative Attributes				
Source document:				
Source organisation:	National Health Data Con	mmittee		
Information model link:				
NHIM Service provision ev	vent			
Data Set Specifications:			Start date	End date
NMDS - Admitted patient	mental health care		01/07/1995	

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

Additional diagnosis

Knowledgebase ID: 000005 Version No: 4 Metadata type: Data Element Admin. status: Current 01/07/98 Definition: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility. Context: Additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian refined Diagnosis related groups.

Identifying and Definitional Attributes

Relational and Representational Attributes

Alphanumeric
Code
ANN.NN
3
6
ICD-10-AM (3rd edition) - disease codes
Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Generally, External cause, Place of occurrence and Activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.
The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.
An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care. The additional diagnosis is derived from and must be substantiated by clinical documentation.
supersedes previous data element Additional diagnosis – ICD-9-CM code vers 3
relates to the data element Diagnosis onset type vers 1
is used in the derivation of Diagnosis related group vers 1
supplements the data element Principal diagnosis vers 3

Administrative Attributes

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

Source organisation:	National Centre f	or Classification in Health (Sydney)	
Information model link:				
NHIM Physical wellbeing				
Data Set Specifications:			Start date	End date
NMDS - Admitted patient ca	re		01/07/1998	
NMDS - Admitted patient me	ental health care		01/07/1998	
NMDS - Admitted patient pa	lliative care		01/07/2000	

Address

Identifying and Definitional Attributes Knowledgebase ID: 000799 Version No: 1 Metadata type: Data Element Concept Admin. status: Current 01/01/03 Definition: The set of descriptors identifying the geographic location of a person, organisation, and/or object place. May be used to map to the Australian Bureau of Statistics' publication -Context: Australian Standard Geographical Classifications using the National Localities Index (also produced by the ABS). This information can then be used to compare aggregate data to other information on a Statistical Local Area basis, for example. Similarly postcode can be obtained from Address for comparison

with other information available on a postcode basis.

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	Multiple addresses may be recorded as required. Each address must have an Address type to indicates the form/type of address (e.g. residential, mailing or business).
	Multiple addresses may be held. Each address must be attributed to either one PARTY or to one PARTY IN A ROLE or to one ACTUAL SETTING.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Address type vers 1
	relates to the data element Postal delivery point identifier vers 1
	relates to the data element State/Territory identifier vers 3
	relates to the data element Suburb/town/locality vers 1

Administrative Attributes

Source document:	AS5017 Health care client identification		
Source organisation:	Standards Australia		
Information model link:			
NHIM Address element			
Data Set Specifications:		Start date	End date
DSS - Health care client ident	ification	01/01/2003	

Address type

Identifying and Definitional Attributes Knowledgebase ID: 000801 Version No: 1 Metadata type: Data Element Admin. status: Current 01/01/03 A code representing a type of person or organisation address. Definition: Context: Relational and Representational Attributes Datatype: Alphabetic **Representational form:** Code Representational layout: А 1 Minimum size: Maximum size: 1 Data domain: В Business or office Μ Mailing or postal R Residential Т Temporary residential U No fixed address/unknown/not stated Guide for use: Multiple addresses may be recorded as required. This field can be a multiple occurring field, each address must have an Address type. Verification rules: Health care establishments should always collect the residential address of a **Collection methods:** person who is a health care client when an occasion of service or admission is provided. In addition, the establishment may also need to record other addresses for the person including: - a mail postal address (for correspondence) temporary residential or accommodation address (such as for a person from rural Australia who is visiting an oncology centre for a course of treatment, or a person who usually resides overseas) business or office address (for specific correspondence purposes) unknown address where the person has no fixed address or does not wish to have their residential or a correspondence address recorded At least one address must be recorded (this may be an unknown Address type). If more than one of the above categories applies to any one address, use that which is listed highest. Overseas health care clients: Record the overseas address as the 'residential address' and record a 'temporary residential address' as their contact address in Australia.

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

Administrative Attributes

Source document:	AS5017 Health care client identification		
Source organisation:	Standards Australia		
Information model link:			
NHIM Address element			
Data Set Specifications:Start dateEnd a		End date	
DSS - Health care client identification		01/01/2003	

Administrative expenses

Identifying and Definitional Attributes Knowledgebase ID: 000244 Version No: 1 Metadata type: Data Element Admin. status: Current 01/07/89 Definition: All expenditure incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation). Context: Health expenditure: Considered to be a sufficiently significant element of non-salary recurrent expenditure as to be separately identified at the national level and also readily and easily collectable.

Relational and Representational Attributes

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

Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recurrent expenditure			
Data Set Specifications:		Start date	End date
NMDS - Public hospital establishments01/07/1989			

Admission

raomarying and bon			
Knowledgebase ID:	000007	Version No:	3
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/00		
Definition:	patient's care and/or trea	atment. Admiss at a patient requ	ospital accepts responsibility for the ion follows a clinical decision based ures same-day or overnight care or or statistical.
	Formal admission:		
	The administrative proce treatment and/or care ar	2	ospital records the commencement of dation of a patient.
	Statistical admission:		
	1	2	ospital records the commencement of a be, for a patient within one hospital
Context:	Admitted patient care.		

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	This treatment and/or care provided to a patient following admission occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
Verification rules:	
Collection methods:	
Related metadata:	supersedes previous data element Admission vers 3
	relates to the data element Admission date vers 4
	relates to the data element Admission time vers 2
	relates to the data element concept Admitted patient vers 3
	relates to the data element concept Episode of care vers 1
	relates to the data element concept Separation vers 3

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Request for/entry into service event			
Data Set Specifications:Start dateEnd date		End date	

32

Admission date

Identifying and Definitional Attributes Knowledgebase ID: 000008 Version No: 4 Metadata type: Data Element Admin. status: Current 01/07/99 Definition: Date on which an admitted patient commences an episode of care. Context: Required to identify the period in which the admitted patient episode and hospital stay occurred and for derivation of length of stay. Relational and Representational Attributes Datatype: Numeric **Representational form:** Date Representational layout: DDMMYYYY 8 Minimum size: Maximum size: 8 Valid date Data domain: Guide for use: Verification rules: Right justified and zero filled. Admission date <= separation date. Admission date >= date of birth **Collection methods: Related metadata:** relates to the data element concept Admission vers 3 supersedes previous data element Admission date vers 3 relates to the data element Admission time vers 2 relates to the data element concept Admitted patient vers 3 is used in conjunction with Care type vers 4 relates to the data element Emergency department departure status vers 2 is used in the derivation of the derived data element Diagnosis related group vers 1 is used in the calculation of the derived data element Emergency department waiting time to admission vers 1 is used in the calculation of the derived data element Length of stay vers 3 relates to the data element Type of visit to emergency department vers 2 is used in the calculation of the derived data element Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee

Information model link:		
NHIM Request for/entry into service event		
Data Set Specifications:Start dateE		End date
NMDS – Admitted patient care	01/07/1999	
NMDS - Admitted patient mental health care01/07/1999		
NMDS - Admitted patient palliative care01/07/2000		

Admission time

Identifying and Defir	nitional Attributes
Knowledgebase ID:	000358 Version No: 2
Metadata type:	Data Element
Admin. status:	Current
	01/07/99
Definition:	Time at which an admitted patient commences an episode of care.
Context:	Admitted patient care:
	Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Time
Representational layout:	HHMM
Minimum size:	4
Maximum size:	4
Dete laurein	Evenessed as hours and minutes using 24 hours clock
Data domain:	Expressed as hours and minutes using 24-hour clock
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element concept Admission vers 3
	is used in conjunction with Admission date vers 4
	supersedes previous data element Admission time vers 1
	relates to the data element concept Admitted patient vers 3
	relates to the data element Emergency department departure status vers 2
	relates to the data element Type of visit to emergency department vers 2
Administrative Attrib	utes
Source document:	
Source organisation:	National Health Data Committee

 Source organisation:
 National Health Data Committee

 Information model link:
 NHIM

 NHIM
 Request for/entry into service event

 Data Set Specifications:
 Start date

Admitted patient

Identifying and Definitional Attributes		
Knowledgebase ID:	000011 Version No: 3	
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/00	
Definition:	A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:	
	 the patient's condition requires clinical management and/or facilities not available in their usual residential environment 	
	- the patient requires observation in order to be assessed or diagnosed	
	- the patient requires at least daily assessment of their medication needs	
	 the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation) 	
	 there is a legal requirement for admission (e.g. under child protection legislation) 	
	 the patient is aged nine days or less. 	
Context:	Admitted patient care.	
Relational and Repr	esentational Attributes	
Datatype:		
Representational form:		
Representational layout:		
Minimum size:		
Maximum size:		
Data domain:		
Guide for use:	This data element concept should be used in conjunction with the definition of same-day patient in the data element Same-day patient.	
	Part 2 of Schedule 3 of the <i>National Health Act</i> (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients.	
	All babies born in hospital are admitted patients.	
Verification rules:		
Collection methods:		
Related metadata:	supersedes previous data element Admitted patient vers 2	
	relates to the data element Care type vers 4	
	relates to the data element Newborn qualification status vers 2	
	relates to the data element Number of qualified days for newborns vers 2	
	relates to the data element Patient days vers 3	

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Administrative Attributes Source document: Source organisation: Information model link: NHIM Recipient role Data Set Specifications:

Start date End date

Comments:

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

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

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

Admitted patient election status

Identifying and Definitional Attributes

Knowledgebase ID:	000415 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/07/00
Definition:	Accommodation chargeable status elected by patient on admission.
Context:	Admitted patient care.
Relational and Repr	resentational Attributes
Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Data domain:	1 Public
	2 Private
Guide for use:	At the time of, or as soon as practicable after admission to a public hospital, the patient must elect in writing to be treated as either
	 a public patient or
	 a private patient in single accommodation or
	 a private patient in shared accommodation.
	This item is independent of patient's hospital insurance status. Private includes private-single and private-shared.
	1 Public patient:
	A person, eligible for Medicare, who, on admission to a recognised hospital or soon after:
	 receives a public hospital service free of charge or
	 elects to be a public patient or
	 whose treatment is contracted to a private hospital.
	2 Private patient:
	A person who, on admission to a recognised hospital or soon after:
	 elects to be a private patient treated by a medical practitioner of his or her choice or
	 elects to occupy a bed in a single room (where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by any treating medical or dental practitioner) or
	 a person, eligible for Medicare, who chooses to be admitted to a private hospital (where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner).
	Please see the various Commonwealth/State Health Care Agreements for

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

Verification rules:	
Collection methods:	Commencing with Version 9 of the Dictionary, four separate data elements Admitted patient accommodation status, Medicare eligibility status, Department of Veterans' Affairs client and Compensable status are recorded in the Dictionary. This is because each element relates to a separate concept and requires separate information to be reported. These data elements replace the previous data elements Patient accommodation eligibility status and Compensable status.
Related metadata:	supersedes previous data element Patient accommodation eligibility status vers 2

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Insurance/benefit characteristic Data Set Specifications: NMDS - Admitted patient care

Age-standardised rate

Knowledgebase ID:	000769	Version No: 1
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	A method of adjusting the crude rate to eliminate the effect of differences in population age structures when comparing crude rates for different periods of time, different geographic areas and/or different population sub-groups (e.g. between one year and the next and/or States and Territories, Indigenous and non-Indigenous populations).	
	against a standard popula	undertaken for each of the comparison populations ation (rather than adjusting one comparison population netimes a comparison population is referred to as a
Context:	-	alth services research: rates in different populations, such as incidence rates, y rates and health service utilisation rates.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNNN.N
Minimum size:	1
Maximum size:	8

Guide for use:

Formula:

Direct method	Indirect method
$SR = \frac{\sum (\mathbf{r}_i \mathbf{P}_i)}{\sum \mathbf{P}_i}$	$SR = \frac{C}{\sum(R_i p_i)} \times R$

Where:

- SR is the age-standardised rate for the population being studied
- \mathbf{r}_i is the age-group specific rate for age group *i* in the population being studied
- P_i is the population of age group *i* in the standard population
- C is the observed number of events* in the population being studied
- $\sum R_i p_i$ is the expected number of events in the population being studied
- R_i is the age-group specific rate for age group *i* in the standard population
- p_i is the population for age group *i* in the population being studied
- R is the crude rate in the standard population

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

	For the purposes of comparisons of population rates for Australia over time and/or populations within Australia (e.g. States and Territories, Indigenous and non-Indigenous) the standard population to be used is the final 30 June estimated Australian resident total population (males plus females) for the most recent year ending in 1 (e.g. 1991, 2001).
	There are two methods (namely direct and indirect) of calculating age-standardised rates:
	 The direct method is generally used for comparisons between study groups.
	 The indirect method is recommended when the age-specific rates for the population being studied are not known but the total number of events is known or when calculating rates for small populations where fluctuations in age-specific rates can affect the reliability of rates calculated using the direct method.
	The standard population used for purposes of international comparisons is generally the World Standard Population as recommended by the World Health Organization or the European Standard Population.
	Five-year age groups should normally be used, with the age group 0–4 separated into 0 and 1 to 4, and ages over 85 years combined, thus 0, 1–4, 5–9, 10–14,, 80–84, 85+. If these age groups are not used, the actual age groups should be detailed in notes accompanying the age standardised population rate information.
	Standardisation separately for males and females is not usually undertaken but may be appropriate for some applications, for example, hospitalisation rates for caesarean section is best undertaken using a female standard population rather than a standard population for both sexes. If standardisation is undertaken in this way this should be detailed in notes accompanying the age standardised population rate information.
	When indirect age standardisation is undertaken for comparisons with or between Indigenous populations, the latest available rates could be used as the standard. In addition, age groups older than 70–74 years could be excluded. This is as recommended in the National Performance Indicators for Aboriginal and Torres Strait Islander Health Technical Specifications.
Collection methods:	
Related metadata:	relates to the data element Crude rate vers 1
Administrative Attrik	outes
Source document:	Textbooks of epidemiology, demography and biostatistics. The notation used in this data element is based on Armitage P & Berry G 1994. Statistical Methods in Medical Research. Oxford: Blackwell Scientific Publications.
Source organisation: Information model link:	Australian Institute of Health and Welfare
NHIM Program evaluation	on
Data Set Specifications:	Start date End date
Comments:	Standardised rates are generally multiplied by 1,000 or 100,000 to avoid small decimal fractions. They are then called standardised rates per 1,000 or 100,000 population.
	The indirect method is also used to calculate standardised mortality ratios (SMRs) and other standardised ratios, for example for health service utilisation. These ratios express the overall experience of a comparison population in terms of the standard population by calculating the ratio of observed to expected deaths in the comparison population:

Formula:

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

The standard population used to calculate SMRs can be any population to which the comparison population is being compared. For example, if death rates for birthplace groups are compared to those of the Australian-born population using SMRs, the standard population would be the Australian-born population. Sometimes the SMR is multiplied by 100 to express the ratio as a %age, although this is not universally accepted. Not multiplying by 100 has the benefit of being able to say that the SMR was, for example, 2.3 times that expected rather than 130% higher.

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

Alcohol consumption – concept

Identifying and Definitional Attributes

Knowledgebase ID:	000802	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/01/03	
Definition:	The ethyl alcohol (ethanol) consumed by a person in alcoholic beverages s as beer, cider, wine, spirits and mixed drinks.	
	Alcohol consumption is u	sually measured in standard drinks.
	An Australian standard d to 12.5 millilitres of alcoho	rink contains 10 grams of alcohol, which is equivalent ol.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

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

Administrative Attributes

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

Source organisation:	CV-Data Working Group		
Information model link:			
NHIM Lifestyle characteri	stic		
Data Set Specifications:		Start date	End date

Alcohol consumption frequency – self report

Identifying and Definitional Attributes Knowledgebase ID: 000803 Version No: 1 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: A person's self-reported frequency of alcohol consumption. Context: Public health, health care and clinical settings. Relational and Representational Attributes Datatype: Numeric Representational form: Code NN Representational layout: Minimum size: 2 Maximum size: 2 Data domain: 01 Every day/7 days per week 02 5 to 6 days per week 03 3 to 4 days per week 04 1 to 2 days per week 05 2 to 3 days per month 06 Once per month 07 7 to 11 days in the past year 08 4 to 6 days in the past year 09 2 to 3 days in the past year 10 Once in the past year 11 Never drank any alcoholic beverage in the past year 12 Never in my life 99 Not reported Guide for use: Verification rules: Collection methods: The World Health Organization, in its 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document, suggests that in assessing alcohol consumption patterns a 'Graduated Quantity Frequency' method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences. This information can be collected (but not confined to) the following ways: in a clinical setting with questions asked by a primary health care professional

- as a self-completed questionnaire in a clinical setting
- as part of a health survey
- as part of a computer aided telephone interview.

	It should be noted that, particularly in telephone interviews, the question(s) asked may not be a direct repetition of the data domain; yet they may still yield a response that could be coded to the full data domain or a collapsed version of the domain.		
Related metadata:	relates to the data element concept Alcohol consumption - concept vers 1		
	is used in conjunction with Alcohol consumption in standard drinks per day – self report vers 1		
	is used in conjunction with Service contact date vers 1		
Administrative Attrib	outes		
Source document:	The Australian Alcohol Guidelines: Health Risk and Benefits endorsed by the National Health and Medical Research Council in October 2001		
Source organisation:	CV-Data Working Group		
Information model link: NHIM Lifestyle character	intin		
NHIMLifestyle characterData Set Specifications:	Start date End date		
DSS – Cardiovascular diseas			
200 – Caralovascular discas	. (cmilcu) 01/01/2003		
Comments:	DSS – Cardiovascular disease (clinical):		
	These data can be used to help determine the overall health profile of an individual or of a population. Certain patterns of alcohol consumption can be associated with a range of social and health problems. These problems include:		
	 social problems such as domestic violence, unsafe sex financial and relationship problems 		
	 financial and relationship problems physical conditions such as high blood pressure, gastrointestinal 		
	 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 <i>Australian Alcohol Guidelines</i> , October 2001).		
	Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.		
	It is recommended that, in surveys of alcohol consumption, data on age, sex, and other socio-demographic variables also be collected where it is possible and desirable to do so. It is recommended that, when alcohol consumption is investigated in relation to health, data on other risk factors including overweight and obesity, smoking, high blood pressure and physical inactivity should be collected.		
	The <i>Australian Alcohol Guidelines: Health Risk and Benefits</i> endorsed by the National Health and Medical Research Council in October 2001 have defined risk of harm in the short term and long term based on patterns of drinking.		
	The table below outlines those patterns.		

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

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

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

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

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

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

Alcohol consumption in standard drinks per day – self report

Identifying and Defir	nitional Attributes		
Knowledgebase ID:	000648 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	A person's self-reported usual number of alcohol-containing standard drinks on a day when they consume alcohol.		
Context:	Public health, health care and clinical settings.		
Relational and Repr	resentational Attributes		
Datatype:	Numeric		
Representational form:	Quantitative value		
Representational layout:	NN		
Minimum size:	2		
Maximum size:	2		
141 <i>uatmum 512</i> C.			
Data domain:	Count of consumption in Standard drinks per day		
Guide for use:	This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the National Health and Medical Research Council, consumed per day. One standard drinks contains 10 grams alcohol		
	0		
	 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:		
	-		
	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).		
Data domain: Guide for use:	 wine, other) and number of standard drinks, as defined by the National Health and Medical Research Council, consumed per day. One standard drinks contains 10 grams alcohol. The following gives the NH&MRC examples of a standard drink: Light beer (2.7%): 1 can or stubbie = 0.8 a standard drink Medium light beer (3.5%): 1 can or stubbie = 1 standard drink Regular Beer - (4.9% alcohol): 1 can = 1.5 standard drinks 1 jug = 4 standard drinks 1 slab (cans or stubbies) = about 36 standard drinks Wine (9.5% - 13% alcohol): 750-ml bottle = about 7 to 8 standard drinks 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		

Verification rules:				
Collection methods:	The World Health Organization's 2000 Inter Consumption and Related Harm document su consumption patterns a 'Graduated Quanti This method requires that questions about alcohol consumption should be asked to he long-term health consequences. The CATL- standard questions that addresses alcohol co	ggests that in asses ty Frequency' metl the quantity and fre lp determine short IRG has not yet rat	ssing alcohol nod is preferred. equency of -term and	
Related metadata:	relates to the data element concept Alcohol	consumption - cor	ncept vers 1	
	is used in conjunction with the data element Alcohol consumption frequency – self report vers 1			
	is used in conjunction with the data element Behaviour-related risk factor intervention vers 1			
	is used in conjunction with the data element Behaviour-related risk factor intervention – purpose vers 1			
	is used in conjunction with the data element Service contact date vers 1			
Administrative Attrib	utes			
Source document:	The Australian Alcohol Guidelines: Health National Health and Medical Research Cou			
Source organisation:	CV-Data Working Group			
Information model link:				
NHIM Lifestyle characteri	stic			
Data Set Specifications:		Start date	End date	
DSS - Cardiovascular disease	(clinical)	01/01/2003		
Comments:	DSS - Cardiovascular disease (clinical):			
	These data are used to help determine the c individual. Certain patterns of alcohol cons range of social and health problems. These	sumption can be ass		
	 social problems such as domestic violence, unsafe sex 			
	 financial and relationship problems 			
	 physical conditions such as high blood pressure, gastrointestinal 			

- physical conditions such as high blood pressure, gastrointestin problems, pancreatitis
- an increased risk of physical injury.

Alcohol can also be a contributor to acute health problems.

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

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

Anaesthesia administered during labour

Knowledgebase ID: 000013 Version No: 1 Metadata type: Data Element Admin. status: Current 01/07/96 01/07/96 Definition: Anaesthesia administered for the operative delivery of the baby (caesarean, forceps or vacuum extraction). Context: Perinatal statistics: Anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	None	
	2	Local anaesthetic to perineum	
	3	Pudendal	
	4	Epidural or caudal	
	5	Spinal	
	6	General	
	8	Other	
	9	Not stated	
Guide for use:		ore than one agent is used, select the largest number (excluding 8 or 9) as is how the data are tabulated.	
Verification rules:			
Collection methods:			
Related metadata:	is used in conjunction with the data element Apgar score at 1 minute vers 1		
	is used in conjunction with the data element Apgar score at 5 minutes vers 1		
	is us	ed in conjunction with the data element Method of birth vers 1	
Administrative Attrib	utes		

Source document:				
Source organisation:	National Perinatal Data Development Comm	uittee		
Information model link:				
NHIM Service provision event				
Data Set Specifications:		Start date	End date	

Analgesia administered during labour

Identifying and Definitional Attributes

Knowledgebase ID:	000014	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	Agents administered to th during labour and deliver	e mother by injection or inhalation to relieve pain y.
Context:	Perinatal statistics:	
	8	nce the duration of labour, may affect the health status an indicator of obstetric intervention.

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	None	
	2	Nitrous oxide	
	3	Intra-muscular narcotics	
	4	Epidural/caudal	
	5	Spinal	
	8	Other	
	9	Not stated	
Guide for use:		ore than one agent is used, select the largest number (excluding 8 or 9) as as how the data will be tabulated.	
Verification rules:			
Collection methods:			
Related metadata:	is us	ed in conjunction with the data element Method of birth vers 1	

Administrative Attributes

Source document:				
Source organisation:	National Perinatal Data Development Comm	ittee		
Information model link:				
NHIM Service provision event				
Data Set Specifications:		Start date	End date	

Anticipated patient election status

Identifying and Definitional Attributes

		17
Knowledgebase ID:	000631	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
Definition:	01/07/01 Accommodation chargeab elective surgery waiting li	le status nominated by the patient when placed on an st.
Context:	Elective surgery waiting t	imes.
Relational and Repr	esentational Attribu	utes
Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Public	
	2 Private	
Guide for use:	The election status nomina elective surgery waiting li	ated by the patient at the time of being placed on an st, to be treated as either:
	 a public patient or 	
	 a private patient. 	
		of patient's hospital insurance status. The definitions tient are those in the 1998- 2003 Australian Health
	1. Public patient:	
	An eligible person who re of charge.	ceives or elects to receive a public hospital service free
	2. Private patient:	
	responsible for paying fee Northern Territory Agreed Clause 57 states that 'Priva	ects to be treated as a private patient; and elects to be s of the type referred to in clause 57 (clause 58 of the ment) of the Australian Health Care Agreements. ate patients and ineligible persons may be charged an l services as determined by the State'.
	Patients whose charges ar regarded as private patier	e to be met by the Department of Veterans' Affairs are
Verification rules:		
Collection methods:		
Related metadata:		
		

Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee

Information model link:NHIMPlanning eventData Set Specifications:

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.

Start date End date

Apgar score at 1 minute

Identifying and Definitional Attributes

Knowledgebase ID:	000344	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	Numerical score to evalua	te the baby's condition at 1 minute after birth.
Context:	Perinatal statistics:	
		ancy outcome, particularly after complications of th. The Apgar score is an indicator of the health of a

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	Apgar score (00–10) or 99 Not stated/inadequately described
Guide for use:	The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.
Verification rules:	
Collection methods:	
Related metadata:	supersedes previous data element Apgar score vers 1
	is a qualifier of Status of the baby vers 1

Administrative Attributes

Source document:			
Source organisation:	National Perinatal Data Development Comm	vittee	
Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:		Start date	End date

Apgar score at 5 minutes

Identifying and Definitional Attributes

Knowledgebase ID:	000345	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	Numerical score to evalua	te the baby's condition at 5 minutes after birth.
Context:	Perinatal statistics:	
		ancy outcome, particularly after complications of th. The Apgar score is an indicator of the health of a

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	Apgar score (00–10)
	99 Not stated/inadequately described
Guide for use:	The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.
Verification rules:	
Collection methods:	
Related metadata:	supersedes previous data element Apgar score vers 1
Administrative Attrib	utes
Source organisation:	National Perinatal Data Development Committee
Information model link:NHIMPhysical wellbeing	1

Start date

End date

Comments:

Data Set Specifications:

Area of usual residence

Knowledgebase ID:	000016	Version No: 3	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	Geographical location of u	usual residence of t	the person.
Context:	accurate aggregation of in Standard Geographical Cl and Statistical Divisions) a SLA also allows analysis r Australian Bureau of Stati	formation to larger assification (ASGC as well as detailed relating the data to stics on the demog	istical Local Area (SLA) to enable er areas within the Australian C) (such as Statistical Subdivisions analysis at the SLA level. The use of o information compiled by the graphic and other characteristics of ated by the inclusion of SLA
	 comparison of the geographical areas, 	J 1	persons residing in different
	 characterisation of for planning purpo 		nd populations for establishments
			rvices to residents of States or ritory of the provider.

Identifying and Definitional Attributes

Datatype:	Numeric
Representational form: Representational layout: Minimum size: Maximum size:	Code NNNNN 5 5
Data domain:	Valid ASGC codes reported using a five-digit numerical code.
Guide for use:	The geographical location is reported using a five digit numerical code. The first digit is the single-digit code to indicate State or Territory. The remaining four digits are the numerical code for the SLA within the State or Territory. The single digit codes for the States and Territories and the four-digit codes for the SLAs are as defined in the <i>Australian Standard Geographical Classification</i> . The <i>Australian Standard Geographical Classification</i> . The <i>Australian Standard Geographical Classification</i> is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used. The codes for SLA are unique within each State and Territory, but not within
	the whole country. Thus, to define a unique location, the code of the State or Territory is required in addition to the code for the SLA.
	The Australian Bureau of Statistics' <i>National Localities Index</i> (NLI) (Catalogue number 1252.0) can be used to assign each locality or address in Australia to a SLA. The NLI is a comprehensive list of localities in Australia with their full code (including State or Territory and SLA) from the main structure of the ASGC.
	For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign a SLA. However, some localities have the same name. For

	most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA. In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the person's residence is used with the Streets Sub-index of the NLI to assign the SLA.
	If the information available on the person's address indicates that it is in a split locality but is insufficient to assign an SLA, the code for the SLA which includes most of the split locality should be reported. This is in accordance with the NLI assignment of SLA when a split locality is identified and further detail about the address is not available.
	The NLI does not assign a SLA code if the information about the address is insufficient to identify a locality, or is not an Australian locality. In these cases, the appropriate codes for undefined SLA within Australia (State or Territory unstated), undefined SLA within a stated State or Territory, no fixed place of abode (within Australia or within a stated State or Territory) or overseas should be used.
Verification rules: Collection methods:	
Related metadata:	supersedes previous data element Area of usual residence vers 2

Administrative Attributes

Source document:	Australian Standard Geographical Classific Statistics, Cat. No. 1216.0	ation, Australian B	ureau of
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Address element			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient care		01/07/1997	
NMDS - Admitted patient mental health care		01/07/1997	
NMDS – Community mental health care		01/07/2001	
NMDS - Admitted patient palliative care		01/07/2000	
NMDS - Non-admitted patient emergency department care		01/07/2003	

Comments:

Australian postcode

Identifying and Defin	nitional Attributes	
Knowledgebase ID:	000788 Version No: 1	
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.	
Context:		
Relational and Repr	resentational Attributes	
Datatype:	Numeric	
Representational form:	Code	
Representational layout:	NNNN	
Minimum size:	4	
Maximum size:	4	
Data domain:	Valid Australia Post Postal Code or blank.	
Guide for use:	Postcode may be used as a means of coding a person's area of usual residence or where an agency or organization is usually located. It can be mapped to Australian Standard Geographical Codes using an Australian Bureau of Statistics' (ABS) concordance to determine Statistical Local Area (SLA).	
Verification rules:	This data should be verified against the Australia Post Postcode File (web site www.auspost.com.au/postcodes). Alternatively, contact State or Territory health authorities for Postcode files.	
Collection methods:	Leave Postcode blank for any overseas address for:	
	 Overseas health care clients 	
	 Unknown person address 	
	 No fixed address. 	
Related metadata:	relates to the data element Address type vers 1	
	relates to the data element Postal delivery point identifier vers 1	
	is used in conjunction with Labour force status vers 1	
	relates to the data element State/Territory identifier vers 3	
	relates to the data element Suburb/town/locality vers 1	
Administrative Attrib	outes	
Source document:	AS5017 Health care client identification	
Source organisation:	Standards Australia	

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Information model link:			
NHIM Address element			
Data Set Specifications:	Start date	End date	
DSS – Cardiovascular disease (clinical)	01/01/2003		
DSS - Health care client identification	01/01/2003		

Australian administered territories and islands each have an Australia Post postcode:
Jervis Bay 2540
Lord Howe Island 2898
Norfolk Island 2899
Christmas Island 6798
Cocos (Keeling) Islands 6799
Macquarie Island 7151
Postal addresses may be different from where a person actually resides, or a service is actually located. As many postcodes have more than one SLA, postcode alone is not a sufficient basis for accurate coding of SLA in many cases.
DSS - Cardiovascular disease (clinical):
Postcode can also be used in association with the ABS Socio-Economic Indexes for Areas (SEIFA) (on CD-ROM Latest Issue: Aug 1996 was released on 30/10/1998) to derive socio-economic disadvantage, which is associated with cardiovascular risk.
People from lower socio-economic groups are more likely to die from cardiovascular disease than those from higher socio-economic groups. In 1997, people aged 25– 64 living in the most disadvantaged group of the population died from cardiovascular disease at around twice the rate of those living in the least disadvantaged group (Australian Institute of Health and Welfare 2001. Heart, stroke and vascular diseases – Australian facts 2001.). This difference in death rates has existed since at least the 1970s.

Behaviour-related risk factor intervention

identifying and Dem	Informati Antiputes	
Knowledgebase ID:	000806	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The intervention taken to factor(s).	modify or manage the patient's behaviour-related risk
Context:	Public health, health care	and clinical settings:
	the outcome of this care, of The recording of Clinician for health service monitor	interventions within an episode of care, in relation to especially when linked to information on risk factors. n's management interventions is critical information ring, planning and patient outcomes. It is a major vided throughout an episode of care.

Identifying and Definitional Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2

Data domain:	01	No intervention
	02	Information and education (not including written regimen)
	03	Counselling
	04	Pharmacotherapy
	05	Referral provided to a health professional
	06	Referral to a community program, support group or service
	07	Written regimen provided
	08	Surgery
	98	Other
	99	Not stated/inadequately defined
Guide for use:	More	than one code can be recorded.
		01 Refers to no intervention taken with regard to the 'Behaviour-related actor intervention – purpose'.
		02 Refers to where there is no treatment provided to the patient for a viour-related risk factor intervention – purpose' other than information and ation.
	towa	03 Refers to any method of individual or group counselling directed rds the 'Behaviour-related risk factor intervention – purpose'. This code des counselling activities that are part of referral options as defined in code 6.
		04 Refers to pharmacotherapies that are prescribed or recommended for anagement of the 'Behaviour-related risk factor intervention – purpose'.

	Code 05 Refers to a referral to a health professional who has the expertise to assist the patient manage the 'Behaviour-related risk factor intervention – purpose'.
	Code 06 Refers to a referral to community program, support group or service that has the expertise and resources to assist the patient manage the 'Behaviour-related risk factor intervention – purpose'.
	Code 07 Refers to the provision of a written regimen (nutrition plan, exercise prescription, smoking contract) given to the patient to assist them with the management of the 'Behaviour-related risk factor intervention – purpose'.
	Code 08 Refers to a surgical procedure undertaken to assist the patient with the management of the 'Behaviour-related risk factor intervention – purpose'.
	Code 99 Not stated/inadequately defined
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Alcohol consumption frequency - self report vers 1
	is used in conjunction with Behaviour-related risk factor intervention – purpose vers 1
	relates to the data element Physical activity sufficiency status vers 1
	is used in conjunction with Service contact date vers 1
	relates to the data element Tobacco smoking status vers 1
	relates to the data element Waist circumference – measured vers 2

Administrative Attributes

Source document:			
Source organisation:	CV-Data Working Group		
Information model lin	<i>k</i> :		
NHIM Request for/en	try into service event		
Data Set Specification	15:	Start date	End date
DSS – Cardiovascular di	sease (clinical)	01/01/2003	

Comments:

Behaviour-related risk factor intervention – purpose

Identifying and Defin	hitiona	al Attributes
Knowledgebase ID:	00080	7 Version No: 1
Metadata type:	Data E	Element
Admin. status:	Curren	nt
	01/01,	/03
Definition:	The be	ehaviour-related risk factor(s) associated with an intervention(s).
Context:	Public	health, health care and clinical settings:
	detern	resence of one or more behaviour-related risk factors can be used to help nine the risk of future adverse health events and the development of ic diseases.
Relational and Repr	resent	tational Attributes
Datatype:	Nume	ric
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:		Smoking
		Nutrition
		Alcohol misuse
		Physical inactivity
		Other Natistated (incide questions described
	9	Not stated/inadequately described
Guide for use:	More t	than one code can be selected.
Verification rules:		
Collection methods:		
Related metadata:	relates	s to the data element Alcohol consumption frequency – self report vers 1
		d in conjunction with the data element Behaviour-related risk factor intervention vers 1
	relates	s to the data element Physical activity sufficiency status vers 1
	is used	d in conjunction with the data element Service contact date vers 1
	relates	s to the data element Tobacco smoking status vers 1
	relates	s to the data element Waist circumference – measured vers 2
Administrative Attrib	utes	
Source document:	SNAP 2001.	Framework - Commonwealth Department of Health and Ageing - June
	AIHW	/ 2002. Chronic Diseases and associated risk factors in Australians, 2001;

Identifying and Definitional Attributes

Source organisation: CV-Data Working Group

Canberra.

Information model link:

NHIM Request for/entry into service event					
Data Set Specifications:	Start date	End date			
DSS – Cardiovascular diseas	e (clinical)	01/01/2003			
Comments:	DSS – Cardiovascular disease (clinical):				
	Behaviour-related risk factors include tobacco smoking, nutrition patterns that are high in saturated fats and excessive energy (calories / kilojoules) (National Heart Foundation of Australia – A review of the relationship between dietary fat and cardiovascular disease, AJND, 1999. 56 (Supp) S5-S22), alcohol misuse and physical inactivity.				
	The importance of behaviour-related risk factors in health has become increasingly relevant in recent times because chronic diseases have emer the principal threat to the health of Australians. Most of the chronic disea have their roots in these risk-taking behaviours (Chronic Diseases and associated risk factors in Australians, 2001; AIHW 2002 Canberra).				
	SNAP initiative:				
	Smoking, Nutrition, Alcohol, Physical Activity (SNAP) Fra Practice is an initiative of the Joint Advisory Group (JAG) of and Population Health. The lifestyle-related behavioural risk factors of smoking, p associated overweight and obesity) and harmful and hazar declining levels of physical activity have been identified as contributors to the burden of disease in Australia, and part National Health Priority Areas (NHPAs) of diabetes, cardid some cancers, injury, mental health and asthma. The NHP, 70% of the burden of illness and injury in Australia. Substa could occur by public health interventions that address the factors.				
	Around 86% of the Australian population att once a year. There is therefore substantial op to observe and influence the lifestyle risk ber general practitioners already undertake risk patients. There are also a number of initiative Divisions of General Practice, State/Territory and peak non-government organisations aim these four behavioural risk factors. Within th for greater collaboration and integration of a factor behaviour based on system-wide roll-o interventions. The aim of the SNAP initiative is to reduce th	portunity for gene haviours of their pa factor managemen es within general p y and Commonwe hed at reducing dis he health system, the pproaches for influ- but of evidence-base he health and socio	ral practitioners atients. Many it with their practices, alth governments ease related to here is potential dencing risk sed best practice		
	impact of smoking, poor nutrition, harmful a physical inactivity on patients and the comm approach to behavioural interventions in prin opportunity to make better use of evidence-b adoption of best practice initiatives widely th	nd hazardous alco unity through a sy mary care. This wi ased interventions	ohol use and astematic Il provide an 5 and to ensure		

Birth order

Identifying and Definitional Attributes

Knowledgebase ID:	000019	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The sequential order of ea	ch baby of a m	ultiple birth.
Context:	NMDS – Perinatal: Required to analyse pregnancy outcome according to birth order and identi the individual baby resulting from a multiple birth pregnancy. Multiple birth 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.		tiple birth pregnancy. Multiple births nd morbidity. Multiple birth stetric complications, labour and
	DSS – Health care client ic	lentification:	
	1		ly recorded for multiple births against ent volunteers the information, it

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	Singleton or first of a multiple birth	
	2	Second of a multiple birth	
	3	Third of a multiple birth	
	4	Fourth of a multiple birth	
	5	Fifth of a multiple birth	
	6	Sixth of a multiple birth	
	8	Other	
	9	Not stated	
Guide for use:	Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be recorded as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).		
Verification rules:			
Collection methods:	This	data should be collected routinely for persons aged 28 days or less.	
Related metadata:	supersedes previous data element Birth order vers 1 is a qualifier of the data element Birth plurality vers 1		

Administrative Attributes

Source document:	AS5017 Health care client identification		
Source organisation:	National Perinatal Data Development Committee		
	Standards Australia		
Information model link:			
NHIM Birth event			
Data Set Specifications:		Start date	End date
NMDS – Perinatal		01/07/1997	
DSS - Health care client iden	tification	01/01/2003	

Comments:

Birth plurality

raonarying and boin			
Knowledgebase ID:	000020	Version No: 1	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	An indicator of multiple b from a single pregnancy.	pirth, showing the total number of births resulting	
Context:	NMDS - Perinatal:		
	Multiple pregnancy increases the risk of complications during pregnancy labour and delivery and is associated with higher risk of perinatal morbia and mortality.		
	DSS – Health care client i	dentification:	
	1	nation is normally recorded for multiple births against e health care client volunteers the information, it	

Identifying and Definitional Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1

Data domain:	1	Singleton
	2	Twins
	3	Triplets
	4	Quadruplets
	5	Quintuplets
	6	Sextuplets
	8	Other
	9	Not stated
Guide for use:	nun subs unk weig Foel	rality of a pregnancy is determined by the number of live births or by the aber of foetuses that remain in utero at 20 weeks gestation and that are sequently born separately. In multiple pregnancies, or if gestational age is nown, only live births of any birthweight or gestational age, or foetuses ghing 400 grams or more, are taken into account in determining plurality. cuses aborted before 20 completed weeks or foetuses compressed in the enta at 20 or more weeks are excluded.
Verification rules:		
Related metadata:	is qu	alified by the data element Birth order vers 2

Administrative Attributes

Source document:			
Source organisation:	National Perinatal Data Development Committee	e	
Information model link:			
NHIM Birth event			
Data Set Specifications:	St	tart date	End date
NMDS – Perinatal	01	l/07/1997	
DSS - Health care client iden	tification 01	1/01/2003	

Comments:

Birthweight

identifying and Deni	IIIIOIIai Allindules	
Knowledgebase ID:	000021	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/96	
Definition:	0	etus or baby obtained after birth. The World Health nes the following categories:
	 extremely low birth 	hweight – less than 1,000 g (up to and including 999 g)
	 very low birthweig 	ht – less than 1,500 g (up to and including 1,499 g)
	 low birthweight – l 	less than 2,500 g (up to and including 2,499 g).

Identifying and Definitional Attributes

Context: Perinatal.

Relational and Representational Attributes

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

Administrative Attributes

Source document:	International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992		
Source organisation: Information model link: NHIM Birth event	National Perinatal Data Development Commi	ttee	
Data Set Specifications:		Start date	End date
Comments:	The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).		
	For live births, birthweight should preferably of life before significant postnatal weight loss tabulations include 500 gram groupings for bi recorded in those groupings. The actual weigh degree of accuracy to which it is measured.	has occurred. Whi irthweight, weight	ile statistical s should not be

Blindness – diabetes complication

Identifying and Defin	nitional Attributes
Knowledgebase ID:	000808 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/01/03
Definition:	Whether the individual has become legally blind in either or both eyes. Legally, blindness is defined as less than 6/60 vision in the better eye with glasses.
	Vision 6/60 is the ability to see only at 6 metres what the normal eye can see at 60 metres.
Context:	Diabetes mellitus specific data element.
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Data domain:	1 Blindness – (< $6/60$) occurred in either or both eyes in the last 12 months 2 Blindness – (< $6/60$) excurred in either or both eyes prior to the last
	2 Blindness – (< 6/60) occurred in either or both eyes prior to the last 12 months
	3 Blindness – (< 6/60) occurred in one eye within 12 months and in the other eye prior to the last 12 months
	4 No blindness
	9 Not stated/inadequately described
Guide for use:	Blindness can be diagnosed in one eye within 12 months even though it has been previously diagnosed on the other eye (refers to code 3).
Verification rules:	
Collection methods:	Ask the individual if he/she has been diagnosed as legally blind (< 6/60) in both or either eye. If so record whether it has occurred within or prior to the last 12 months.
	Alternatively determine blindness from appropriate documentation obtained from an ophthalmologist or optometrist.
Related metadata:	relates to the data element Health professionals attended – diabetes mellitus vers 1
	relates to the data element Cataract - history vers 1
	relates to the data element Ophthalmological assessment – outcome vers 1
	relates to the data element Ophthalmoscopy - performed vers 1
	relates to the data element Referred to ophthalmologist – diabetes mellitus vers 1
	relates to the data element Visual acuity vers 1

Identifying and Definitional Attributes

Administrative Attributes

Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
Source organisation: Information model link: NHIM Physical wellbeing Data Set Specifications:	National Diabetes Data Working Group	Start date	End date
DSS – Diabetes (clinical)		01/01/2003	
Comments:	Patients with diabetes have an increased risk complications including retinopathy, catarac vision.		
	Diabetic retinopathy is a leading cause of blin characterised by proliferation of the retina's l into the vitreous, causing vitreous haemorrha and retinal detachment. It is often accompany macular oedema, which can express as blurre retinopathy increases with increasing duration retinopathy is asymptomatic. Up to 20% of p retinopathy at the time of diagnosis of diabet proliferation diabetic retinopathy and macular diabetes is about 40%. The Diabetic Retinopath panretinal photocoagulation reduces the risk	plood vessels, which age, proliferation of the by microaneury ed vision. The previous of diabetes. In the eople with diabetes es. The cumulative ar oedema after 20 thy Study Group s	th may project f fibrous tissue ysms and alence of ne early stage, s Type 2 have e prevalence of years of Type 1 howed that
	Although diabetes retinopathy cannot totally blood sugar level slows the onset and progre Control and Complications Trial – DCCT). C associated diabetic eye problems that could l	ssion of retinopath ataract and glaucor	y (The Diabetes
	Regular eye checkups are important for patie mellitus. This helps to early detect abnormali vision-threatening complications.		
		According to the NSW Principles of Care and Guidelines for the Clinical Aanagement of Diabetes Mellitus, a comprehensive ophthalmological xamination should be carried out:	
	 At diagnosis and then every 1–2 years was at age 30 years or more. 	for patients whose	e diabetes onset
	 Within five years of diagnosis and the whose diabetes onset was at age less the 	5 5	or patients
	If retinopathy is detected, review diabetes co	ntrol and improve	if necessary.
	References:		
	Vision Australia, No. 2, 1997-8; University of	Melbourne.	
	The Diabetic Retinopathy Study Research Gr of proliferative diabetic retinopathy.	oup. Photocoagula	tion treatment
	Clinical application of Diabetic Retinopathy 9 Number 8. Ophthalmology. 1981; 88:583-600		g, DRS Report
	Diabetes Control and Complications Trial: D Medicine, 329(14), September 30, 1993.	CCT New England	Journal of

Blood pressure – concept

Identifying and Definitional Attributes

Knowledgebase ID:	000809	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/01/03	
Definition:	The pressure exerted by b capillaries or veins.	lood against the walls of the blood vessels i.e. arteries,

Context:

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Blood pressure - diastolic measured vers 1
	relates to the data element Blood pressure – systolic measured vers 1

Administrative Attributes

vascular diseases - Australian facts 2001. Ca	nberra: AIHW, Nat	ional Heart
CV-Data Working Group		
ent		
	Start date	End date
E	vascular diseases – Australian facts 2001. Ca Foundation of Australia, National Stroke Fo CV-Data Working Group	ent

Comments:

Blood pressure – diastolic measured

Version No: 1 Knowledgebase ID: 000649 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: The person's measured diastolic blood pressure. Context: Public health, health care and clinical settings: High blood pressure is a major risk factor for coronary heart disease, heart failure, stroke, and renal failure with the risk increasing along with the level of blood pressure. Relational and Representational Attributes Numeric Datatype: Representational form: Quantitative value NNN Representational layout: Minimum size: 2 3 Maximum size: Data domain: Measured pressure head in millimetres of mercury (mm Hg) 999 Not collected The diastolic pressure is recorded as phase V Korotkoff (disappearance of Guide for use: sound) however phase IV Korotkoff (muffling of sound) is used if the sound continues towards zero but does not cease. If Blood pressure - diastolic is not collected or not able to be collected, code 999. Verification rules: Collection methods: Measurement protocol for resting blood pressure: The diastolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the minimum pressure to which the arteries are exposed. The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured. Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide). Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy. Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the velcro on the cuff is not totally attached, the cuff is probably too small. Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow. Ensure cuff is at heart level, whatever the position of the patient. Palpate the radial pulse of the arm in which the blood pressure is being

Identifying and Definitional Attributes

	measured.	1. 1 1 1.	1 .
	• Inflate cuff to the pressure at which the r this value. Deflate cuff, wait 30 seconds, above the pressure at which the radial pr	and then inflate cu	
	• Deflate the cuff at a rate of 2–3 mm Hg/l	oeat (2–3 mm Hg/	sec) or less.
	• Recording the diastolic pressure use pha sound). Use phase IV Korotkoff (mufflin continues towards zero but does not ceas repeating the procedure in the same arm	g of sound) only if se. Wait 30 seconds	sound s before
	• If the first two readings differ by more the readings are high, take several readings are high, take several readings are high, take several readings are high at the several readings at the sev	0	
Related metadata:	is used in conjunction with Blood pressure – is used in conjunction with Service contact da	-	vers 1
Administrative Attrib	outes		
Source document:	The National Heart Foundation Blood Press 'Guidelines for the Management of Hyperter based on World Health Organization Recom Subcommittee of the WHO-SH: 1999 WHO- hypertension. J Hypertension 1999; 17:151-8	nsion – 1999' which mendations. (Guid ISH guidelines for	h are largely delines
	Australian Bureau of Statistics 1998. Nationa 1995. Cat. No. 4801.0. Canberra: ABS. (p. 20)		v User's Guide
	National Diabetes Outcomes Quality Review dictionary.	/ Initiative (NDOQ	QRIN) data
Source organisation:	CV-Data Working Group		
	National Diabetes Data Working Group		
Information model link:			
NHIM Service provision ev	vent		
Data Set Specifications:		Start date	End date
DSS – Cardiovascular disease	e (clinical)	01/01/2003	
DSS – Diabetes (clinical)		01/01/2003	
Comments:	The pressure head is the height difference a equilibrium level above the surface subjected usually measured as a head of Mercury, and nominated for this data element.)	d to pressure. (Bloo	od pressure is
	The current (2002) definition of hypertension pressure above which treatment is recomme presence of other risk factors, e.g. age, diabe Management of Hypertension).	nded, and this dep	pends on the
	DSS - Cardiovascular disease (clinical):		
	In the primary care setting, blood pressure of the first visit, particularly if there is evidence		
	Variation of up to 5 mm Hg in blood pressur In certain conditions (e.g. chronic aortic diss all blood pressure recordings should be take reading.	ection, subclavian	artery stenosis)
	Measure sitting and standing blood pressure in other situations in which orthostatic hypo		
	Measure and record heart rate and rhythm. I with hypertension indicates increased risk o		ation in a patient

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

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

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

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

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

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

DSS - Diabetes (clinical):

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

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

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

References:

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

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

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

Blood pressure – systolic measured

Identifying and Definitional Attributes

Knowledgebase ID:	000650	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The person's measured sy	rstolic blood pressure.
Context:	Public health, health care	and clinical settings:
		najor risk factor for coronary heart disease, heart ailure with the risk increasing along with the level of

Datatype: Representational form: Representational layout:	Numeric Quantitative value NNN
Minimum size: Maximum size:	2 3
Data domain:	Measured pressure head in millimetres of mercury (mm Hg) 999 Not collected
Guide for use:	For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). If Blood pressure – systolic is not collected or not able to be collected, code 999.
Verification rules:	
Collection methods:	 Measurement protocol for resting blood pressure: The systolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the maximum pressure to which the arteries are exposed. The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured. Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide). Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracyBladder 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 w this value. Deflate cuff, wait 30 above the pressure at which th) seconds, and then inflate c	ruff to 30 mm Hg
	• Deflate the cuff at a rate of 2–3	mm Hg/beat (2–3 mm Hg/	/sec) or less.
	• For recording the systolic read appearance of sound). Wait 30 the same arm. Average the rea more than 6 mm Hg systolic or readings after five minutes of c	seconds before repeating the dings. If the first two readir r if initial readings are high,	ne procedure in ngs differ by
Related metadata:	is used in conjunction with Blood p	pressure – diastolic measure	ed vers 1
	is used in conjunction with Service	contact date vers 1	
Administrative Attrib	utes		
Source document:	The National Heart Foundation Blood Pressure Advisory Committee's 'Guidelines for the Management of Hypertension – 1999' which are largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO-ISH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17:151–83).		
	Australian Bureau of Statistics 1998 1995. Cat. No. 4801.0. Canberra: Al		y User's Guide
	National Diabetes Outcomes Quali dictionary.	ty Review Initiative (NDOC	QRIN) data
Source organisation:	CV-Data Working Group		
	National Diabetes Data Working G	froup	
Information model link:			
NHIM Service provision	event		
Data Set Specifications:		Start date	End date
DSS – Cardiovascular disease	e (clinical)	01/01/2003	
DSS – Diabetes (clinical)		01/01/2003	
Comments:	The pressure head is the height difference a pressure can raise a fluid's equilibrium level above the surface subjected to pressure. (Blood pressure is usually measured as a head of Mercury, and this is the unit of measure nominated for this data element.)The current (2002) definition of hypertension is based on the level of blood pressure above which treatment is recommended, and this depends on the presence of other risk factors, e.g. age, diabetes etc.(NHF 1999 Guide to Management of Hypertension).		od pressure is measure of hypertension is recommended,
	DSS – Cardiovascular disease (clini	ical):	
	In the primary care setting, blood p the first visit, particularly if there is		
	Variation of up to 5 mm Hg in bloc In certain conditions (e.g. chronic a all blood pressure recordings shou reading.	nortic dissection, subclavian	artery stenosis)
	Measure sitting and standing blood in other situations in which orthost		_
	Measure and record heart rate and with hypertension indicates increas		ation in a patient
	In all patients, consideration should measurements outside the clinic se pressure at home or by non-invasiv	tting either by self-measure	ement of blood

75

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

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

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

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

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

DSS - Diabetes (clinical):

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

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

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

References:

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

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

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

Bodily location of main injury

Identifying and Definitional Attributes

Knowledgebase ID:	000086	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	The bodily location of the person at the health care f	injury chiefly responsible for the attendance of the acility.
Context:	Injury surveillance:	
	research, casemix studies	cessary for purposes including epidemiological and planning. The data element Nature of main injury gether with data element Bodily location of main osis.

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2

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

Guide for use:	If the full ICD-10-AM code is used to code the (see data elements Principal diagnosis and Ado		
	If any code from 01 to 12 or 26 to 29 in the data has been selected, the body region affected by		
	Select the category that best describes the locat categories are judged to be equally appropriate on the code list. A major injury, if present, show minor injury. If a major injury has been sustain with one or more minor injuries (e.g. some sma should be coded in preference to coding 'multi an injury which, on its own, would be unlikely may be regarded as 'minor'. Bodily location of with other Nature of main injury codes (code 2 indicate that a specific body region code is not	e, select the one th uld always be cod ned (e.g. a fracture all abrasions), the iple injuries'. As a to have led to the main injury code 22 may be used as	hat comes first led rather than a ed femur), along major injury general guide, e attendance is not required
Verification rules:			
Collection methods:			
Related metadata:	is used in conjunction with the data element N non-admitted patient vers 1	ature of main inju	iry –
Administrative Attrib	utes		
Source document:			
Source organisation:	National Injury Surveillance Unit		
	National Data Standards for Injury Surveillanc	e Advisory Group	р
Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:	:	Start date	End date
NMDS - Injury surveillance	(01/07/1996	
Comments:	This item is related to the ICD-10-AM injury ar However, coding to the full ICD-10-AM injury data element Principal diagnosis) is not availab injury surveillance is undertaken. This item, in element Nature of main injury – non-admitted alternative. Data coded to the full ICD-10-AM of this item, facilitating data comparison. Further injury surveillance program can be obtained fr Surveillance Unit, Flinders University, Adelaid	and poisoning cla ble in most setting combination with patient, is a pract codes can be aggr information on th om the National I	assification (see gs where basic h the data ticable regated to match he national

Body mass index

Knowledgebase ID:	000367	Version No: 2
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	-	s weight (body mass) relative to height used to assess the or excess in adults and excess only in children and
Context:	Public health and healt	h care:
	healthy weight, and ov obesity in children and association between BM	is used as an indicator of underweight, normal or erweight and obesity in adults, and overweight and adolescents. On a population basis there is a strong II and health risks such as coronary heart disease, diabetes mellitus and high blood pressure in adults. In eys, BMI may be used:
	1	revalence of thinness and overweight and their ic distribution (problem identification)
	 to evaluate healt (assessment of ir 	h promotion and disease prevention programs aterventions)
	 to monitor progr 	ess towards National public health policy
	 to ascertain determined 	rminants and consequences of thinness and overweight
	 in nutrition and 	physical activity surveillance and long-term planning.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Quantitative value		
Representational layout:	NN.NN*/NN.N**		
Minimum size:	4		
Maximum size:	5		
Data domain:	Calculated ratio for body mass index		
	888.8 Unknown		
	999.9 Not collected		
Guide for use:	Formula: $BMI = \frac{\text{weight (kg)}}{\text{height squared(m^2)}}$ Body mass index is a continuous variable. Code body mass index to one or two decimal places (i.e. 99.99 or 99.9). If any component necessary for its calculation (i.e. weight or height for adults and weight, height, sex or date of birth for children and adolescents) is unknown or has not been collected (i.e. is coded to 888.8, 999.9).		

Verification rules:

Collection methods:	*NN.NN for BMI calculated from measured height and weight.
	**NN.N for BMI calculated from self-reported height and/or self-reported weight
	BMI calculated from measured height and weight should be distinguished from BMI calculated from self-reported height and/or weight. When either self-reported height or self-reported weight is used in the calculation, BMI should be recorded as self-reported BMI. Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all.
	BMI should be derived after the data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Related metadata:	supersedes previous data element Adult body mass index vers 1
	is used in the derivation of Body mass index – classification vers 2
	relates to the data element Date of birth vers 4
	is calculated using the data element Height – measured vers 2
	is calculated using the data element Height – self-reported vers 2
	relates to the data element Sex vers 3
	is calculated using the data element Weight – measured vers 2
	is calculated using the data element Weight – self-reported vers 2
Administrative Attrib	utes
Source document:	Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.
	Cole TJ, Bellizi MC, Flegal KM, Bietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240–1243
Source organisation:	The World Health Organization and the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children's Hospital at Westmead on behalf of the Commonwealth Department of Health and Ageing.
Information model link:	
NHIM Physical wellbeing	
Data Set Specifications:	Start date End date
Comments:	This data element applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the US Centers for Disease Control 2000 BMI-for-age chart in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th %ile would be classified as overweight, while a BMI greater than the 95th %ile would be classified as obese. These %iles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.
	BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity.
	BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as magnetic resonance imaging and dual x-ray absorptiometry.

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

good reliability.

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

Body mass index – classification

identifying and Den		
Knowledgebase ID:	000368	Version No: 2
Metadata type:	Derived Data Element	
Admin. status:	Current 01/07/03	
Definition:	The category of weight d children and adolescents.	eficit or excess in adults and weight excess only in
Context:	Public health and health	care:
	healthy weight and overv obesity in children and ac association between BMI	s used as an indicator of underweight, normal or weight and obesity in adults and of overweight and dolescents. On a population basis there is a strong and health risk. In order to correctly categorise lescents, please refer to the categorisation protocol or Use.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N*/N.N**
Minimum size:	1
Maximum size:	3

Data domain:

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

Guide for use:

Adults:

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

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

Children/adolescents:

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

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

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

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

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

Collection methods:	*N for BMI category determined (1, 2, 3 or 9) for persons (children and adolescents) aged 2 to 17 years. **N.N for BMI category determined (1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3 or 9.9) for	
	persons aged 18 years or older. Standard definitions of overweight and obesity in terms of BMI are used to derive age-specific and age-adjusted indicators of overweight and obesity for reporting progress towards national public health policy.	
Related metadata:	supersedes previous data element Adult body mass index – classification vers 1	
	is used in conjunction with data element Body mass index vers 2	
Administrative Attrib	utes	
Source document:	Obesity: Preventing and Managing the Global Epidemic (Report of a WHO Consultation: World Health Organization 2000)	
	Cole TJ, Bellizi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240–1243	
Source organisation:	World Health Organization (see also Comments) and the consortium to develop an Australian standard definition of child/adolescent overweight and obesity at the Children's Hospital at Westmead on behalf of the Commonwealth Department of Health & Ageing	
Information model link:		
NHIM Physical wellbeing		
Data Set Specifications:	Start date End date	
<i>Comments:</i>	This data element applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the US Centers for Disease Control 2000 BMI-for-age chart in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th %ile would be classified as overweight, while a BMI greater than the 95th %ile would be classified as obese. These %iles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults. BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity. The robust nature of the measurements and the widespread routine inclusion of weights and heights in clinical and population health surveys mean that a more select 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).	on ce ire he i o le
	BMI values for adults are age-independent and the same for both sexes.	
	However, BMI values for children and adolescents aged 2 to 17 years are age- and sex-specific and are classified by comparing against the above table, Table 1: Classification of BMI for children and adolescents.	
	For adults and children and adolescents BMI may not correspond to the same degree of fatness in different populations due, in part, to differences in body proportions. The classification table shows a simplistic relationship between BMI and the risk of comorbidity, which can be affected by a range of factors, including the nature of the diet, ethnic group and activity level. The risks associated with increasing BMI are continuous and graded and begin at a BMI of 25 (or equivalent to 25 for children and adolescents). The interpretation of BMI grades in relation to risk may differ for different populations. Both BMI	[

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

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

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

Presentation of data:

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

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

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

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

Capital expenditure

Knowledgebase ID:	000248	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	establishment having guidelines as to the di concise indication of t	regard to State hea fferentiation betwo ne basis on which	enditure as reported by the particular alth authority and other authoritative een capital and recurrent expenditure (a capital and recurrent expenditure have ional minimum data sets).
Context:	Health expenditure:		
	establishment expend number of major cates the national level, so c major categories. Capi related establishments	ture. Just as recur gories to enable a p apital expenditure tal expenditure in is a relatively uno n health establishr	igh variable, element of total health rent expenditure is broken down into a proper analysis of health expenditure at e is to be broken down into a number of the context of hospitals and closely developed area. Nevertheless, there is a nent capital expenditure data at the ntial users.

Identifying and Definitional Attributes

Datatype:	Numeric		
Representational form:	Currency		
Representational layout:	\$999,999,999		
Minimum size:	2		
Maximum size:	12		
Data domain:	Amount of expenditure in Australian dollars rounded to the nearest dollar.		
Guide for use:	Record values up to hundreds of millions of dollars. Calculate separately for each type described below:		
	This includes outlays on construction, major alterations and additions to buildings that relate to the establishment. Included are transfer and similar costs in respect of the purchase (sale) of second hand dwellings and installation of new permanent fixtures such as stoves, air conditioning, lighting, plumbing and other fixed equipment normally installed before dwellings are occupied. Costs relating to repair and maintenance replacement of buildings that amount to recurrent expenditure should not be included.		
	2 Computer equipment/installations:		
	Expenditure of a capital nature on computer installations and equipment such as mainframe computers, mini-computers, extensive personal computer networks and related hardware should be included here.		
	3 Major medical equipment:		
	Expenditure on major items of medical equipment such as CT scanners, MRI equipment, X-ray equipment, ICU monitors and transplant equipment should be included here.		

	4	Plant and (other) equipment:	
	Details of expenditure on plant and other equipment should be included here. Plant and/or equipment that is an integral part of any building or construction (and is thus included under expenditure on land and buildings), equipment included above under major medical equipment, motor vehicles and items of equipment that would normally be classified as recurrent expenditure should not be included.		
	5	Expenditure in relation to intangible assets:	
	This category bears specific regard to the private sector. Included here expenditure during the financial year in respect of intangible assets su formation expenses or goodwill.		
	6	Other capital expenditure:	
	Any expenditure of a capital nature not included elsewhere should be included here. For example, if any State or establishment treats expenditure on new and second hand motor vehicles (including ambulances) as capital expenditure, this should be included as should any expenditure on furniture and fittings if treated by a State or establishment as expenditure of a capital nature.		
Verification rules:	Must be	e in Currency format	
Collection methods:			
Related metadata:		to the data element Capital expenditure – gross (accrual accounting) ers 2	
	relates t	to the data element Capital expenditure – net (accrual accounting) vers 2	
Administrative Attribution	utes		

Source organisation:	National minimum data set working parties		
Information model link:			
NHIM Capital expenditure			
Data Set Specifications:		Start date	End date
NMDS – Public hospital estab	lishments	01/07/1998	

Comments:

Capital expenditure – gross (accrual accounting)

Knowledgebase ID:	000325	Version No: 2		
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/97			
Definition:	Expenditure in a period c (excluding financial asset	on the acquisition or enhancement of an asset s).		
Context:	Health expenditure:			
	health establishment expe into a number of major ca expenditure at the nation into a number of major ca hospitals and closely rela Nevertheless, there is a co	e is a significant, though variable, element of total enditure. Just as recurrent expenditure is broken down ategories to enable a proper analysis of health al level, so capital expenditure is to be broken down ategories. Capital expenditure in the context of ted establishments is a relatively undeveloped area. onsiderable interest in health establishment capital ational level from many different potential users.		

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Currency		
Representational layout:	\$999,999,999		
Minimum size:	2		
Maximum size:	12		
Data domain:	Amount of expenditure in Australian dollars rounded to the nearest dollar.		
Guide for use:	Record values up to hundreds of millions of dollars.		
	This definition is for use where the accrual method of accounting has been adopted.		
	Calculate separately for each type of capital expenditure described below:		
	1 Land:		
	A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.		
	2 Buildings and building services (including plant):		
	An edifice that has a service potential constructed, acquired or held by a financial lease for the specific purposes of the entity. Includes hospitals, residential aged care services and other buildings used for providing the service. Includes expenditure on installation, alteration and improvement of fixtures, facilities and equipment that are an integral part of the building and that contribute to the primary function of a building to either directly or indirectly support the delivery of products and services. Excludes repair and replacement of worn-out or damaged fixtures (to be treated as maintenance).		
	3 Constructions (other than buildings):		
	Expenditure on construction, major alterations and additions to fixed assets other than buildings such as car parks, roads, bridges, storm water channels, dams, drainage and sanitation systems, sporting facilities, gas, water and		

	electricity mains, communication systems, landscaping and grounds reticulation systems. Includes expenditure on land reclamation, land clearance and raising or levelling of building sites.		
	4-7	Equipment:	
	An asset, not an integral part of any building or construction, used by an entity to support the delivery of products and services. Items may be fixed or moveable.		
	4	Information technology:	
		iter installations and equipment such as mainframe and mini-computers, al computer networks and related hardware.	
	5	Major medical equipment:	
	Major items of medical equipment such as medical imaging (CT scanners, MRI, radiology), ICU monitors and transplant equipment.		
	6	Transport:	
	Expenditure on vehicles or equipment used for transport such as motor vehicles, aircraft, ships, railway, tramway rolling stock, and attachments (such as trailers). Includes major parts such as engines.		
	7	Other equipment:	
	Includes machinery and equipment not elsewhere classified, such as furniture, art objects, professional instruments and containers.		
	8	Intangible:	
		et which does not have physical substance, such as copyright, design, trademark, franchise or licence.	
Verification rules: Collection methods:	Must b	e in currency format	
Related metadata:	-	edes previous data element Capital expenditure vers 1 to the data element Capital expenditure – net (accrual accounting) vers 2	
	relates	to the data element Capital experience – net (accrual accounting) vers 2	

Administrative Attributes

Source document:				
Source organisation:	National minimum data set working parties			
Information model link:				
NHIM Capital expenditure				
Data Set Specifications:		Start date	End date	
NMDS - Public hospital establishments		01/07/1997		

Comments:

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

Capital expenditure – net (accrual accounting)

raonarying and Bon		
Knowledgebase ID:	000396	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	1 1	e less trade-in values of replaced items and receipts or otherwise disposed items.
Context:	Health expenditure:	
	establishment expenditur number of major categori the national level, so capi major categories. Capital related establishments is a	s a significant, though variable, element of total health re. Just as recurrent expenditure is broken down into a es to enable a proper analysis of health expenditure at tal expenditure is to be broken down into a number of expenditure in the context of hospitals and closely a relatively undeveloped area. Nevertheless, there is a ealth establishment capital expenditure data at the different potential users.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Currency	
Representational layout:	\$999,999,999	
Minimum size:	2	
Maximum size:	12	
Data domain:	Amount of expenditure in Australian dollars rounded to the nearest dollar.	
Guide for use:	Record values up to hundreds of millions of dollars.	
	This definition is for use where the accrual method of accounting has been adopted.	
	Calculate separately for each type of capital expenditure described below:	
	1 Land:	
	A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.	
	2 Buildings and building services (including plant):	
	An edifice that has a service potential constructed, acquired or held by a financial lease for the specific purposes of the entity. Includes hospitals, residential aged care services and other buildings used for providing the service. Includes expenditure on installation, alteration and improvement of fixtures, facilities and equipment that are an integral part of the building and that contribute to the primary function of a building to either directly or indirectly support the delivery of products and services. Excludes repair and replacement of worn-out or damaged fixtures (to be treated as maintenance).	
	3 Constructions (other than buildings):	
	Expenditure on construction, major alterations and additions to fixed assets other than buildings such as car parks, roads, bridges, storm water channels, dams, drainage and sanitation systems, sporting facilities, gas, water and	

	electricity mains, communication systems, landscaping and grounds reticulation systems. Includes expenditure on land reclamation, land clearance and raising or levelling of building sites.	
	4-7	Equipment:
		et, not an integral part of any building or construction, used by an entity port the delivery of products and services. Items may be fixed or ple.
	4	Information technology:
	-	ter installations and equipment such as mainframe and mini-computers, al computer networks and related hardware.
	5	Major medical equipment:
	,	tems of medical equipment such as medical imaging (CT scanners, MRI, gy), ICU monitors and transplant equipment.
	6	Transport:
	vehicles	liture on vehicles or equipment used for transport such as motor s, aircraft, ships, railway, tramway rolling stock, and attachments (such ers). Includes major parts such as engines.
	7	Other equipment:
		es machinery and equipment not elsewhere classified, such as furniture, acts, professional instruments and containers.
	8	Intangible:
		et which does not have physical substance, such as copyright, design, trademark, franchise or licence.
Verification rules:	Must b	e in Currency format
Collection methods:		
Related metadata:	superse	edes previous data element Capital expenditure vers 1
		to the data element Capital expenditure – gross (accrual accounting) rers 2

Administrative Attributes

Source document:			
Source organisation:	National minimum data set working parties		
Information model link:			
NHIM Capital expenditure			
Data Set Specifications:		Start date	End date
NMDS – Public hospital estab	lishments	01/07/1997	

Comments:

Cardiovascular medication – current

Knowledgebase ID: Version No: 1 000810 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: Whether the individual is taking some of the following cardiovascular medications: - Angiotensin converting enzyme (ACE) inhibitors Angiotensin II (A2) antagonists Beta blockers Calcium antagonists Context: Public health, health care and clinical settings. Relational and Representational Attributes Numeric Datatype: **Representational form:** Code Representational layout: Ν Minimum size: 1 Maximum size: 4 Data domain: 1 Angiotensin converting enzyme (ACE) inhibitors 2 Angiotensin II (A2) receptor blockers 3 Beta blockers 4 Calcium antagonists 8 None of the above 9 Not stated/Inadequately described A person may be taking one or more of the following medications for a *Guide for use:* cardiovascular condition. Therefore more than one code may be recorded sequentially. Code 1 ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril). Code 2 Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan). Code 3 Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol). Code 4 Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil). Example 1: If a person takes one of the ACE inhibitors and a Beta blocker, the code recorded would be 13. Example 2: If a person takes one of the ACE inhibitors, an Angiotensin II receptor blocker and a Beta blocker, the code recorded would be 123. Code 8 is used when none of the listed medications is being taken by the person.

Identifying and Definitional Attributes

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

Verification rules:			
Collection methods:	The person should be asked a series of questions about any current medication for a cardiovascular condition as follows:		
	Are you currently taking any medicatior YesNo	for a cardiovascular	condition?
	If the person answers 'NO', then code 8 s	should be applied.	
	If the person answers 'YES', then ask wh Guide for use).		st of drugs in the
	Ace InhibitorsYes	No	
	Angiotensin II receptor blockersYes	No	
		No	
	Calcium antagonistsYes	No	
	The appropriate code should be recorded in use.	l for each type of mec	lication currently
Related metadata:	relates to the data element Blood pressu	e – diastolic measure	d vers 1
	relates to the data element Blood pressur	e – systolic measured	vers 1
	relates to the data element Date of birth	vers 4	
	relates to the data element Hypertension	- treatment vers 1	
Administrative Attrib	utes		
Source document:	National Diabetes Outcomes Quality Redictionary. Australian Medicines Handb Contents of Cardiovascular, Version 3, 1 (05/042002).	ook: last modified by	February 2001
Source organisation:	National Diabetes Data Working Group		
Information model link:			
NHIM Request for/entry ir	to service event		
Data Set Specifications:		Start date	End date
DSS – Diabetes (clinical)		01/01/2003	
× ,		. ,	

Comments:

Care type

Identifying and Definitional Attributes

Knowledgebase ID:	000168	Version No: 4
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	admitted patient during a	overall nature of a clinical service provided to an n episode of care (admitted care), or the type of ospital for boarders or posthumous organ
Context:	Admitted patient care and	l hospital activity:
	1	type of care received will determine the appropriate ployed to classify the episode of care.

Relational and Repr	eser	ntational Attributes
Datatype:	Num	eric
Representational form:	Code	
Representational layout:	(N)N	I.N
Minimum size:	3	
Maximum size:	4	
Data domain:	1.0	Acute care (admitted care)
	2.0	Rehabilitation care (admitted care)
	2.1	Rehabilitation care delivered in a designated unit (optional)
	2.2	Rehabilitation care according to a designated program (optional)
	2.3	Rehabilitation care is the principal clinical intent (optional)
	3.0	Palliative care
	3.1	Palliative care delivered in a designated unit (optional)
	3.2	Palliative care according to a designated program (optional)
	3.3	Palliative care is the principal clinical intent (optional)
	4.0	Geriatric evaluation and management
	5.0	Psychogeriatric care
	6.0	Maintenance care
	7.0	Newborn care
	8.0	Other admitted patient care
	9.0	Organ procurement – posthumous (other care)
	10.0	Hospital boarder (other care)
Guide for use:	Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principa clinical intent of the care received.	
	Adm	itted care can be one of the following:
	1.0 A	cute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric)

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

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

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

Optional

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

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

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

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

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

Optional

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

3.2 In a designated palliative care program (code 3.2), care is delivered by a specialised team of staff who provide palliative care to patients in beds that may

or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

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

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

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

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

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

6.0 Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting e.g. at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

7.0 Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated

	 patients aged less than 10 days and not admitted at birth (e.g. transferred from another hospital) are admitted with newborn care type
	 patients aged greater than 9 days not previously admitted (e.g. transferred from another hospital) are either boarders or admitted with an acute care type
	 within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
	 a newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status.
	Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.
	8.0 Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above.
	Other care can be one of the following:
	9.0 Organ procurement – posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.
	Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.
	10.0 Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
	Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.
Verification rules:	
Collection methods:	
Related metadata:	is used in conjunction with Number of qualified days for newborns vers 2
	is used in conjunction with Newborn qualification status, version 2 supersedes previous data element Type of episode of care vers 3

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Service provision event			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient ca	re	01/07/2000	
NMDS - Admitted patient mental health care		01/07/2000	
NMDS - Admitted patient palliative care		01/07/2000	

Comments:

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

Carer availability

Knozuladachasa ID:	000022	Version No:	3
Knowledgebase ID:		version no.	5
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:		•	ber, friend or neighbour, has been ined care and assistance to the person
			a pension or benefit for their caring er carers organised by formal services.
Context:	Personal and social suppo	ort, clinical setti	ngs:
	informal support network disabilities within the com maintaining people with community, but the abser contributing to institution the role they play has pro	ks play in caring nmunity. Not o often high level nce of an inform nalisation. Incre mpted greater i at carers and th	ecognition of the critical role that g for frail older people and people with nly are informal carers responsible for s of functional dependence within the nal carer is a significant risk factor asing interest in the needs of carers and interest in collecting more reliable and e relationship between informal care services.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Has no carer	
	2 Has a carer	
	9 Not stated/inadequately described	
Guide for use:	This data element is purely descriptive of a client's circumstances. It is not intended to reflect whether the carer is considered by the service provider to be capable of undertaking the caring role.	
	In line with this, the expressed views of the client and/or their carer should be used as the basis for determining whether the client is recorded as having a carer or not.	
	A carer is someone who provides a significant amount of care and/or assistance to the person on a regular and sustained basis. Excluded from the definition of carers are paid workers or volunteers organised by formal services (including paid staff in funded group houses). When asking a client about the availability of a carer, it is important for agencies to recognise that a carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the client does not have to live with the client in order to be called a carer.	
	The availability of a carer should also be distinguished from living with someone else. Although in many instances a co-resident will also be a carer, this	

	is not necessarily the case. The data element Living arrangement is designed to record information about person(s) with whom the client may live.
Verification rules:	
Collection methods:	Agencies and service providers may collect this item at the beginning of each service episode and also assess this information at subsequent assessments or re-assessments. Some agencies/providers may record this information historically so that they can track changes over time. Historical recording refers to the practice of maintaining a record of changes over time where each change is accompanied by the appropriate date.
Related metadata:	supersedes previous data element Carer availability vers 2
	relates to the data element Formal support access status vers 1
	relates to the data element Living arrangement vers 1

is used in conjunction with Service contact date vers 1

Source document:	HACC Data Dictionary Version 1.0, 1998		
Source organisation:	Australian Institute of Health and Welfare		
Information model link:			
NHIM Request for/entry ir	nto service event		
Data Set Specifications:		Start date	End date
DSS - Cardiovascular disease	(clinical)	01/01/2003	

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

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

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

Identifying and Definitional Attributes Knowledgebase ID: Version No: 1 000811 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes. Context: Public health, health care and clinical settings. Relational and Representational Attributes Datatype: Numeric Representational form: Code Representational layout: Ν Minimum size: 1 Maximum size: 1 Data domain: 1 Cataract currently present or has been previously removed from the right eye 2 Cataract currently present or has been previously removed from the left eve 3 Cataract currently present or has been previously removed from both eyes No cataract present or has not been previously removed from either eye 4 9 Not stated/inadequately described Guide for use: Verification rules: Collection methods: Examination of the lens of the eye through a dilated pupil (visible through the pupil by the use of an ophthalmoscope) by an ophthalmologist or optometrist, as a part of the ophthalmological assessment. Ask the individual if he/she has a cataract in either or both eyes or has had a Cataract removed from either or both eyes previously. Alternatively obtain information from an ophthalmologist or optometrist or from appropriate documentation. **Related metadata:** relates to the data element Health professionals attended - diabetes mellitus vers 1 relates to the data element Blindness - diabetes complication vers 1 relates to the data element Ophthalmological assessment - outcome vers 1 relates to the data element Ophthalmoscopy - performed vers 1 relates to the data element Referred to ophthalmologist - diabetes mellitus vers 1 relates to the data element Visual acuity vers 1

Volume 1

Administrative Attributes

Source document:	National Diabetes Outcomes Quality Review dictionary.	Initiative (NDOQ	PRIN) data
Source organisation: Information model link: NHIM Physical wellbeing	National Diabetes Data Working Group		
Data Set Specifications:		Start date	End date
DSS – Diabetes (clinical) <i>Comments:</i>	Cataract is a clouding of the lens of the eye or vision. The formation of cataract occurs more of ocular trauma, uveitis, or diabetes mellitus eye problem that could lead to blindness.	e rapidly in patient	ts with a history
	Regular eye checkups are important for patie mellitus. This helps to early detect abnormali vision-threatening complications. A compreh examination includes: - check visual acuity with Snellen chart	ities and to avoid onensive ophthalmo	or postpone blogical
	 examine for cataract 		

- examine fundi with pupils dilated.

Category reassignment date

Identifying and Definitional Attributes

Knowledgebase ID:	000391	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	different urgency category	nt awaiting elective hospital care is assigned to a y as a result of clinical review for the awaited to a different patient listing status category ('ready for e').
Context:	Elective surgery:	
	5	the calculation of Waiting time at removal from st and Waiting time at a census date.

Relational and Representational Attributes

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

Administrative Attributes

National Health Data Committee		
	Start date	End date
iting times	01/07/1997	30/06/2002
	National Health Data Committee iting times	Start date

Comments:

Census date

Identifying and Defir	nitional Attributes			
Knowledgebase ID:	000174	Version No: 2		
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/97			
Definition:	Date on which the hospita characterisation of patient	-	, ,	of and
Context:	Elective surgery:			
	This data element is neces census.	ssary for the calculat	tion of the waiting	; time until a
Relational and Repr	esentational Attrib	utes		
Datatype:	Numeric			
Representational form:	Date			
Representational layout:	DDMMYYYY			
Minimum size:	8			
Maximum size:	8			
Data domain:	Valid date			
Guide for use:	This date is recorded whe	n a census is done c	of the patients on a	ı waiting list.
Verification rules:				
Collection methods:				
Related metadata:	supersedes previous data	element Census dat	te vers 1	
	is used in the calculation of	of Waiting time at a	census date vers 2	2
Administrative Attrib	utes			
Source document:				
Source organisation:	National Health Data Cor	nmittee		
Information model link:				
NHIM Surveillance/monito	oring event			
Data Set Specifications:			Start date	End date
			01 /05 /1005	

Comments:

NMDS - Elective surgery waiting times

01/07/1997

Information model link: NHIM Recipient role

Data Set Specifications:

DSS - Health care client identification

End date

Start date

01/01/2003

Centrelink customer reference number

Identifying and Definitional Attributes		
Knowledgebase ID:	000797	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:		gned by Centrelink for the purposes of identifying s) eligible for specific services, including some public as oral health services.
Context:	All Health services.	
Relational and Repr	esentational Attrib	utes
Datatype:	Alphanumeric	
Representational form:	Identification number	
Representational layout:	NNNNNNNNA	
Minimum size:	0	
Maximum size:	10	
Data domain:	The reference number cor character.	nprises 9 numeric characters and one alphabetic
Guide for use:	persons eligible to receive The number may be repor- the service provided. The organisations for any pur-	Reference Number should only be collected from e health services that are to be funded by Centrelink. rted to a Centrelink agency to reconcile payment for data should not be used by private sector pose unless specifically authorised by law. For build not be carried out unless specifically authorised
Verification rules:		
Collection methods:	The Centrelink Customer Cards' and 'Pensioner Co	Reference Number is provided on 'Health Care ncession Cards'.
Related metadata:		
Administrative Attrib	outes	
Source document:	AS5017 Health care client	identification
Source organisation:	Standards Australia	

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

Cerebral stroke due to vascular disease – history

Identifying and Defir	nitional Attributes
Knowledgebase ID:	000812 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/01/03
Definition:	Whether the individual has had a cerebral stroke due to vascular disease.
Context:	Public health, health care and clinical settings.
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Detale	
Data domain:	1 Cerebral stroke – occurred in the last 12 months
	2 Cerebral stroke – occurred prior to the last 12 months
	3 Cerebral stroke – occurred both in and prior to the last 12 months
	4 No history of cerebral stroke due to vascular disease
	9 Not stated/inadequately described
Guide for use:	
Verification rules:	
Collection methods:	Obtain this information from appropriate documentation or from the patient
Related metadata:	relates to the data element Blood pressure – diastolic measured vers 1
	relates to the data element Blood pressure – systolic measured vers 1
	relates to the data element Hypertension - treatment vers 1
Administrative Attrib	utes
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Source organisation:	National Diabetes Data Working Group
Information model link:	0 1
NHIM Physical wellbeing	
Data Set Specifications:	Start date End date
DSS – Diabetes (clinical)	01/01/2003
200 – Diaberes (cillical)	01/01/2003
Comments:	Cerebral stroke is a medical emergency condition with a high mortality rate, which is often recognised as a vascular complication of diabetes mellitus.

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

References:

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

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

Cessation of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes			
Knowledgebase ID:	000422 Version No: 2		
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/01		
Definition:	Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.		
Context:	Alcohol and other drug treatment services.		
Relational and Rep	resentational Attributes		
Datatype:			
Representational form:			
Representational layout:			
Minimum size:			
Maximum size:			
Data domain:			
Guide for use:	A client is identified as ceasing a treatment episode if one or more of the following apply:		
	 their treatment plan is completed 		
	 they have had no contact with the treatment provider for a period of three months, nor is there a plan in place for further contact 		
	- their 'principal drug of concern for alcohol and other drugs' has changed		
	 their 'main treatment type for alcohol and other drugs' has changed 		
	- their 'treatment delivery setting for alcohol and other drugs' has changed		
	 their treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice, transferred to another service provider, died etc). 		
Verification rules:			
Collection methods:			
Related metadata:	supersedes previous data element Cessation of treatment vers 1		
	relates to the data element Date of cessation of treatment episode for alcohol and other drugs vers 2		
	relates to the data element Reason for cessation of treatment episode for alcohol and other drugs vers 2		
Administrative Attributes			
Source document:			
Source organisation:	Intergovernmental Committee on Drugs NMDS WG		
Information model link:			
NHIM Exit/leave from ser	vice event		

Comments:

Data Set Specifications:

Start date

End date

Cholesterol-HDL – measured

Identifying and Definitional Attributes

Knowledgebase ID:	000651 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/01/03
Definition:	A person's measured high-density lipoprotein cholesterol (HDL-C).
Context:	Public health, health care and clinical settings:
	The evidence is strong that HDL-C has a direct protective effect against the development of arteriosclerosis.
Relational and Repr	resentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	N.NN
Minimum size:	2
Maximum size:	3
Data domain:	Measurement in mmol/L to 2 decimal places
	9.99 Not measured/inadequately described
Guide for use:	When reporting, record whether or not the measurement of HDL Cholesterol was performed in a fasting specimen.
	In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the date of assessment should be recorded.
	DSS – Diabetes (clinical):
	When reporting, record absolute result of the most recent HDL Cholesterol measurement in the last 12 months to the nearest 0.01 mmol/L.
Verification rules:	
Collection methods:	Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.
	• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
	12 Hour fust where only water and included only have been consumed.
	 Prolonged tourniquet use can artefactually increase levels by up to 20%.
Related metadata:	• Prolonged tourniquet use can artefactually increase levels by up to 20%.
Related metadata:	
Related metadata:	 Prolonged tourniquet use can artefactually increase levels by up to 20%. is used in the calculation of Cholesterol-LDL calculated vers 1 relates to the data element Cholesterol-total – measured vers 1
Related metadata:	• Prolonged tourniquet use can artefactually increase levels by up to 20%. is used in the calculation of Cholesterol-LDL calculated vers 1
Related metadata:	 Prolonged tourniquet use can artefactually increase levels by up to 20%. is used in the calculation of Cholesterol-LDL calculated vers 1 relates to the data element Cholesterol-total – measured vers 1 relates to the data element Dyslipidaemia – treatment vers 1
Related metadata:	 Prolonged tourniquet use can artefactually increase levels by up to 20%. is used in the calculation of Cholesterol-LDL calculated vers 1 relates to the data element Cholesterol-total – measured vers 1 relates to the data element Dyslipidaemia – treatment vers 1 is used in conjunction with Fasting status vers 1

Administrative Attributes

Source document:	National Heart Foundation of Australia ar and New Zealand, Lipid Management Gu S57–S88.		•
Source organisation:	CV-Data Working Group		
0	National Diabetes Data Working Group		
Information model link:			
NHIM Service provision ev	vent		
Data Set Specifications:		Start date	End date
DSS - Cardiovascular disease	e (clinical)	01/01/2003	
DSS – Diabetes (clinical)		01/01/2003	
Comments:	DSS – Cardiovascular disease (clinical):		
	High-density lipoprotein cholesterol (HDI shown to be a negative predictor of future	, ,	red and has been
	An inverse relationship between the level premature coronary heart disease (CHD) I number of prospective population studies HDL-C has been the single most powerful Key studies of the relationship between H Framingham Heart Study (Castelli et al. 19 al. 1998), the Helsinki Heart Study (Manni (Stamler et al. 1986; Neaton et al. 1992).	nas been a consisten In many of these st predictor of future DLs and CHD inclu 986), the PROCAM S	t finding in a large udies, the level of coronary events. de the Study (Assman et
	There are several well-documented functions of HDLs that may explain ability of these lipoproteins to protect against arteriosclerosis (Barter and 1996). The best recognised of these is the cholesterol efflux from cells pri- by HDLs in a process that may minimise the accumulation of foam cells 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 modifica LDLs and may therefore reduce the atherogenicity of these lipoproteins		Barter and Rye m cells promoted foam cells in the ns (e.g. i-oxidant e modification of
	Overall, it has been concluded from the prevery 0.025 mmol/L increase in HDL-C, the For a review of the relationship between F (1996). A level below 1.0 mmol/L increase et al. 1989; Assmann et al. 1998). (Lipid Ma 2001; 175: S57–S88.	ne coronary risk is re IDL-C and CHD, see s risk approximately	educed by 2–5%. e Barter and Rye y 2-fold (Gordon
	In settings such as general practice where ongoing and where a measure can change should be recorded.		
	DSS - Diabetes (clinical):		
	Lowered HDL-C, with increased serum tr lipoprotein cholesterol are important risk diabetes.		
	In the NSW Principles of Care and Guidel Diabetes Mellitus, recommendations are the triglycerides are to be measured:		0
	 every 1–2 years (if normal) 		
	- every 3–6 months (if abnormal or o	n treatment)	
	and the target is:		
	- to increase HDL Cholesterol to more	e than or equal to 1.	0 mmol/L
	 to reduce total Cholesterol to less the 	an 5.5 mmol/L	
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- to reduce triglyceride levels to less than 2.0 mmol/L.

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

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

References:

National Heart Foundation of Australia - Lipid Management Guidelines 2001.

Cholesterol-LDL – calculated

Identifying and Definitional Attributes

Knowledgebase ID:	000652 Version No: 1
Metadata type:	Derived Data Element
Admin. status:	Current
	01/01/03
Definition:	A person's calculated low-density lipoprotein cholesterol (LDL-C).
Context:	Public health, health care and clinical setting.
Relational and Repr	resentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN.N
Minimum size:	2
Maximum size:	3
Data domain:	Calculated value recorded in mmol/L to one decimal place
Guide for use:	Formula:
·	LDL-C = (plasma total cholesterol) - (high-density lipoprotein cholesterol) - (fasting plasma triglyceride divided by 2.2).
Verification rules:	
Collection methods:	The LDL-C is usually calculated from the Friedwald Equation (Friedwald et al. 1972), which depends on knowing the blood levels of the total cholesterol and high-density lipoprotein cholesterol and the fasting level of the triglyceride.
	Note that the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L.
	Note also that while cholesterol levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 6 weeks after an event.
	• Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.
	• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
Related metadata:	is calculated using Cholesterol-HDL – measured vers 1
	is calculated using Cholesterol-total – measured vers 1
	is calculated using Fasting status vers 1
	is used in conjunction with Service contact date vers 1
	is calculated using Triglycerides – measured vers 1
Administrative Attrib	

Administrative Attributes

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

Source organisation:	CV-Data Working Group		
Information model link:			
NHIM Service provision eve	ent		
Data Set Specifications:		Start date	End date
DSS – Cardiovascular disease	(clinical)	01/01/2003	
Comments:	High blood cholesterol is a key factor in heart especially coronary heart disease (CHD).	, stroke and vascul	lar disease,
	Poor nutrition can be a contributing factor to as a population's level of saturated fat intake level of blood cholesterol.		
	The majority of the cholesterol in plasma is tr LDL-C. Thus, the evidence linking CHD to pl is essentially the same.	-	-
	DSS - Cardiovascular disease (clinical):		
	Many studies have demonstrated the signification components as risk factors for heart, stroke and		
	Scientific studies have shown a continuous re and CHD and overwhelming evidence that li CHD progression, morbidity and mortality.		
	There are many large-scale, prospective popurelationship between plasma total (and LDL) developing CHD. The results of prospective prospec	cholesterol and the	e future risk of
	 the majority of people with CHD do no plasma total cholesterol or LDL-C 	ot have markedly e	levated levels of
	 there is a continuous positive but curvation of plasma total (and LDI having a coronary event and of dying) 	L) cholesterol and t	
	 there is no evidence that a low level of predisposes to an increase in non-coror 		holesterol
	The excess non-coronary mortality at low cho Heart Study (Yano et al. 1983; Stemmermann people who smoked and is consistent with a smoking-related disease that is responsible for a low plasma cholesterol.	et al. 1991) was ap view that smokers	parent only in may have occult
	It should be emphasised that the prospective between plasma total cholesterol and LDL-C (Lipid Management Guidelines – 2001, MJA 2 Commonwealth Department of Health & Age Health and Welfare (1999) National Health Pr Cardiovascular Health 1998. AIHW Cat. No. 2 Canberra 14–17).	and the risk of dev 2001; 175: S57–S88 a eing and Australiar riority Areas Repor	eloping CHD. and 1 Institute of rt:
	In settings such as general practice where the ongoing and where a measure can change over should be recorded.		

Cholesterol-total – measured

Identifying and Definitional Attributes

Knowledgebase ID:	000653 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/01/03
Definition:	A person's measured total cholesterol (TC).
Context:	Public health, health care and clinical settings.
Relational and Repr	resentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN.N
Minimum size:	3
Maximum size:	4
Data domain:	Measurement in mmol/L to one decimal place
	99.9 Not stated/Inadequately described
Guide for use:	Record the absolute result of the TC measurement. When reporting, record whether or not the measurement of Cholesterol-total – measured was performed in a fasting specimen.
	DSS – Diabetes (clinical):
	When reporting, record absolute result of the most recent Cholesterol-total - measured in the last 12 months to the nearest 0.1 mmol/L.
Verification rules:	
Collection methods:	Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.
	• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
	• Prolonged tourniquet use can artefactually increase levels by up to 20%.
Related metadata:	relates to the data element Cholesterol-HDL – measured vers 1
	is used in the calculation of Cholesterol-LDL calculated vers 1
	relates to the data element Dyslipidaemia – treatment vers 1
	is used in conjunction with Fasting status vers 1
	is used in conjunction with Service contact date vers 1
	relates to the data element Triglycerides – measured vers 1
Administrative Attrib	outes

Administrative Attributes

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

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

Source organisation: CV-Data Working Group *Information model link:*

NHIM Service provision event

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

Comments:

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

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

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

DSS - Cardiovascular disease (clinical):

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

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

Several generalisations can be made from these cholesterol lowering trials:

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

There is high level evidence that in patients with existing coronary heart disease, lipid intervention therapy reduces the risk of subsequent stroke. DSS – Diabetes (clinical):

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

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

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

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

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

Classification of health labour force job

identifying and Den	Indian Allindules	
Knowledgebase ID:	000023	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/95	
Definition:	a general organisational c	on is a broad description of the roles and levels within or industrial structure for health professions, and g the professions according to organisational
Context:	Health labour force:	
	1	onal labour force across job classification categories variables allows analysis of:
	 career progression 	
	 age and gender dis 	tribution
	 imputed salary/wa 	age distribution.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Alphanumeric		
Representational form:	Code		
Representational layout:	ANN		
Minimum size:	3		
Maximum size:	3		
Data domain:	A01	Medicine – General practitioner working mainly in general practice	
	A02	Medicine – General practitioner working mainly in a special interest area	
	A03	Medicine - Salaried non-specialist hospital practitioner: RMO or intern	
	A04	Medicine – Salaried non-specialist hospital practitioner: other hospital career medical officer	
	A05	Medicine – Specialist	
	A06	Medicine – Specialist in training (e.g. registrar)	
	B01	Dentistry (private practice only) - Solo practitioner	
	B02	Dentistry (private practice only) - Solo principal with assistant(s)	
	B03	Dentistry (private practice only) – Partnership	
	B04	Dentistry (private practice only) - Associateship	
	B05	Dentistry (private practice only) - Assistant	
	B06	Dentistry (private practice only) - Locum	
	C01	Nursing – Enrolled nurse	
	C02	Nursing – Registered nurse	
	C03	Nursing – Clinical nurse	
	C04	Nursing – Clinical nurse consultant/supervisor	
	C05	Nursing – Nurse manager	
	C06	Nursing – Nurse educator	
	C07	Nursing – Nurse researcher	

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

Guide for use: Verification rules: Collection methods: Related metadata:

Administrative Attributes

Source document:Source organisation:National Health Labour Force Data Working GroupInformation model link:NHIMLabour characteristic

Data Set Specifications:	Start date E	and date
NMDS - Health labour force	01/07/1995	
Comments:	Position or job classifications are specific to each profession and ma	av differ b

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.

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Client type – alcohol and other drug treatment services

Knowledgebase ID:	000426	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	1	erms of whether the treatment episode concerns other drug use or that of another person.
Context:	Alcohol and other drug tr	reatment services:
	episode concerns their ow	between clients according to whether the treatment on alcohol and/or other drug use or that of another for description of the people accessing alcohol and rices.

Identifying and Definitional Attributes

Relational and Representational Attributes

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

Administrative Attributes

Source document:			
Source organisation:	Intergovernmental Committee on Drugs N	IMDS WG	
Information model link:			
NHIM Request for/entry into service event			
Data Set Specifications:		Start date	End date
NMDS – Alcohol and other d	rug treatment services	01/07/2003	

Comments:

Clinical intervention

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

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype: Representational form: Representational layout: Minimum size: Maximum size: Data domain: Guide for use: Verification rules: **Collection** methods: **Related metadata:**

Administrative Attributes

Source document: Source organisation:

National Health Data Committee

Information model link:NHIMService provision eventData Set Specifications:

Comments:

Start date End date

000024	Version No: 1		
Data Element Concept			
Current			
01/07/95			
the waiting list. This exan different urgency rating f	nination may result in rom the initial classif	n the patient bein ication. The need	g assigned a for clinical
Admitted patient care.			
esentational Attrib	utes		
relates to the data elemen	t Clinical urgency ve	rs 2	
outes			
- 0	0	g Group	
	Data Element Concept Current 01/07/95 The examination of a pati the waiting list. This exam different urgency rating for review varies with a patier treating clinician. Admitted patient care. esentational Attribu relates to the data elemen outes Hospital Access Program	00024 Version Nor. 1 Data Element Concept Current 01/07/95 The examination of a patient by a clinician after the waiting list. This examination may result in different urgency rating from the initial classif review varies with a patient's condition and is treating clinician. Admitted patient care. Esentational Attributes relates to the data element Clinical urgency ver	000024 Version No: 1 Data Element Concept Current 01/07/95 The examination of a patient by a clinician after the patient has the waiting list. This examination may result in the patient beind different urgency rating from the initial classification. The need review varies with a patient's condition and is therefore at the of treating clinician. Admitted patient care. Esentational Attributes relates to the data element Clinical urgency vers 2 outes Hospital Access Program Waiting List Working Group

Identifying and Definitional Attributes

Comments:

Clinical urgency

Knowledgebase ID:	000025	Version No: 2	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	A clinical assessment of the hospital care.	ne urgency with which a patient requires elective	
Context:	Elective surgery:		
	management and clinician health consumers a reason expect to wait for care. Cl measure of system perfor proportion of patients wh	list patients by clinical urgency assists hospital as in the prioritisation of their workloads. It gives hable estimate of the maximum time they should inical urgency classification allows a meaningful mance to be calculated, namely the number or to wait for times in excess of the maximum desirable cy category (data element 'Overdue patient').	

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency		
	2 Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency		
	3 Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency		
Guide for use:	The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.		
Verification rules:			
Collection methods:			
Related metadata:	is used in conjunction with Category reassignment date vers 2 relates to the data element concept Clinical review vers 1 is a qualifier of Extended wait patient vers 1 is a qualifier of Overdue patient vers 3 is used in conjunction with Patient listing status vers 3 is a qualifier of Waiting time at a census date vers 2 is a qualifier of Waiting time at removal from elective surgery waiting list vers 2		
	care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery. is used in conjunction with Category reassignment date vers 2 relates to the data element concept Clinical review vers 1 is a qualifier of Extended wait patient vers 1 is a qualifier of Overdue patient vers 3 is used in conjunction with Patient listing status vers 3		

Administrative Attributes

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

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

Commencement of treatment episode for alcohol and other drugs

Identifying and Defi	nitional Attributes	
Knowledgebase ID:	000427	Version No: 2
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/01	
Definition:		ment episode for alcohol and other drugs is the first ssment and/or treatment occurs with the treatment
Context:	Alcohol and other drug tr	eatment services.
Relational and Rep	resentational Attribu	utes
Datatype:		
Representational form:		
Representational layout:		
Minimum size:		
Maximum size:		
Data domain:		
Guide for use:	A client is identified as confollowing apply:	mmencing a treatment episode if one or more of the
	 they are a new clier 	ıt
		commencing treatment after they have had had no atment provider for a period of three months or had or further contact
	 their Principal drug 	g of concern for alcohol and other drugs has changed
	- their Main treatmen	nt type for alcohol and other drugs has changed
	 their Treatment del 	ivery setting for alcohol and other drugs has changed.
Verification rules:		
Collection methods:		
Related metadata:	supersedes previous data	element Commencement of treatment vers 1
	relates to the data element alcohol and other d	Date of commencement of treatment episode for rugs vers 2
Administrative Attrib	outes	
Source document:		

Source accument:			
Source organisation:	Intergovernmental Committee on Drugs NM	1DS WG	
Information model link:			
NHIM Request for/entry into service event			
Data Set Specifications:		Start date	End date

Comments:

Compensable status

identifying and Dem	IIIONAI AUIDULES
Knowledgebase ID:	000026 Version No: 3
Metadata type:	Data Element
Admin. status:	Current
	01/07/00
Definition:	A compensable patient is an individual who is entitled to receive or has received a compensation payment with respect to an injury or disease.
	A compensable patient is a person who:
	 is entitled to claim damages under Motor Vehicle Third Party insurance or
	 is entitled to claim damages under worker's compensation or
	 has an entitlement to claim under public liability or common law damages.
Context:	To assist in the analyses of utilisation and health care funding.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Compensable	
	2 Non-compensable	
	9 Not stated/not known	
Guide for use:	This definition excludes eligible beneficiaries (Department of Veterans' Affairs), Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.	
	DVA beneficiaries are identified by the data element Department of Veterans' Affairs patient.	
Verification rules:		
Collection methods:		
Related metadata:	supersedes previous data element Compensable status vers 2	
Administrative Attrib	utes	
Source document:		

Source organisation:		National Health Data Committee
Informa	ation model link:	
NHIM	Insurance/benefit c	haracteristic

Comments:

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

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

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

Complication of labour and delivery

Knowledgebase ID: 000027 Version No: 2 Metadata type: Data Element Admin. status: Current 01/07/98 Medical and obstetric complications (necessitating intervention) arising after the Definition: onset of labour and before the completed delivery of the baby and placenta. Perinatal statistics: Context: Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth. Relational and Representational Attributes Datatype: Alphanumeric Representational form: Code Representational layout: ANN.NN 3 Minimum size: 6 Maximum size: Data domain: ICD-10-AM 3rd edition Guide for use: There is no arbitrary limit on the number of conditions specified. Complications should be coded within the Pregnancy, Childbirth, Puerperium Verification rules: chapter 15 of Volume 1, ICD-10-AM

Identifying and Definitional Attributes

	1
Collection methods:	
Related metadata:	supersedes previous data element Complication of labour and delivery – ICD-9-CM code vers 1
	is used in conjunction with Method of birth vers 1
	is used in conjunction with Perineal status vers 2
	is used in conjunction with Postpartum complication vers 2
	is used in conjunction with Presentation at birth vers 1

Administrative Attributes

Source document:	International Classification of Diseases - Ten Modification (3rd edition 2002) National Cer Sydney.		
Source organisation:	National Perinatal Data Development Comm	nittee	
Information model link:			
NHIM Birth event			
Data Set Specifications:		Start date	End date

Complications of pregnancy

Identifying and Definitional Attributes

Knowledgebase ID:	000028	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	directly attributable to the	to the period immediately preceding delivery that are pregnancy and may have significantly affected care ncy and/or pregnancy outcome.
Context:	Perinatal statistics:	
	1	ence the course and outcome of pregnancy, possibly ssions and/or adverse effects on the foetus and

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANN.NN
Minimum size:	3
Maximum size:	6
Data domain:	ICD-10-AM 3rd edition disease codes
Guide for use:	Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.
Verification rules:	Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM
Collection methods:	
Related metadata:	supersedes previous data element Complications of pregnancy – ICD-9-CM code vers 1
	is used in conjunction with Maternal medical conditions vers 2
Administrative Attrib	utes
Source document:	International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002) National Centre for Classification in Health,

	Sydney.	
Source organisation:	National Perinatal Data Development Committee	
Information model link:		
NHIM Physical wellbeing		
Data Set Specifications:	Start date	End date

Congenital malformations

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

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANN.NN
Minimum size:	3
Maximum size:	6
Data domain:	ICD-10-AM 3rd edition
Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see the data element Congenital malformations – BPA classification).
Verification rules:	
Collection methods:	
Related metadata:	supersedes previous data element Congenital malformations – ICD-9-CM code vers 1
	is used in conjunction with Neonatal morbidity vers 2
Administrative Attrib	utes
Source document:	International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002) National Centre for Classification in Health, Sydney.
Source organisation: Information model link: NHIM Physical wellbeing	National Perinatal Data Development Committee
Data Set Specifications:	Start date End date

Congenital malformations – BPA code

Identifying and Defin	nitional Attributes	
Knowledgebase ID:	000029	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	Structural abnormalities (diagnosed prior to separa	(including deformations) that are present at birth and ation from care.
Context:	Perinatal statistics:	
	malformations, to detect	ds in the reported incidence of congenital new drug and environmental teratogens, to analyse niological studies, and to determine survival rates and ic services.

Identifying and Definitional Attributes

Relational and Representational Attributes

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

Administrative Attributes

Source document:	British Paediatric Association Classification of Diseases (1979)		
Source organisation: Information model link: NHIM Physical wellbeing	National Perinatal Data Development Committee		
Data Set Specifications:	Start date End date		
Comments:	There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the States and Territories have used the 5-digit British Paediatric Association (BPA) Classification of Diseases to code congenital malformations since the early 1980s.		

Contract establishment identifier

Identifying and Definitional Attributes

, ,			
Knowledgebase ID:	000416 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
- 4	01/07/00		
Definition:	The establishment identifier of the other hospital involved in the contracted care.		
Context:	Admitted patient care and public hospital establishments.		
Relational and Repr	esentational Attributes		
Datatype:	Alphanumeric		
Representational form:	Code		
Representational layout:	NNANNN		
Minimum size:	6		
Maximum size:	6		
Data domain:	Valid list of establishment numbers		
Guide for use:	The contracted hospital will record the establishment identifier of the contracting hospital.		
	The contracting hospital will record the establishment identifier of the contracted hospital.		
Verification rules:			
Collection methods:			
Related metadata:	relates to the data element Contract procedure flag vers 1		
	relates to the data element Contract role vers 1		
	relates to the data element Contract type vers 1		
	relates to the data element Contracted care commencement date vers 1		
	relates to the data element Contracted care completion date vers 1		
	relates to the data element Contracted hospital care vers 1		
	relates to the data element Establishment identifier vers 4		
	relates to the data element Total contract patient days vers 1		

Administrative Attributes

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

Contract procedure flag

Identifying and Definitional Attributes Knowledgebase ID: Version No: 1 000417 Metadata type: Data Element Admin. status: Current 01/07/00 **Definition:** Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service. Context: Admitted patient care. Relational and Representational Attributes Datatype: Alphanumeric Representational form: Code Representational layout: Ν Minimum size: 1 Maximum size: 1 Data domain: 1 Contracted admitted procedure 2 Contracted non-admitted procedure Otherwise blank Procedures performed at another hospital under contract (Hospital B) are Guide for use: recorded by both hospitals, but flagged by the contracting hospital only (Hospital A). This flag is to be used by the contracting hospital to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service. Allocation of procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract. Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate. Some jurisdictions may require these to be separately identified and they could be distinguished from contracted hospital procedures through the use of an additional code in the contract procedure flag data item. Verification rules: Collection methods: **Related metadata:** relates to the data element Contract establishment identifier vers 1 relates to the data element Contract role vers 1 relates to the data element Contract type vers 1 relates to the data element Contracted care commencement date vers 1 relates to the data element Contracted care completion date vers 1 relates to the data element Contracted hospital care vers 1 relates to the data element Total contract patient days vers 1

End date

Start date

Administrative Attributes Source document: Source organisation: Information model link: NHIM Request for/entry into service event Data Set Specifications:

Comments:

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Contract role

Identifying and Defir	nitional Attributes	
Knowledgebase ID:	000418 V	ersion No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/00	
Definition:		al is the purchaser of hospital care (contracting n admitted or non-admitted service (contracted
Context:	Admitted patient care and pu	ıblic hospital establishments.
Relational and Repr	esentational Attribute	2S
Datatype:	Alphabetic	
Representational form:	Code	
Representational layout:	А	
Minimum size:	1	
Maximum size:	1	
Data domain:	A Hospital A	
	B Hospital B	
Guide for use:	Hospital A is the contracting	hospital (purchaser).
	Hospital B is the contracted h	lospital (provider).
Verification rules:		
Collection methods:		
Related metadata:	relates to the data element Co	ontract establishment identifier vers 1
	relates to the data element Co	ontract procedure flag vers 1
	relates to the data element Co	ontract type vers 1
	relates to the data element Co	ontracted care commencement date vers 1
	relates to the data element Co	ontracted care completion date vers 1
	relates to the data element Co	ontracted hospital care vers 1
	relates to the data element To	otal contract patient days vers 1
Administrative Attrib	utes	
Source document:		
Source accument.		

Source notament.		
Source organisation:		
Information model link:		
NHIM Organisation role		
Data Set Specifications:	Start date	End date

Contract type

Identifying and Defi	onal Attributes			
Knowledgebase ID:	00419 Version No: 1			
Metadata type:	ata Element			
Admin. status:	urrent			
	01/07/00			
Definition:	Contract type describes the contract arrangement between the contractor and the contracted hospital. Contract types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.			
Context:	dmitted patient care and public hospital establishmer	its.		
Relational and Repr	entational Attributes			
Datatype:	lumeric			
Representational form:	ode			
Representational layout:	1			
Minimum size:				
Maximum size:				
Data domain:	Contract type B			
	Contract type ABA			
	Contract type AB			
	Contract type (A)B			
	Contract type BA			
Guide for use:	he contracting hospital (purchaser) is termed Hospital	l A.		
	he contracted hospital (provider) is termed Hospital B	b .		
	Contract type B:			
	health authority/other external purchaser contracts hervice which is funded outside the standard funding a	-		
	Contract type ABA:			
	atient admitted by Hospital A.			
	lospital A contracts Hospital B for admitted or non-ad	mitted patient service.		
	atient returns to Hospital A on completion of service b	oy Hospital B.		
	or example, a patient has a hip replacement at Hospita ftercare at Hospital B, under contract to Hospital A. Co he patient returns to Hospital A for the remainder of ca	omplications arise and		
	Contract type AB:			
	atient admitted by Hospital A.			
	lospital A contracts Hospital B for admitted or non-ad	mitted patient service.		
	atient does not return to Hospital A on completion of	service by Hospital B.		
	or example, a patient has a hip replacement at Hospita ftercare at Hospital B, under contract to Hospital A. Pa lospital B.			

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	4 Contract type (A)B:
	This Contract type occurs where a Hospital A contracts Hospital B for the whole episode of care. The patient does not attend Hospital A. For example, a patient is admitted for endoscopy at Hospital B under contract to Hospital A.
	5 Contract type BA:
	Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care.
	For example, a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after-care.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Contract establishment identifier vers 1
	relates to the data element Contract procedure flag vers 1
	relates to the data element Contract role vers 1
	relates to the data element Contracted care commencement date vers 1
	relates to the data element Contracted care completion date vers 1
	relates to the data element Contracted hospital care vers 1
	relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Organisation role Data Set Specifications:

Start date End date

Contracted care commencement date

Identifying and Definitional Attributes				
Knowledgebase ID:	000420 Version	1 No: 1		
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/00			
Definition:	The date the period of contracted	are commenced.		
Context:	Admitted patient care.			
Relational and Repr	esentational Attributes			
Datatype:	Numeric			
Representational form:	Date			
Representational layout:	DDMMYYYY			
Minimum size:	8			
Maximum size:	8			
Data domain:	Valid date			
Guide for use:		cting hospital to record the commencement and will be the admission date for the		
Verification rules:				
Collection methods:				
Related metadata:	relates to the data element Contract	establishment identifier vers 1		
	relates to the data element Contract	procedure flag vers 1		
	relates to the data element Contract	role vers 1		
	relates to the data element Contract	type vers 1		
	relates to the data element Contracte	ed care completion date vers 1		
	relates to the data element Contracte	ed hospital care vers 1		
	relates to the data element Total con	tract patient days vers 1		
Administrative Attrib	utes			

ntify in ا ما م Attribut

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Request for/entry into service event Data Set Specifications:

Start date End date

Contracted care completion date

Identifying and Definitional Attributes

Knowledgebase ID:	000428 V	ersion No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	The date the period of contra	cted care is completed.
,	1	1
Context:	Admitted patient care.	
Relational and Repr	esentational Attribute	es
Datatype:	Numeric	
Representational form:	Date	
Representational layout:	DDMMYYYY	
Minimum size:	8	
Maximum size:	8	
Data domain:	Valid date	
Guide for use:	This item is to be used by the	contracting hospital to record the date of
		hospital care and will be the separation date for
	-	
Verification rules:		
Collection methods:		
Related metadata:		ontract establishment identifier vers 1
	relates to the data element Co	
	relates to the data element Co	
	relates to the data element Co	
		ontracted care commencement date vers 1
	relates to the data element Co	_
	relates to the data element To	otal contract patient days vers 1

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Exit/leave from service event Data Set Specifications:

Start date End date

Contracted hospital care

Identifying and Definitional Attributes

Knowledgebase ID:	000337	Version No: 1	
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/00		
Definition:	purchaser of hospital care	s provided to a patient under an agreement between a (contracting hospital or external purchaser) and a r non-admitted service (contracted hospital).	
Context:	Admitted patient care.		
Relational and Repr	esentational Attrib	utes	
Datatype:			
Representational form:			
Representational layout:			
Minimum size:			
Maximum size:			
Data domain:			
Guide for use:	services are provided whi hospital's total services. It data items where all of the	al care data items should only be completed where ch represent some, but not all of the contracted is not necessary to complete contracted hospital care e hospital services are contracted by a health wned and/or operated public hospitals.	
	Contracted hospital care must involve all of the following:		
	-	can be a public or private hospital, or a health ent or region) or another external purchaser	
	 a contracted hospit procedure centre 	al, which can be a public or private hospital or day	
	thus, services prov episode of care, wh	ng the contracted hospital for the contracted service; ided to a patient in a separate facility during their here the patient is directly responsible for payment of rice, are not considered contracted services for	
	 the patient being p provision of the con 	hysically present in the contracted hospital for the ntracted service.	
		investigations performed at another location on contracting hospital would not be considered porting purposes.	
	contract status of an episo applied when coding all e	Id procedure codes should not be affected by the de: the Australian Coding Standards should be pisodes. In particular, procedures which would not d not be coded solely because they were performed at ntract.	
		a health care service (ie not a recognised hospital) priate but are not considered to be contracted hospital	
	reflect the total treatment	sodes involving contracted hospital care, should provided (all patient days and procedures), even nt was provided under contract by another hospital.	

Verification rules: Collection methods: Related metadata:

relates to the data element Contract establishment identifier vers 1 relates to the data element Contract procedure flag vers 1 relates to the data element Contract role vers 1 relates to the data element Contract type vers 1 relates to the data element Contracted care commencement date vers 1 relates to the data element Contracted care completion date vers 1 relates to the data element Inter-hospital same-day contracted patient vers 2 relates to the data element Total contract patient days vers 1

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Service provision event Data Set Specifications:

Start date End date

Coronary artery disease – history of intervention or procedure

Identifying and Defin	nitional Attributes		
Knowledgebase ID:	000813 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent.		
Context:	Public health, health care and clinical settings.		
Relational and Repr	esentational Attributes		
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 CABG, angioplasty or stent – undertaken in last 12 months		
	2 CABG, angioplasty or stent – undertaken prior to the last 12 months		
	3 CABG, angioplasty or stent – both within and prior to the last 12 months		
	4 No CABG, angioplasty or stent undertaken		
	9 Not stated/inadequately described		
Guide for use:			
Verification rules:			
Collection methods:	Ask the individual if he/she has had a CABG, angioplasty or coronary stent. If		
	so, determine when it was undertaken within or prior to the last 12 months or both.		
Related metadata:	relates to the data element Blood pressure – diastolic measured vers 1		
	relates to the data element Blood pressure – systolic measured vers 1		
	relates to the data element Cerebral stroke due to vascular disease – history vers 1		
	relates to the data element Hypertension - treatment vers 1		
	relates to the data element Myocardial infarction – history vers 1		
Administrative Attrib	utes		
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
Source organisation:	National Diabetes Data Working Group		

Comments:

Information model link:		
NHIM Physical wellbeing		
Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	

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

Angioplasty is an elective surgery technique of blood vessels reconstruction.

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

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

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

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

Country of birth

Knowledgebase ID:	000035	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	The country in which the	person was born.
Context:	population sub-groups. C consistently reported of p the Census of Population (ABS) statistical collectior be used in conjunction wi Australia, etc., to derive n different population sub-	tant in the study of access to services by different country of birth is the most easily collected and possible data items. The item provides a link between and Housing, other Australian Bureau of Statistics' as and regional data collections. Country of birth may th other data elements such as Period of residence in nore sophisticated measures of access to services by groups and may help in identifying population at increased risk of cardiovascular disease.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNNN
Minimum size:	4
Maximum size:	4
Data domain:	Standard Australian Classification of Countries (SACC) 4-digit (individual country) level. ABS catalogue no. 1269.0 (1998).
Guide for use:	A country, even if it comprises other discrete political entities such as 'states', is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.
Verification rules:	DSS – Health care client identification: Country of birth for newborn babies should be 'Australia'.
Collection methods:	, <u> </u>
Related metadata:	supersedes previous data element Country of birth vers 2

Administrative Attributes

Source document:		ABS Catalogue No. 1269.0 (1998)	
Source organisation:		Australian Bureau of Statistics	
Information model link:			
NHIM Demographic characteristic			

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

Comments:

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

Creatinine serum – measured

Identifying and Definitional Attributes

Knowledgebase ID:	000655	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	A person's measured serv	ım creatinine.	
Context:	Clinical settings and popu	ulation survey:	
	by itself is an insensitive r	neasure of rena	ermine renal function. Serum creatinine Il function because it does not reliably ore than 50% of renal function has been

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNN
Minimum size:	2
Maximum size:	4
Data domain:	Measured in µmol/L (micromoles per litre)
Guide for use:	Record the absolute result of the most recent serum creatinine measurement.
	Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.
	Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/function. The calculation uses the Cockcroft-Gault formula.
	DSS – Diabetes (clinical):
	Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest μ mol/L (micromoles per litre)
Verification rules:	
Collection methods:	Measurement of creatinine should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.
	• Single venous blood test taken at the time of other screening blood tests.
	Fasting not required.
Related metadata:	is used in conjunction with Date of birth vers 4
Кениен тенинин.	relates to the data element Diabetes status vers 1
	is used in conjunction with Renal disease – end stage, diabetes complication vers 1
	is used in conjunction with Service contact date vers 1
	is used in conjunction with Sex vers 3
	is used in conjunction with Weight – measured vers 2

Administrative Attributes

Source document:	Caring for Australians with Renal Impairment (CARI) Guidelines. Australian Kidney Foundation			
Source organisation:	CV-Data Working Group			
National Diabetes Data Working Group				
Information model link:				
NHIM Service provision ev	ent			
Data Set Specifications:		Start date	End date	
DSS – Cardiovascular disease	(clinical)	01/01/2003		
DSS – Diabetes (clinical)		01/01/2003		
Comments:	In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the service contact date should be recorded.			
	There is no agreed standard as to which units serum creatinine should be recorded in.			
	In combination with age, sex and body weight, it could be used for a more accurate assessment of renal function.			
	Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function.			
	GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal function in the elderly tends to be overestimated, and GFR should be used to assess renal function, according to the Cockcroft-Gault formula:			
	$GFR (ml/min) = \frac{(140 - age [yrs])}{814 \text{ x serum cr}}$	$\frac{(1) \times body \text{ wt } (kg)}{(mmol/l)} \begin{bmatrix} x \ 0.8 \end{bmatrix}$	35 (for women)	
	To determine chronic renal impairment			
	GFR > 90 ml/min: normal			
	GFR > 60 - 90 ml/min: mild renal impairment			
	GFR > 30 - 60 ml/min: moderate renal impairment			
	GFR 0 – 30 ml/min: severe renal i	mpairment		
	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 re- residual renal function may declin (> 1 g/24 hours), significant come to a nephrologist well before func Guidelines 2002. Australian Kidne	ne rapidly (ie. hypertensive, orbid illness) should be consi ction declines to less than 30	proteinuric idered for referral ml/min. (CARI	

Crude rate

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

Relational and Representational Attributes

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

Data domain:	
Guide for use:	Formula:
	R = d/n
	Where:
	R is the crude rate for the population being studied
	d is the number of events for that population group
	n is the total population for that population group
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Age-standardised rate vers 1

Administrative Attributes

Source document:	Textbooks of epidemiology, demography and biostatistics. The presentation of formulae in this data element is based on the notation used in Armitage P & Berry G 1994. Statistical Methods in Medical Research. Oxford: Blackwell Scientific Publications.		
Source organisation:	Australian Institute of Health and Welfare		
Information model link:			
NHIM Program evaluation			
Data Set Specifications:		Start date	End date

Comments:

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

CVD drug therapy – condition

Identifying and Definitional Attributes

Knowledgebase ID:	000664	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:) for which drug therapy is being used for the treatment of cardiovascular disease.
Context:	Public health, health care	and clinical settings:
		categorisation of drug management regimens used in ng-term care of patients with or at increased risk of

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	NN		
Minimum size:	2		
Maximum size:	2		
Data domain:	01	Heart failure	
	02	Ischaemic heart disease	
	03	Hypertension	
	04	Atrial fibrillation (AF)	
	05	Other dysrhythmia or conductive disorder	
	06	Dyslipidaemia	
	07	Peripheral vascular disease (PVD)	
	08	Renal vascular disease	
	09	Stroke	
	10	Transient ischaemic attack (TIA)	
	97	Other	
	98	No CVD drugs prescribed	
	99	Not recorded	
Guide for use:	More	e than one code can be recorded.	
,	Aust	categorisations may be made using the most recent version of the ralian Modification of the appropriate International Classification of ases codes.	
Verification rules:			
Collection methods:			
Related metadata:	is us	ed in conjunction with Service contact date vers 1	
	relates to the data element Vascular history vers 1		
		, ,	

Administrative Attributes

Source document:	The reference document for CVD drug therapy is the Australian Medicines Handbook, 2000.		
Source organisation:	CV-Data Working Group		
Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:		Start date	End date
DSS – Cardiovascular disease	(clinical)	01/01/2003	
-			

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

Date of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000036	Version No: 4
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	The date of birth of the pe	erson.
Context:	Required to derive age at a point of time for clinical or administrative use.	
	National Minimum Data	Sets:
	Used for demographic an diagnosis related group (a	alyses, for analysis by age and for use to derive a admitted patients).
	NMDS - Perinatal:	
	Requires the collection of	the date of birth for the mother and the baby(s).

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	If date of birth is not known, provision should be made to collect age (in years) and a date of birth derived from age.
Verification rules:	This field must not be null.
	National Minimum Data Sets:
	For the provision of State and Territory hospital data to Commonwealth agencies this field must:
	 be less than or equal to Admission date, Date patient presents or Service contact date
	 be consistent with diagnoses and procedure codes, for records to be grouped.
Collection methods:	It is recommended that in cases where all components of the date of birth are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.
	NMDS – Perinatal:
	Data collection systems must be able to differentiate between the date of birth of the mother and the baby(s). This is important in the Perinatal data collection as the date of birth of the baby is used to determine the antenatal length of stay and the postnatal length of stay.
Related metadata:	supersedes previous data element Date of birth vers 3
	is used in the derivation of Diagnosis related group vers 1
	is qualified by Estimated date flag vers 1
	is used in the calculation of Length of stay (antenatal) vers 1

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

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Demograph	ic characteristic		
Data Set Specifications:		Start date	End date
NMDS - Admitted patient ca	are	01/07/2003	
NMDS - Admitted patient m	ental health care	01/07/2003	
NMDS - Admitted patient palliative care		01/07/2003	
NMDS - Alcohol and other drug treatment services		01/07/2003	
NMDS - Community mental health care		01/07/2003	
NMDS - Health labour force		01/07/2003	
NMDS - Non-admitted patient emergency department care		01/07/2003	
NMDS – Perinatal		01/07/2003	
DSS - Cardiovascular disease (clinical)		01/01/2003	
DSS – Diabetes (clinical)		01/01/2003	
DSS - Health care client iden	tification	01/01/2003	
DSS – Cardiovascular disease (clinical)		01/01/2003 01/01/2003	

Comments:

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

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

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

DSS - Cardiovascular disease (clinical):

Age is an important non-modifiable risk factor for cardiovascular conditions. The prevalence of cardiovascular conditions increases dramatically with age. For example, more than 60% of people aged 75 and over had a cardiovascular condition in 1995 compared with less than 9% of those aged under 35. Aboriginal and Torres Strait Islander peoples are more likely to have cardiovascular conditions than other Australians across almost all age groups. For example, in the 25–44 age group, 23% of Indigenous Australians reported cardiovascular conditions compared with 16% among other Australians (Heart, Stroke and Vascular Diseases: Australian Facts 2001. AIHW).

DSS - Diabetes (clinical):

Age over 45 is one of the predisposing factors for developing Type 2 diabetes and age over 35 in individuals of Aboriginal and Torres Strait Islander and certain other ethnic origins. The prevalence of diabetes increases with age, approaching 25% among those over 75.

References:

National Institute of Aging U.S. Department of Health and Human Services

NHMRC Evidence Based Guidelines for Case Detection and Diagnosis of Type 2 Diabetes

Date of cessation of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID:	000424	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	Date on which a treatmen	t episode for al	cohol and other drugs ceases.
Context:	Alcohol and other drug tr	eatment service	28:
	Required to identify the co other drug treatment serv		eatment episode by an alcohol and

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used. Refer to data element concept Cessation of treatment episode for alcohol and other drugs to determine when a treatment episode ceases.
Verification rules:	Must be later than or the same as the Date of commencement of treatment for alcohol and other drugs.
Collection methods:	
Related metadata:	relates to the data element concept Cessation of treatment episode for alcohol and other drugs vers 2
	supersedes previous data element Date of cessation of treatment vers 1
	relates to the data element Reason for cessation of treatment episode for alcohol and other drugs vers 2

Administrative Attributes

Source document:			
Source organisation:	Intergovernmental Committee on Drugs N	IMDS – WG	
Information model link:			
NHIM Exit/leave from service event			
Data Set Specifications:		Start date	End date
NMDS - Alcohol and other d	rug treatment services	01/07/2001	

Date of change to qualification status

Identifying and Defir	nitional Attributes		
Knowledgebase ID:	000342	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
Definition:		1	rre, on which the newborn's qualified) to unqualified or vice versa.
Context:			
Relational and Repr	esentational Attrib	utes	
Datatype:	Numeric		
Representational form:	Date		
Representational layout:	DDMMYYYY		
Minimum size:	8		
Maximum size:	8		
Data domain:	Valid date		
Guide for use:	Record the date or dates c from acute (qualified) to u		wborn's Qualification status changes ice versa.
	If more than one change c counted against the final o	-	status occurs on a single day, the day is itus.
Verification rules:	Must be greater than or ea	qual to admission	on date
Collection methods:			
Related metadata:	is used in conjunction wit	h Admitted pat	ient vers 3
	is used in the calculation of	of Number of q	ualified days for newborns vers 2
	is used in conjunction wit	h Newborn qua	alification status vers 2

Identifying and Definitional Attributes

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Service provision event Data Set Specifications: Start date End date

is used in conjunction with Care type vers 4

Date of commencement of service event

Identifying and Define	hitional Attributes	
Knowledgebase ID:	000356 Version No: 2	
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	The day on which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client's care.	5
Context:	Hospital non-admitted patient care and public health care.	
Relational and Repr	esentational Attributes	
Datatype:	Numeric	
Representational form:	Date	
Representational layout:	DDMMYYYY	
Minimum size:	8	
Maximum size:	8	
Data domain:	Valid dates	
Guide for use:	For the emergency departments the date of triage is recorded separately. In an emergency department the service event commences when the medical officer (or, if no medical officer is on duty in the emergency department, a treating nurse) provides treatment or diagnostic service. The commencement of a service event does not include contact associated with triage.	
Verification rules:		
Collection methods:		
Related metadata:	supersedes previous data element Date of service event vers 1	
	relates to the data element Date of triage vers 1	
	relates to the data element Date patient presents vers 2	
	relates to the data element Emergency department waiting time to admission vers 1	
	relates to the data element Emergency department waiting time to service delivery vers 2	
	relates to the data element concept Patient presentation at emergency department vers 1	
	relates to the data element Time of commencement of service event vers 2	
	relates to the data element Time of triage vers 1	
	relates to the data element Time patient presents vers 2	
A		

Identifying and Definitional Attributes

Administrative Attributes

Source document:	
Source organisation:	National Institution Based Ambulatory Model Reference Group National Health Data Committee

Information model link:			
Start date	End date		
01/07/2001			

Comments:

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

Date of commencement of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID:	000430	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	Date on which a treatm	ent episode for alcohol and other drugs commences.
Context:	Alcohol and other drug	treatment services:
	Required to identify the and other drug treatme	e commencement of a treatment episode by an alcohol nt service.

Relational and Representational Attributes

Numeric
Date
DDMMYYYY
8
8

Data domain:	Valid dates	
Guide for use:	The first date of the treatment episode is the first service contact within the treatment episode when assessment and/or treatment occurs.	
Verification rules:	Must be earlier than or the same as the Date of cessation of treatment episode for alcohol and other drugs.	
Collection methods:		
Related metadata:	relates to the data element concept Commencement of treatment episode for alcohol and other drugs vers 2	
	supersedes previous data element Date of commencement of treatment vers 1	

Administrative Attributes

Source document:			
Source organisation:	Intergovernmental Committee on Drugs NM	DS WG	
Information model link:			
NHIM Request for/entry into service event			
Data Set Specifications:		Start date	End date
NMDS - Alcohol and other drug treatment services		01/07/2001	

Date of completion of last previous pregnancy

Identifying and Definitional Attributes				
Knowledgebase ID:	000037 Version No: 1			
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/96			
Definition:	Date on which the pregnancy preceding the current pregnancy was completed.			
Context:	Perinatal statistics:			
	Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low birthweight.			
Relational and Repr	esentational Attributes			
Datatype:	Numeric			
Representational form:	Date			
Representational layout:	DDMMYYYY			
Minimum size:	8			
Maximum size:	8			
Data domain:	Valid date			
Guide for use:	Estimate day of month (DD), if first day is unknown.			
Verification rules:				
Collection methods:				
Related metadata:	is qualified by Outcome of last previous pregnancy vers 1			
	is a qualifier of Previous pregnancies vers 1			
Administrative Attrib	utes			
Source document:				
Source organisation:	National Perinatal Data Development Committee			
Information model link:	1			
NHIM Physical wellbeing				
Data Set Specifications:	Start date End date			
Comments:	This data item is recommended by the World Health Organization. It is currently collected in some States and Territories.			

Date of diagnosis

Identifying and Definitional Attributes

Knowledgebase ID:	000666	Version No: 1	
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The date a disease or condition is diagnosed.		
Context:	Health services and clinical setting:		
	0 1	ovides the basis for analysis of health service usage, nd monitoring of specific disease entities and	

Relational and Representational Attributes

Valid date

Numeric
Date
DDMMYYYY
8
8

D (1 .	
Data	domain:	

Guide for use: Verification rules: Collection methods: Related metadata:

relates to the data element Diabetes status vers 1
relates to the data element concept Diagnosis vers 1
is used in conjunction with Service contact date vers 1
relates to the data element Vascular history vers 1
relates to the data element Vascular procedures vers 1

Administrative Attributes

Source document:				
Source organisation:	CV-Data Working Group			
Information model link:				
NHIM Service provision event				
Data Set Specifications:		Start date	End date	
DSS – Cardiovascular disease (clinical)		01/01/2003		

Comments:

Classification systems, which enable the allocation of a code to the diagnostic information, can be used in conjunction with this data element.

Date of diagnosis of cancer

Identifying and Definitional Attributes

Knowledgebace ID:	000771 Version No: 1		
Knowledgebase ID: Metadata tuma	Data Element		
Metadata type: Admin. status:			
Aumin. status:	Current		
Definition:	01/07/02 The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).		
Context:	Patient administration systems, cancer notification systems, population cancer statistics, research.		
Relational and Repr	esentational Attributes		
Datatype:	Numeric		
Representational form:	Date		
Representational layout:	DDMMYYYY		
Minimum size:	8		
Maximum size:	8		
Data domain:	Valid date		
Guide for use:	Date of diagnosis must be:		
	>= Date of birth		
	<= Date of death		
	Diagnosis of cancer after death:		
	If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate.		
	Incidental diagnosis of cancer:		
	If a patient is admitted for another condition (e.g. a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.		
Verification rules:			
Collection methods:	Reporting rules:		
	The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:		
	Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.		
	Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.		
	Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).		

	If components of the date are not known, an e where possible with an estimated date flag to estimated date is not possible, a standard date with a flag to indicate the date is not known.	indicate that it is e	estimated. If an
Related metadata:	relates to the data element Date of birth vers 4		
	relates to the data element Estimated date flag vers 1		
Administrative Attrib	utes		
Source document:	Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001		
Source organisation:	International Agency for Research on Cancer		
-	World Health Organization		
	International Association of Cancer Registries	3.	
Information model link:			
NHIM Request for/entry in	to service event		
Data Set Specifications:		Start date	End date

Date of first contact

Version No: 2 Knowledgebase ID: 000039 Metadata type: Data Element Admin. status: Current 01/07/98 Definition: The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family. The definition includes: - visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care. This applies irrespective of whether the person is present or not. The definition excludes: first visits where the visit objective is not met, such as first visit made where no one is home. Context: To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This data element enables the capture of the commencement of care irrespective of the setting in which the activities took place. Relational and Representational Attributes Datatype: Numeric Representational form: Date Representational layout: DDMMYYYY Minimum size: 8 Maximum size: 8 Valid date Data domain: Guide for use: Verification rules: This should occur after a previous Date of last contact of a previous care episode and prior to or on the same as Date of first delivery of service. Collection methods: The Date of first contact can be the same as Date of first delivery of service and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date. **Related metadata:** supersedes previous data element Date of first contact with the community

Identifying and Definitional Attributes

relates to the data element Date of last contact vers 2

nursing service vers 1

Administrative Attributes

Source document:			
Source organisation:	Australian Council of Community Nursing Services		
Information model link:			
NHIM Request for/entry in	nto service event		
Data Set Specifications:	Start d	date	End date
Comments:	This item is recommended for use in community servi liaison or discharge planning positions or provide spe		

expenditure across the sector.

assessment services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource

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Date of first delivery of service

Identifying and Definitional Attributes Version No: 2 Knowledgebase ID: 000038 Metadata type: Data Element Admin. status: Current 01/07/98 Definition: The date of first delivery of service to a person in a non-institutional setting. The definition excludes: visit made to persons in institutional settings such as liaison visits or _ discharge planning visits, made in a hospital or residential aged care service, with the intent of planning for the future delivery of community-based services first visits where there is no contact with the person, such as a first visit where no-one is at home telephone, letter or other such contacts made with the person prior to the first home visit. In situations where the first delivery of service determines that no future visit needs to be made, the Date of first delivery of service and the Date of last delivery of service will be the same. Context: The Date of first delivery of service is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates
Guide for use:	
Verification rules:	This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Date of first contact.
Collection methods:	As long as contact is made with the person in a non-institutional setting, the Date of first delivery of service must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.
Related metadata:	supersedes previous data element Date of first community nursing visit vers 1

Administrative Attributes

Source document:	
Source organisation:	Australian Council of Community Nursing Services

Information model link: NHIM Request for/entry into service event *Data Set Specifications:*

Comments:

This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing hospital-in-the-home services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

Start date

End date

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Date of last contact

Version No: 2 Knowledgebase ID: 000040 Metadata type: Data Element Admin. status: Current 01/07/98 Date of the last contact between a staff member of the community service and a Definition: person in any setting. The definition includes: - visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode; bereavement visits in any setting; visits made to the person's home to complete the service, including the collection of equipment. The definition excludes: visits made by liaison/discharge planning staff of a community service _ for the purpose of assessment of need related to a subsequent episode of care. Context: To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service. **Relational and Representational Attributes** Numeric Datatype: Representational form: Date **Representational layout:** DDMMYYYY Minimum size: 8 8 Maximum size:

Identifying and Definitional Attributes

Data domain:	Valid dates
Guide for use:	This could be the same as the date of discharge.
Verification rules:	May occur after or on the same day as Date of last delivery of service
Collection methods:	
Related metadata:	relates to the data element Date of first contact vers 2
	supersedes previous data element Date of last community service contact with client/family vers 1

Administrative Attributes

Source document:

Information model link:NHIMExit/leave from service eventData Set Specifications:

Comments:

If service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.

Start date End date

Date of procedure

Identifying and Defi	nitional Attributes
Knowledgebase ID:	000772 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/07/02
Definition:	The date on which a procedure commenced during an inpatient episode of care.
Context:	Admitted patient care:
	Required to provide information on the timing of the procedure in relation to the episode of care
Relational and Repr	resentational Attributes
Datatype:	Numeric
Representational form:	
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Data aomain:	valid date
Guide for use:	Admitted patients:
	Record date of procedure for all procedures undertaken during an episode of care in accordance with ICD-10-AM 3rd edition.
Verification rules:	
Collection methods:	Right justified and zero filled (e.g. 1 May 2001 should read 01052001)
Concernon methous.	Date of procedure >= admission date
	Date of procedure <= separation date
Related metadata:	relates to the data element Procedure vers 5
Administrative Attrib	nutes
Source document:	
	National Contro for Classification in Health
Source organisation:	National Centre for Classification in Health
Information model link:	ront
NHIM Service provision ev	Start date End date
Data Set Specifications:	Start unte Enu unte
Comments:	The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM
	Reference: Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998–1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Date of referral to rehabilitation

Identifying and Definitional Attributes

Knowledgebase ID:	000656	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The date on which a perso	on is referred to a rehabilitation service.
Context:	Clinical settings.	
Relational and Repr	esentational Attrib	utes
Datatype:	Numeric	
Representational form:	Date	
Representational layout:	DDMMYYYY	
Minimum size:	8	
Maximum size:	8	
Data domain:	Valid date	
Guide for use:		nown then provision should be made to collect month using 01 as DD if only the month and year are known.
Verification rules:		
Collection methods:	To be collected at the time	e of commencement of rehabilitation.
Related metadata:	relates to the data elemen	t Date of diagnosis vers 1
	relates to the data elemen	t Vascular history vers 1
	relates to the data elemen	t Vascular procedures vers 1
Administrative Attrib	utes	

Administrative Attributes

Source document:				
Source organisation:	CV-Data Working Group			
Information model link:				
NHIM Service provision event				
Data Set Specifications:		:	Start date	End date
DSS - Cardiovascular disease	e (clinical)	(01/01/2003	

Comments:

Required to derive those referred to a rehabilitation service from those eligible to attend and who actually attend. This data element can be used to determine the time lag between referral and commencement of rehabilitation.

Date of triage

Identifying and Defin	nitional Attributes		
Knowledgebase ID:	000353	Version No: 1	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
Definition:	The day on which the pa	tient is triaged.	
Context:	Admitted patient care:		
	Required to identify the waiting times.	commencement of the service a	nd calculation of
Relational and Repr	esentational Attrib	outes	
Datatype:	Numeric		
Representational form:	Date		
Representational layout:	DDMMYYYY		
Minimum size:	8		
Maximum size:	8		
Data domain:	Valid date		
Guide for use:			
Verification rules:			
Collection methods:			
Related metadata:	relates to the data elemen delivery vers 2	nt Emergency department waiti	ng time to service
	relates to the data elemen department vers 1	nt concept Patient presentation a	at emergency
	relates to the data element	nt Time of triage vers 1	
Administrative Attrib	outes		
Source document:			
Source organisation:	National Institution Base National Health Data Co	d Ambulatory Model Reference mmittee	e Group
Information model link:			
NHIM Assessment event			
Data Set Specifications:		Start dat	te End date
NMDS – Emergency departm	nent waiting times	01/07/19	199
Comments:	This data element suppo	rts the provision of unit record a	and/or summary lev

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

Date patient presents

Identifying and Definitional Attributes

Knowledgebase ID:	000350	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	The day on which the pat	ient/client presents for the delivery of a service.
Context:	Admitted patient care.	
	Community health care.	
	Hospital non-admitted pa	tient care:
	Required to identify comp times.	nencement of a visit and for calculation of waiting

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	For community health care, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences.
	The time of patient presentation at the emergency department is the earliest occasion of being registered clerically or triaged.
	The date that the patient presents is not necessarily:
	 the listing date for care (see Listing date for care data element concept), nor
	- the date on which care is scheduled to be provided, nor
	 the date on which commencement of care actually occurs (for admitted patients see Admission date, for hospital non-admitted patient care and community health care see Date of commencement of service event).
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Admission date vers 4
	relates to the data element Date of commencement of service event vers 2
	relates to the data element Date of triage vers 1
	supersedes previous data element Date patient presents vers 1
	relates to the data element Emergency department waiting time to admission vers 1
	relates to the data element Emergency department waiting time to service delivery vers 2

relates to the data element concept Patient presentation at emergency department vers 2
relates to the data element Time of commencement of service event vers 2
relates to the data element Time of triage vers 1
relates to the data element Time patient presents vers 2
relates to the data element Triage category vers 2
relates to the data element Type of visit to emergency department vers 2

Administrative Attributes

Source document:

Source organisation:	National Institution Based Ambulatory Model Reference Group	
	National Health Data Committee	
Information model link:		
IHIM Request for/entry into service event		

Data Set Specifications:	Start date	End date
NMDS - Emergency department waiting times	01/07/2001	
NMDS - Non-admitted patient emergency department care	01/07/2003	

Comments:This data element is required to identify commencement of a visit and for
calculation of waiting times. It supports the provision of unit record and/or
summary level data by State and Territory health authorities as part of the
NMDS – Emergency department waiting times.

Day program attendances

Identifying and Definitional Attributes Knowledgebase ID: 000211 Version No: 1 Derived Data Element Metadata type: Admin. status: Current 01/07/89 A count of the number of patient/client visits to day centres. Each individual is Definition: to be counted once for each time they attend a day centre. Where an individual is referred to another section of the hospital/centre and returns to the day centre after treatment only one visit is to be recorded. Context: Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals. Relational and Representational Attributes Datatype: Numeric Quantitative value Representational form: Representational layout: NNNNN Minimum size: 1 5 Maximum size: Data domain: Number of attendances Guide for use: Verification rules: Collection methods: **Related metadata:** Administrative Attributes Source document: Source organisation: National minimum data set working parties Information model link:

NHIM Service provision event Data Set Specifications:

End date Start date

Comments:

Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Department of Veterans' Affairs file number

Identifying and Defir	nitional Attributes
Knowledgebase ID:	000204 Version No: 2
Metadata type:	Data Element
Admin. status:	Current
	01/07/02
Definition:	A unique number issued to a veteran by the Department of Veterans' Affairs.
Context:	This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.
Relational and Repr	esentational Attributes
Datatype:	Alphanumeric
Representational form:	Identification number
Representational layout:	AAANNNNA
Minimum size:	9
Maximum size:	9
Data domain:	Valid identification number
Guide for use:	All veterans and veteran community clients are issued with a DVA File Number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA File Number.
	The DVA File Number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to the appropriate government agency to reconcile payment for the service provided.
	1st character is the State Code (an alpha) – N, V, Q, W, S or T for the appropriate State/Territory. ACT is included in NSW (N) and NT with SA (S).
	Next 7 characters are the File Number, made up of:
	War Code + numeric digits, where:
	if War Code is 1 alpha character, add 6 digits (ANNNNNN)
	if War Code is 2 alpha characters, add 5 digits (AANNNNN)
	if War Code is 3 alpha characters, add 4 digits (AAANNNN)
	9th character is the Segment Link (an alpha) which represent members related to the veteran. The alpha code is generated in the order that cards are issued. For example A, B, C, D etc.
	CAUTIONARY NOTE: For Veterans the 9th character is left blank.
	Note that Veterans may have a Medicare Card Number and a Department of Veterans' Affairs (DVA) Number or only a DVA Number.
	DVA card number:
	This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the Gold and White cards may be used in conjunction with the data element an imprinter. This method records the DVA

Ida ntifui d Dofiniti A ttrik ..

file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA File Number for data linking unless specifically authorised by law.

Verification rules:	
Collection methods:	
Related metadata:	supersedes previous data element Department of Veterans' Affairs file number vers 1
	relates to the data element Department of Veterans' Affairs patient vers 1

Administrative Attributes

Source document:			
Source organisation:	Department of Veterans' Affairs		
Information model link:			
NHIM Recipient role			
Data Set Specifications:		Start date	End date

C anto

Comments:	DVA has three (3) types of health cards:
	- Gold Card
	- White Card
	- Repatriation Pharmaceutical Benefits Card.
	Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.
	The Gold Card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.
	The White Card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post-traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.
	The White Card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.
	A White Card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war-related.
	When a Gold/White Card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare Card Number is not required or relevant.
	It should be noted that there are a number of Gold Card holders who do not have a Medicare Card.
	The Repatriation Pharmaceutical Benefits Card is an orange coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Department of Veterans' Affairs patient

Identifying and Defir	nitior	nal Attributes		
Knowledgebase ID:	0004	21	Version No:	1
Metadata type:	Data	Element		
Admin. status:	Curr	ent		
	01/0	7/00		
Definition:		ligible person whose artment of Veterans' A		s hospital admission are met by the
Context:	Heal	th services:		
	To as	ssist in analyses of ut	ilisation and he	alth care funding.
Relational and Repr	eser	ntational Attrib	utes	
Datatype:	Num	neric		
Representational form:	Code	2		
Representational layout:	Ν			
Minimum size:	1			
Maximum size:	1			
Data domain:	1	Yes		
	2	No		
Guide for use:		r to the <i>Veterans' Enti</i> ficiaries.	tlements Act 198	6 for details of eligible DVA
Verification rules:				
Collection methods:	Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.			
Related metadata:			-	f Veterans' Affairs file number vers 2 t accommodation eligibility status

Identifying and Definitional Attributes

Administrative Attributes

Source document:		
Source organisation:		
Information model link:		
NHIM Insurance/benefit characteristic		
Data Set Specifications:	Start date	End date
NMDS - Non-admitted patient emergency department care	01/07/2003	
NMDS – Admitted patient care	01/07/2000	30/06/2001
		30/06/2001

Comments:Eligible veterans and war widow/widowers can receive free treatment at any
public hospital, former Repatriation Hospitals (RH) or a Veteran Partnering (VP)
contracted private hospital as a private patient in a shared ward, with the doctor
of their choice. Admission to a public hospital does not require prior approval
from the DVA.

When treatment cannot be provided within a reasonable time in the public health system at a former RH or a private VP hospital, there is a system of contracted non-VP private hospitals which will provide care.

Admission to a contracted private hospital requires prior financial authorisation from DVA. Approval may be given to attend a non-contracted private hospital when the service is not available at a public or contracted non-VP private hospital.

In an emergency a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to DVA.

If an eligible veteran or war widow/widower chooses to be treated under Veterans' Affairs arrangements, which includes obtaining prior approval for non-VP private hospital care, DVA will meet the full cost of their treatment.

Dependency in activities of daily living

Knowledgebase ID:	000309	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	An indicator of a per assistance.	son's ability to carry out activities of daily living without
Context:	which addresses tha environment, where care allocated is not of resource allocation vulnerability of syste is against this backg monitored. It is import that of the institution predict or dictate sta	the person's need, rather than the actual service provision t need. This is essential information in the community the relationship between a person's functional status and direct. The involvement of 'informal' carers, the possibility n being driven by availability rather than need, and the ern to inequity, all require a 'standard' view of the person. If cound that resource allocation and carer burden can then be ortant to distinguish between this view of dependency and nal system, where a dependency 'measure' may be used to ffing needs or to allocate funding. The following is an num items, which are indicative of dependency.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	NNN		
Minimum size:	1		
Maximum size:	3		
Data domain:	a) Mobility* 1 2 3 4		
	b) Toileting 1 2 3 4		
	c) Transferring 1 2 3 4 5		
	d) Bathing 1 2 3 4		
	e) Dressing 1 2 3 4		
	f) Eating 1 2 3 4 5		
	g) Bed mobility 1 2 3 4 5		
	h) Bladder continence 1 2 3 4 5 6		
	i) Bowel continence 1 2 3 4 5		
	j) Extra surveillance* 1 2 3 4 5 6 7		
	k) Technical care** not required, or time in minutes		
Guide for use:	Services may elect to adopt the measures as defined in this item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores. All items must be completed. Select the appropriate code from the options provided for activities a) to g)		

when:

1 = Independent

- 2 = Requires observation or rare physical assistance
- 3 = Cannot perform the activity without some assistance
- 4 = Full assistance required (totally dependent); for bed mobility a hoist is used
- 5 = For transferring person is bedfast; for eating tube-fed only; for bed mobility – 2 persons physical assist is required
- * applies to walking, walking aid or wheelchair

Select the appropriate code for h) Bladder continence when:

- 1 = Continent of urine (includes independence in use of device)
- 2 = Incontinent less than daily
- 3 = Incontinent once per 24 hour period
- 4 = Incontinent 2 6 times per 24 hour period
- 5 = Incontinent more than 6 times per 24 hour period

6 = Incontinent more than once at night only

- Select the appropriate code for I) Bowel continence when:
- 1 = Continent of faeces (includes independence in use of device)
- 2 = Incontinent less than daily
- 3 = Incontinent once per 24 hour period
- 4 = Incontinent regularly, more than once per 24 hour period
- 5 = Incontinent more than once at night only

Select the appropriate code for j) Extra surveillance* when:

- 1 = No additional attention required
- 2 = Less than 30 minutes individual attention per day
- 3 = More than 30 and more than or equal to 90 minutes individual attention per day
- 4 = Requires at least two hours intervention per week on an episodic basis
- 5 = More than 90 minutes but less than almost constant individual attention
- 6 = Requires almost constant individual attention
- 7 = Cannot be left alone at all

* Extra surveillance refers to behaviour, which requires individual attention and/or planned intervention. Some examples of extra surveillance are:

- aggressiveness
- wandering
- impaired memory or attention
- disinhibition and other cognitive impairment.

Select the appropriate code for k) Technical care** not required, or time in minutes, when:

1 = No technical care requirements

or

- ____ = Daytime technical (minutes per week)
- ____ = Evening technical (minutes per week)
- _____ = Night-time technical (minutes per week)
- _____ = Infrequent technical (minutes per month)

** Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some

	of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:
	 medication administration (including injections)
	 dressings and other procedures
	– venipuncture
	 monitoring of dialysis
	 implementation of pain management technology.
Verification rules:	
Collection methods:	Commencement of Care episode. (There may be several visits in which assessment data are gathered.)
Related metadata:	supersedes previous data element Client dependency vers 1
Administrative Attrib	utes
Source document:	
Source organisation:	Australian Council of Community Nursing Services
Information model link:	
NHIM Functional wellbeing	
Data Set Specifications:	Start date End date
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The CNMDSA recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use

dependency tool from a limited range of options as outlined in Guide for use. The data domain specified in this item consists of a number of standard elements, which can be used to map to and/or score from the majority of them.

Depreciation

Knowledgebase ID: 000246 Version No: 1 Metadata type: Data Element Admin. status: Current 01/07/89 Definition: Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure. Context: Health expenditure: This item has been retained for national minimum data sets because of its significance for the private sector. Current period depreciation charges form a significant component of expenditure for any health establishment whose financial statements are based on accrual accounting.

Identifying and Definitional Attributes

Relational and Representational Attributes

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

Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recurrent expenditure			
Data Set Specifications:		Start date	End date
NMDS - Public hospital establishments		01/07/1989	

Comments:With the long-term trend towards accrual accounting in the public sector, this
item will ultimately become significant for public sector establishments. Public
sector establishments in some States have adopted modified accrual accounting
identifying depreciation only, before reaching full accrual accounting.
Depreciation is now reported for most public sector establishments and should
be reported as a separate recurrent expenditure.Depreciation should be identified separately from other recurrent expenditure
categories.

Identifying and Definitional Attributes

Knowledgebase ID:	000654	Version No: 1
Metadata type:	Data Elemen	
Admin. status:	Current	
11 <i>umm, 510105</i> .	01/01/03	
Definition:		erson with or at risk of diabetes.
	-	
Context:	Public health	health care and clinical settings.
Relational and Repr	esentatio	al Attributes
Datatype:	Numeric	
Representational form:	Code	
Representational layout:	NN	
Minimum size:	2	
Maximum size:	2	
Data domain:	01 Type	1 diabetes
Data aomain:	<i>7</i> 1	2 diabetes
		tional diabetes mellitus (GDM)
		(secondary diabetes)
		bus gestational diabetes mellitus (GDM)
		red fasting glucose (IFG)
	-	red glucose tolerance (IGT)
	-	iagnosed with diabetes
	09 Not a	ssessed
	99 Not	tated/inadequately described
Guide for use:		ere there is a GDM or Previous GDM (i.e. data domains 3 & 5) and ory of Type 2 diabetes then record 'Code 2' Type 2 diabetes.
	This same principle applies where a history of either IFG (impaired fasting glycaemia) or IGT (impaired glucose tolerance) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.	
	Code 01 Typ	1 diabetes:
	those case beta-cell d aetiology forms of b assigned (Type can l	estruction, usually leading to absolute insulin deficiency. Includes attributed to an autoimmune process, as well as those with estruction and who are prone to ketoacidosis for which neither an or pathogenesis is known (idiopathic). It does not include those ta-cell destruction or failure to which specific causes can be .g. cystic fibrosis, mitochondrial defects). Some subjects with this e identified at earlier clinical stages than 'diabetes mellitus'.
	Code 02 Typ	
		udes the common major form of diabetes, which results from insulin secretion, almost always with a major contribution from stance.
		ational diabetes mellitus (GDM):
		arbohydrate intolerance resulting in hyperglycaemia of variable th 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):

	Code 04 Other (Secondary diabetes):
	This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.
	Code 05 Previous GDM:
	Where the person has a history of GDM.
	Code 06 Impaired fasting glycaemia (IFG):
	IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.
	Code 07 Impaired glucose tolerance (IGT):
	IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.
	Code 08 Not diagnosed with diabetes:
	The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).
	Code 09 Not assessed:
	The subject has not had their diabetes status assessed.
	Code 99 is for unknown or information unavailable.
Verification rules:	
Collection methods:	The diagnosis is derived from and must be substantiated by clinical documentation.
	DSS – Diabetes (clinical):
	A type of diabetes should be recorded and coded for each episode of patient care.
Related metadata:	relates to the data element Date of diagnosis vers 1
	relates to the data element Diabetes therapy type vers 1
	is used in conjunction with Service contact date vers 1
Administrative Attrib	outes
Source document:	Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a WHO Consultation (Alberti & Zimmet 1998).

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

Information model link:

NHIM Physical wellbeing				
Data Set Specifications:		Start date	End date	
DSS - Cardiovascular disease	(clinical)	01/01/2003		
DSS – Diabetes (clinical)		01/01/2003		
Comments:	DSS – Cardiovascular disease (clinical): People with diabetes have two to five times in stroke and vascular disease (Zimmet & Alber the meet common cause of death in people w	ti 1997). Cardiovas		
	the most common cause of death in people was Diabetes is also an important cause of stroke, have a worse prognosis after stroke.		iabetes may	
	Heart, stroke and vascular disease and diabetes share common risk factors, but also diabetes is an independent risk factor for heart, stroke and vascular disease.			
	During the 1995 National Health Survey, about 15 per cent of those with diabetes reported having heart disease, at almost six times the rate noted among people without diabetes. In 1996–97, almost one in six hospital separations, with coronary heart disease as any listed diagnosis, also had diabetes recorded as an associated diagnosis. Heart disease appears earlier in life and is more often fatal among those with diabetes.			
	Diabetes may accentuate the role of elevated blood pressure in stroke. The incidence and prevalence of peripheral vascular disease in those with diabetes increase with the duration of the diabetes.			
	Mortality is increased among patients with peripheral vascular disease and diabetes, in particular if foot ulcerations, infection or gangrene occur. There is limited information on whether the presence of heart, stroke and vascular disease promotes diabetes in some way.			
	High blood pressure, high cholesterol and obdiabetes. As well as all being independent can they are in combination with glucose intoleration other risk factors such as physical inactivity a a greater risk for heart, stroke and vascular di	diovascular risk fa nce (a feature of di nd smoking, these	ctors, when abetes) and	
	Evidence is accumulating that high cholester often occur together, may have a common aet similarities, trends in cardiovascular mortality mortality are moving in opposite directions.	iological factor. De	espite these	
	While the ageing of the population following reductions in cardiovascular mortality may have contributed to these contrasting trends, the role of other factors also needs to be clearly understood if common risk factor prevention strategies are to be considered (from Commonwealth Department of Health & Ageing and Australian Institute of Health and Welfare (1999) National Health Priority Areas Report: Cardiovascular Health).			
	In settings such as general practice where the monitoring of a person's health is ongoing and where diabetes status can change over time, the service contact date should be recorded.			
	DSS – Diabetes (clinical):			
	Uncontrolled diabetes leads to a variety of co- limitation of activity, disability, illness and pr ongoing assessment is required to identify pe complications so that early preventive strateg is no cure for diabetes, with modern treatment active life and avoid long-term complications	emature mortality. ople at risk of deve ies can be applied. It most people can	Therefore eloping Although there	
	Aetiological classifications contained in the sc Diagnosis and Classification of Diabetes Mell Diagnosis and Classifications of Diabetes Mel Consultation' (Alberti & Zimmet 1998).	itus and its Compli	ications Part 1:	

Diabetes therapy type

Identifying and Definitional Attributes

raonarying and Bon			
Knowledgebase ID:	000668 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The type of diabetes therapy the person is currently receiving.		
Context:	Public health, health care and clinical setting:		
	Its main use is to enable categorisation of management regimes against best practice for diabetes.		
Relational and Repr	resentational Attributes		
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	NN		
Minimum size:	2		
Maximum size:	2		
Data domain:	01 Diet and exercise only		
	02 Oral hypoglycaemic – sulphonylurea only		
	03 Oral hypoglycaemic – biguanide (e.g. metformin) only		
	04 Oral hypoglycaemic – alpha-glucosidase inhibitor only		
	05 Oral hypoglycaemic – thiazolidinedione only		
	06 Oral hypoglycaemic – meglitinide only		
	07 Oral hypoglycaemic – combination (e.g. biguanide and sulphonylurea)		
	08 Oral hypoglycaemic – other		
	09 Insulin only		
	10 Insulin plus oral hypoglycaemic		
	98 Nil – not currently receiving diabetes treatment		
	99 Not stated/inadequately described		
Guide for use:	Code 01 includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates; low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.		
	Code 98 no current diet, tablets or insulin therapy(ies)		
	Code 99 missing information		
Verification rules:			
Collection methods:	To be collected at the commencement of treatment and at each review.		
Related metadata:	relates to the data element Diabetes status vers 1		
	relates to the data element Renal disease therapy vers 1		
	is used in conjunction with Service contact date vers 1		
	relates to the data element Vascular history vers 1		
	relates to the data element Year insulin started vers 1		
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Administrative Attributes

Source document:			
Source organisation:	National Diabetes Data Working Group		
	CV-Data Working Group		
Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:		Start date	End date
DSS - Cardiovascular disease	e (clinical)	01/01/2003	
DSS – Diabetes (clinical)		01/01/2003	
Comments:	In settings where the monitoring of a person's health is ongoing and where		

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

DSS - Diabetes (clinical):

The objectives and priorities of treatment must be tailored to the individual considering age, sex, weight and individual health status.

An individual management plan for each patient should include the following:

- establishment of targets of treatment
- healthy eating plan
- education in self-monitoring
- adjustment of treatment and in approaches to coping with emergencies
- exercise program
- risk factor reduction, e.g. smoking cessation
- use of oral hypoglycaemic agents, if required
- use of insulin, if required
- screening for and treatment of complications of diabetes.

In addition to glycaemic control, management of diabetes of either type requires close attention to other risk factors for the development of complications, and the impact of lifestyle changes on blood glucose levels should be monitored. In patients with Type 2 diabetes, an increase in physical activity is essential in management of lipids and glucose level. Increased physical activity has been recognised as perhaps the most feasible way of modifying glucose intolerance, a risk factor for developing diabetes and macrovascular disease (Guest & O'Dea 1992).

References:

Berkow R, editor. The Merck Manual. 16th ed. Rahway (New Jersey, USA): Merck Research Laboratories; 1992.

Diagnosis

Identifying and Definitional Attributes

Knowledgebase ID:	000398	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/98	
Definition:	A diagnosis is the decision of the disease or condition	n reached, after assessment, of the nature and identity n of a patient.
Context:	Health services:	
	0 1	ovides the basis for analysis of health service usage, nd monitoring of specific disease entities.

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Additional diagnosis vers 4
	relates to the data element Complication of labour and delivery vers 2
	relates to the data element Complications of pregnancy vers 2
	relates to the data element Congenital malformations vers 2
	relates to the data element External cause - admitted patient vers 4
	relates to the data element Maternal medical conditions vers 2

relates to the data element Neonatal morbidity vers 2

relates to the data element Postpartum complication vers 2 relates to the data element Principal diagnosis vers 3

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Physical wellbeing Data Set Specifications:	National Health Data Committee Start date End date
Comments:	Classification systems which enable the allocation of a code to the diagnostic information:
	International Classification of Diseases – Tenth Revision – Australian Modification (ICD-10-AM)
	British Paediatric Association Classification of Diseases
	North America Nursing Diagnosis Association
	International Classification of Primary Care
	International Classification of Impairments, Disabilities and Handicaps
	International Classification of Functioning

Diagnosis onset type

Identifying and Definitional Attributes

Knowledgebase ID:	000773	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	A qualifier for each coded the diagnosis to the episod	diagnosis to indicate the onset and/or significance of le of care
Context:	Health services:	
	Improved analysis of diag safety and adverse event i	nostic information, especially in relation to patient nonitoring

Relational and Representational Attributes

Datatype:	Num	neric
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1	Primary condition
	2	Post-admit condition
	9	Unknown or uncertain
Guide for use:	recoi assig	gn the relevant diagnosis type flag to all of the ICD-10-AM disease codes rded in the hospital morbidity system. Specific guidelines for correct nment of diagnosis flag type are in ICD-10-AM Australian Coding dards, Third Edition 1 July 2002.
	The following rules only apply to:	
	_	diagnoses which meet the criteria in the Australian Coding Standards (ACS) 0001 Principal diagnosis and ACS 0002 Additional diagnoses or a specialty standard which requires the use of an additional code(s).
	-	hospital morbidity data
	-	'episode of care' refers to hospital or day procedure episodes of care
	1 Pri	mary condition
	_	a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status. In the case of neonates, the condition(s) present at birth.
	-	a previously existing condition not diagnosed until the current episode of care
	-	in delivered obstetric cases, all conditions which arise from the beginning of labour to the end of second stage
	2 Pos	st-admit condition
	-	a condition which arises during the current episode of care and would not have been present on admission
	9 Un	known or uncertain
	-	a condition where the documentation does not support assignment to 1 or 2

	Explanatory Notes:
	The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.
	The flag on morphology codes should match that on the corresponding neoplasm code.
	Conditions meeting the criteria of principal diagnosis may, in some cases, have a flag of 2.
Verification rules:	
Collection methods:	A diagnosis onset type should be recorded and coded upon completion of an episode of admitted patient care.
Related metadata:	relates to the data element Activity when injured vers 2
	relates to the data element Additional diagnosis vers 4
	relates to the data element External cause – admitted patient vers 4
	relates to the data element Place of occurrence of external cause of injury vers 5
	relates to the data element Principal diagnosis vers 3

Administrative Attributes

Source document:			
Source organisation:	National Centre for Classification in Health		
Information model link:			
NHIM Request for/entry ir	nto service event		
Data Set Specifications:		Start date	End date

Comments:

Diagnosis related group

Knowledgebase ID: 000042 Version No: 1 Metadata type: Data Element Admin. status: Current 01/07/93 A patient classification scheme which provides a means of relating the number Definition: and types of patients treated in a hospital to the resources required by the hospital. Context: The development of Australian refined diagnosis related groups has created a descriptive framework for studying hospitalisation. Diagnosis related groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANNA
Minimum size:	4
Maximum size:	4
Data domain:	Australian refined diagnosis related groups, Commonwealth of Australia. Version effective from 1 July each year.
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	is derived from Additional diagnosis vers 4
	is derived from Admission date vers 4
	is derived from Date of birth vers 4
	is derived from Infant weight, neonate, stillborn vers 3
	is derived from Intended length of hospital stay vers 2
	is derived from Mode of separation vers 3
	is derived from Principal diagnosis vers 3
	is derived from Procedure vers 5
	is derived from Separation date vers 5
	is derived from Sex vers 3

Administrative Attributes

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

Information model link:					
NHIM Physical wellbeing					
Data Set Specifications:	Start date	End date			
NMDS - Admitted patient care	01/07/1993				
NMDS - Admitted patient mental health care	01/07/1997				

Comments:

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

Division of General Practice number

identifying and Dei	Initional Attributes	
Knowledgebase ID:	000669	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:		Practice number as designated by the Commonwealth a. Each separately administered Division of General entifying number.
Context:	Public health and health	i care:
		ocused collection, linkage, pooling, analysis, reporting ated data, which could potentially be linked to other

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNN
Minimum size:	3
Maximum size:	3
Data domain:	Codes defined in the Commonwealth Department of Health and Ageing: General Practice in Australia: 2000. First Edition May 2000.
Guide for use:	Divisions of General Practice are geographically based networks of general practitioners. In geographical terms, each Division of General Practice can be described by the postcodes that fall within its jurisdiction.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Person identifier vers 1

Administrative Attributes

Source document:	Commonwealth Department of Health and Ageing: General Practice in Australia: 2000. First Edition May 2000.		
Source organisation:	CV-Data Working Group		
Information model link:			
NHIM Service provider role			
Data Set Specifications:		Start date	End date
DSS - Cardiovascular disease	(clinical)	01/01/2003	

Comments:

Domestic services

Identifying and Definitional Attributes				
Knowledgebase ID:	000241	Version No: 1		
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/89			
Definition:	domestic services for staff including salaries and wa	services including electricity, other fuel and power, , accommodation and kitchen expenses but not ges, food costs or equipment replacement and repair should be reported with no revenue offsets, except for		
Context:	Health expenditure:			
	e	nt of non-salary recurrent expenditure for most data set and is thus required for any health e national level.		

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Currency
Representational layout:	\$999,999,999
Minimum size:	2
Maximum size:	12
Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods: Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

nmittee			
NHIM Recurrent expenditure			
Start date	End date		
01/07/1989			
	Start date		

Comments:The possibility of separating fuel, light and power from domestic services
which would bring the overall non-salary recurrent expenditure categories
closer to the old Hospitals and Allied Services Advisory Council categories was
briefly considered by the Resources Working Party but members did not hold
strong views in this area.

Drug supplies

Identifying and Definitional Attributes Knowledgebase ID: Version No: 1 000238 Metadata type: Data Element Admin. status: Current 01/07/89 Definition: The cost of all drugs including the cost of containers. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers. Context: Health expenditure: This is a significant element of non-salary recurrent expenditure and also national level data on drug expenditure in hospitals is of considerable interest in its own right to a wide range of persons and organisations.

Relational and Representational Attributes

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

Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

National Health Data Committee				
Information model link:				
NHIM Recurrent expenditure				
Data Set Specifications:		End date		
NMDS - Public hospital establishments				
	ure	ure Start date		

Comments:

Dyslipidaemia – treatment

Identifying and Definitional Attributes

Knowledgebase ID:	000814 Version No: 1				
Metadata type:	Data Element				
Admin. status:	Current				
	01/01/03				
Definition:	Whether an individual is currently treated for dyslipidaemia (abnormal lipid levels) using anti-lipid medication.				
	, , , , , , , , , , , , , , , , , , , ,				
Context:	Public health, health care and clinical settings.				
Relational and Repr	esentational Attributes				
Datatype:	Numeric				
Representational form:	Code				
Representational layout:	Ν				
Minimum size:	1				
Maximum size:	1				
Data domain:	1 Yes – currently treated for dyslipidaemia using anti-lipid medication				
	2 No – not currently treated for dyslipidaemia using anti-lipid medication				
	9 Not stated/inadequately described				
Guide for use:	Record as code 1 if on drug treatment for dyslipidaemia.				
T 7 • A • A • 1					
Verification rules:					
Collection methods:	Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.				
	internativery obtain the relevant information none appropriate documentation.				
Related metadata:	relates to the data element Cholesterol-HDL – measured vers 1				
	relates to the data element Cholesterol-total - measured vers 1				
	relates to the data element Fasting status vers 1				
	relates to the data element Triglycerides – measured vers 1				
Administrative Attrib	utes				
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data				
	dictionary.				
· · ·					
Source organisation:	National Diabetes Data Working Group				
Information model link:					
<i>Information model link:</i> NHIM Request for/entry ir	ito service event				
<i>Information model link:</i> NHIM Request for/entry ir <i>Data Set Specifications:</i>	ato service event <i>Start date End date</i>				
<i>Information model link:</i> NHIM Request for/entry ir	ito service event				

Comments:

Dyslipidaemia is an excessive accumulation of one or more of the major lipids transported in plasma. Plasma lipid levels may be reduced by a variety of

agents having different mechanisms of action. They also have different effects on the plasma lipid profile.

Dyslipidaemia is associated with many health problems including diabetes and hypertension. It is often related to overweight and obesity. Usually caused by inappropriate diet and sedentary lifestyle, dyslipidaemia has been reaching epidemic proportions. Active lifestyle and low calorie diets are the best way of prevention, however sometimes for the treatment of dyslipidaemia the use of pharmacotherapy is required. Abnormal levels of blood lipids are associated with increased risk of developing coronary health disease especially in diabetic patients.

The risk of coronary and other macrovascular disorders is 2–5 times higher in people with diabetes than in non-diabetic subjects and increases in parallel with the degree of dyslipidaemia. Diabetes mellitus greatly modifies the significance of lipoprotein levels, particularly when associated with smoking, hypertension and family history of cardiovascular disease. Poor metabolic control of diabetes seems to have impact on abnormal lipoprotein level.

Primary dyslipidaemia, due to genetic and environmental (especially dietary) factors, is diagnosed if secondary causes have been excluded (hypothyroidism, nephrotic syndrome, cholestasis, anorexia nervosa, diabetes mellitus Type 2, renal impairment).

Elective care

Identifying and Definitional Attributes						
Knowledgebase ID:	000348	Version No: 1				
Metadata type:	Data Element Concept					
Admin. status:	Current					
	01/07/95					
Definition:	Care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours.					
Context:	Admitted patient care.					
Relational and Representational Attributes						
Datatype:						
Representational form:						
Representational layout:						
Minimum size:						
Maximum size:						
Data domain:						
Guide for use:						
Verification rules:						
Collection methods:						
Related metadata:	relates to the data elemen	t Waiting list cates	gory vers 3			
Administrative Attributes						
Source document:						
Source organization:	Hospital Access Program	Waiting List Wor	king Group			
	National Health Data Cor	nmittee				
Information model link:						
NHIM Service provision event						
Data Set Specifications:			Start date	End date		

Comments:

Elective surgery

Identifying and Definitional Attributes Knowledgebase ID: 000046 Version No: 1 Metadata type: Data Element Concept Admin. status: Current 01/07/95 Elective care where the procedures required by patients are listed in the surgical Definition: operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians. Context: Admitted patient care. **Relational and Representational Attributes** Datatype: Representational form: **Representational layout:** Minimum size: Maximum size: Data domain: Guide for use: Verification rules: Collection methods: **Related metadata:** relates to the data element Waiting list category vers 3 Administrative Attributes Source document: Source organisation: Hospital Access Program Waiting List Working Group National Health Data Committee Information model link: NHIM Service provision event

Start date

End date

Comments:

Data Set Specifications:

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Emergency department – public hospital

Identifying and Deminional Attributes			
Knowledgebase ID:	000815	Version No: 1	
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/03		
Definition:		ublic hospital that is organised and administered to o those in the community who perceive the need for or gent 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.		
		nt provides triage, assessment, care and/or treatment n medical condition(s) and/or injury.	
Context:	Emergency department ca	are.	
Relational and Representational Attributes			

Identifying and Definitional Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element concept Non-admitted patient emergency department service episode vers 1

Administrative Attributes

Source document:			
Source organisation:	National reference group for non-admitted p	atient data develor	oment, 2001–02
Information model link:			
NHIM Service delivery setti	ng		
Data Set Specifications:		Start date	End date

Comments:

This data element concept has been defined to support the NMDS – Non-admitted patient emergency department care. It is not intended as a definitive statement of the role or purpose of an emergency department. The national definition of an emergency department and the care that is

provided in an emergency department is characterised by jurisdictional and local differences. For example, there is no national agreement on the identification and classification of emergency department-related settings such as observation units, short-stays units, or the use of 'admitted patient beds' located in an emergency department setting.

Emergency department is therefore defined as a concept, and not necessarily as a physical premises, setting or site.

Emergency department arrival mode – transport

Identifying and Define	nitio	nal Attributes	
Knowledgebase ID:	0008	816 Version No: 1	
Metadata type:	Data	a Element	
Admin. status:	Curr	rent	
	01/0	07/03	
Definition:		mode of transport by which the person arrives at the emergency artment.	
Context:	Eme	ergency department care.	
Relational and Repr	ese	ntational Attributes	
Datatype:	Nur	neric	
Representational form:	Cod	e	
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 2 8 9	Ambulance, air ambulance or helicopter rescue service Police/correctional services vehicle Other Not stated/unknown	
Guide for use:		e 8 (Other) includes patients who walked in, came by private tra lic transport, community transport, or taxi.	nsport,
Verification rules: Collection methods: Related metadata:			
Administrative Attrib	utes	3	
Source document:			
Source organisation:	Nati	onal reference group for non-admitted patient data developmen	ıt, 2001–02
Information model link:			
NHIM Request for/entry in	nto ser		
Data Set Specifications:		Start date En	d date
NMDS - Non-admitted patie	nt eme	ergency department care 01/07/2003	

Identifying and Definitional Attributes

Emergency department departure status

Identifying and Definitional Attributes Knowledgebase ID: Version No: 2 000359 Metadata type: Data Element Admin. status: Current 01/07/03 Definition: The status of the patient at the end of the non-admitted patient emergency department service episode Context: Non-admitted patient emergency department care. **Relational and Representational Attributes** Datatype: Numeric Representational form: Code Ν Representational layout: 1 Minimum size: Maximum size: 1 Data domain: 1 Admitted to this hospital (including to units or beds within the emergency department) 2 Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital 3 Referred to another hospital for admission 4 Did not wait to be attended by a health care professional 5 Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed 6 Died in emergency department as a non-admitted patient 7 Dead on arrival, not treated in emergency department A non-admitted patient emergency department service episode ends when Guide for use: either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk. Code 2 includes patients who departed under their own care, under police custody and under the care of a residential aged care facility or other carer. Code 2 excludes those who died in the emergency department, which should be coded to Code 6. Verification rules: **Collection methods: Related metadata:** relates to the data element Date of commencement of service event vers 2 relates to the data element Date patient presents vers 2 supersedes previous data element Departure status vers 1 relates to the data element concept Emergency department - public hospital vers 1 relates to the data element Emergency department waiting time to admission vers 1

relates to the data element Emergency department waiting time to service delivery vers 2 relates to the data element concept Patient presentation at emergency department vers 1 relates to the data element Time of commencement of service event vers 2 relates to the data element Time patient presents vers 2 relates to the data element Type of visit to emergency department vers 2

Administrative Attributes

Source document:

Source organisation:	National reference group for non-admitted patient data development, 2001-02			
Information model link:				
NHIM Exit/leave from service event				
Data Set Specifications:		Start date	End date	
NMDS - Emergency department waiting times		01/07/2003		
NMDS - Non-admitted patien	nt emergency department care	01/07/2003		

Emergency department waiting time to admission

Identifying and Definitional Attributes				
Knowledgebase ID:	000397	Version No: 1		
Metadata type:	Derived Data Element			
Admin. status:	Current			
	01/07/98			
Definition:	The time elapsed for each department to admission	patient from presentation to the emergency to hospital.		
Context:	of waiting time, for perfo based on this data item w	are: imes data item. This item is used to examine the length rmance indicators and benchmarking. Information rill have many uses including to assist in the planning itals and in health care research.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Time
Representational layout:	HHMM
Minimum size:	4
Maximum size:	4
Data domain:	Count in numbers of hours and minutes
Guide for use:	Calculated from admission date and time minus date and time patient presents for those emergency department patients who are admitted.
Verification rules:	
Collection methods:	To be collected on patients presenting to emergency department for unplanned care in public hospitals with emergency department and private hospitals providing contracted services for the public sector.
Related metadata:	is calculated using Admission date vers 4
	is calculated using Admission time vers 2
	is calculated using Date patient presents vers 2
	is calculated using Emergency department departure status vers 2
	relates to the data element concept Patient presentation at emergency department vers 1
	is calculated using Time patient presents vers 2

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Performance indica	tor		
Data Set Specifications:		Start date	End date

Emergency department waiting time to service delivery

Identifying and Defin	Identifying and Definitional Attributes				
Knowledgebase ID:	000347	Version No: 2			
Metadata type:	Derived Data Element				
Admin. status:	Current				
	01/01/00				
Definition:	The time elapsed for each department to commence			0,	
Context:	Non-admitted patient em	ergency department	t care.		
Relational and Repr	esentational Attrib	utes			
Datatype:	Numeric				
Representational form:					
Representational layout:	MMMMM				
Minimum size:	5				
Maximum size:	5				
Data domain:	Time in minutes				
Guide for use:	Calculated from the date and time of service event minus date and time patient presents. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.				
Verification rules:					
Collection methods:					
Related metadata:	supersedes previous data service delivery ver		v department wait	ing time to	
	relates to the data elemen vers 1	t concept Emergenc	y department – pı	ıblic hospital	
	is calculated using Date o	f commencement of	service event ver	s 2	
	is calculated using Date p	atient presents vers	2		
	is calculated using Time c			rs 2	
	is calculated using Time p	patient presents vers	52		
Administrative Attrib	outes				
Source document:					
Source organisation:	National reference group	for non-admitted pa	tient data develop	oment, 2001–02	
Information model link:					
NHIM Performance indicat	tor				
Data Set Specifications:			Start date	End date	
NMDS - Emergency departm	nent waiting times		01/07/2000		

It is recognised that at times of extreme urgency or multiple synchronous Comments: presentations, or if no medical officer is on duty in the emergency department, this service may be provided by a nurse.

01/07/2003

NMDS - Non-admitted patient emergency department care

Employment status – acute hospital and private psychiatric hospital admissions

Identifying and Definitional Attributes				
Knowledgebase ID:	000395	Version No:	2	
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/97			
Definition:	Self-reported employmen an acute or private psychi	-	son, immediately prior to admission to	
Context:	Implementation Committ important factor explaining The committee recommen- the various groups of com-	ee (1988) identi ng health differe ided that natior cern. This requi comic status. In e	ry Council Health Targets and fied socioeconomic status as the most entials in the Australian population. hal health statistics routinely identify fres routine recording in all collections order of priority, these would be and education.	

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Unemployed/pensioner		
	2 Other		
Guide for use:			
Verification rules:			
Collection methods:	In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:		
	Occupation?		
	For example:		
	 housewife or home duties 		
	 pensioner miner 		
	– tree feller		
	 retired electrician 		
	 unemployed trades assistant 		
	– child		
	– child – student		

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Related metadata: supersedes previous data element Employment status vers 1 relates to the data element Employment status – public psychiatric hospital admissions vers 2

Administrative Attributes

Source document:			
Source organisation:	National minimum data set working parties		
Information model link:			
NHIM Labour characteristic	c		
Data Set Specifications:		Start date	End date
NMDS - Admitted patient me	ental health care	01/07/1997	

Employment status – public psychiatric hospital admissions

Identifying and Defir	nitional Attributes	
Knowledgebase ID:	000317	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	Self-reported employmen a public psychiatric hospi	t status of a person, immediately prior to admission to tal.
Context:	Implementation Committee important factor explaining The committee recomment the various groups of com- of indicators of socioecoments	inisters' Advisory Council Health Targets and ee (1988) identified socioeconomic status as the most ng health differentials in the Australian population. nded that national health statistics routinely identify cern. This requires routine recording in all collections omic status. In order of priority, these would be ne, occupation and education.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1

Data domain:	1	Child not at school
	2	Student
	3	Employed
	4	Unemployed
	5	Home duties

- · · · ·			
Guide for use:			
Verification rules:			
Collection methods:	In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:		
	What is your/the person's Occupation?		
	For example:		
	 housewife or home duties 		
	 pensioner miner 		
	– tree feller		
	 retired electrician 		
	 unemployed trades assistant 		
	– child		
	– student		
	– accountant		

However, for national reporting purposes it is preferable to distinguish these

two data items logically.

Related metadata:supersedes previous data element Employment status vers 1
relates to the data element Employment status – acute hospital and private
psychiatric hospital admissions vers 2

Administrative Attributes

Source document:			
Source organisation:	National minimum data set working parties	5	
Information model link:			
NHIM Labour characteristic			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient mental health care		01/07/1997	

Identifying and Defi	nitional Attributes
Knowledgebase ID:	000445 Version No: 1
Metadata type:	Data Element Concept
Admin. status:	Current
	01/07/00
Definition:	The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.
Context:	Admitted patient care.
Relational and Rep	esentational Attributes
Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	This treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element concept Admission vers 3
	relates to the data element concept Admission date vers 4
	relates to the data element concept Admitted patient vers 3
	relates to the data element Care type vers 4
	relates to the data element concept Separation vers 3
	relates to the data element Separation date vers 5
Administrative Attrib	outes
Source document:	
Source organisation:	National Health Data Committee

Identifying and Definitional Attributes

 Source document:

 Source organisation:
 National Health Data Committee

 Information model link:

 NHIM
 Service provision event

 Data Set Specifications:
 Start date

Erectile dysfunction

Knowledgebase ID: 000817 Version No: 1 Metadata type: Data Element Admin. status: Current 01/01/03 Whether a male individual has a history of erection failure or has received Definition: treatment to achieve erection sufficient for penetration in the last 12 months and prior. Context: Public health, health care and clinical settings. Relational and Representational Attributes Numeric Datatype: Representational form: Code Representational layout: Ν Minimum size: 1 1 Maximum size: Data domain: 1 Erectile dysfunction - developed in the last 12 months 2 Erectile dysfunction - developed prior to the last 12 months 3 No erectile dysfunction 9 Not stated/inadequately described Guide for use: Record for male patients only. Verification rules: Collection methods: Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration. Determine whether this developed within or prior to the last 12 months. **Related metadata:** relates to the data element Peripheral neuropathy - status vers 1 relates to the data element Peripheral vascular disease in feet - status vers 1 Administrative Attributes Source document: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Source organisation: National Diabetes Data Working Group Information model link: NHIM Physical wellbeing Data Set Specifications: Start date End date DSS - Diabetes (clinical) 01/01/2003 Comments: Erectile dysfunction or impotence is defined as inability to achieve or maintain an erection of sufficient rigidity to perform sexual intercourse successfully. It may be due to psychological causes, macrovascular disease or pelvic autonomic neuropathy. An organic cause is more likely in the presence of other macro or micro vascular complications. Erectile problems occur in up to 50% of men with diabetes who are over 40 years old.

Identifying and Definitional Attributes

Establishment identifier

Identifying and Definitional Attributes				
Knowledgebase ID:	000050	Version No:	4	
Metadata type:	Derived Data Element			
Admin. status:	Current			
	01/07/03			
Definition:			episode or event occurred. Each olishment to have a unique identifier at	
Context:				
Relational and Repr	resentational Attrib	utes		
Datatype:	Alphanumeric			
Representational form:	Code			
Representational layout:	NNA(N)NNNNN			
Minimum size:	9			
Maximum size:	9			
Data domain:	Concatenation of:			
	State/Territory identifier	(character posi	tion 1)	
	Establishment sector (cha	racter position	2)	
	Region code (character positions 3-4)			
	Establishment number (ch	naracter positio	ns 5–9)	
Guide for use:				
Verification rules:				
Collection methods:				
Related metadata:	supersedes previous data	element Establ	ishment identifier vers 3	
	is composed of Establishn	nent number ve	ers 4	
	is composed of Establishn			
	relates to the data elemen			
			ier type – health care vers 1	
	is composed of Region co		xxxxx 2	
	is composed of State/Terr	nory identifier	ve15 J	
Administrative Attrib	outes			

Source document: Source organisation: National Health Data Committee Information model link: NHIM Organisation characteristic

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

Comments:

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

NMDS - Admitted patient care:

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

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

Establishment number

Identifying and Definitional Attributes

Knowledgebase ID:	000377	Version No: 4
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	An identifier for an estab	lishment, unique within the State or Territory.
Context:	All health services.	
Relational and Repr	esentational Attrib	utes
Datatype:	Numeric	
Representational form:	Identification number	
Representational layout:	NNNNN	
Minimum size:	5	
Maximum size:	5	
Data domain:	Valid establishment num	ber
Guide for use:		
Verification rules:		
Collection methods:		
Related metadata:	is a composite part of Est	ablishment identifier vers 4
	supersedes previous data	element Establishment number vers 3

Administrative Attributes

Source document:		
Source organisation:		
Information model link:		
NHIM Organisation characteristic		
Data Set Specifications:	Start date	End date
DSS - Health care client identification	01/01/2003	

Comments:

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

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

Establishment sector

Identifying and Definitional Attributes

Knowledgebase ID:	000379	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	A section of the health can identify.	re industry with which a health care establishment can

Context:

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
11100000000	-

Data domain:	1	Public
	2	Private
Guide for use:		
Verification rules:		
Collection methods:		
Related metadata:	is a	composite part of Establishment identifier vers 4
	sup	ersedes previous data element Establishment sector vers 2

Administrative Attributes

Source document:		
Source organisation:		
Information model link:		
NHIM Organisational setting		
Data Set Specifications:	Start date	End date
DSS - Health care client identification	01/01/2003	

Establishment type

Knowledgebase ID:	000327 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/07/89
Definition:	Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment.
	Residential establishments are considered to be separately administered if managed as an independent unit in terms of financial, budgetary and activity statistics. The situation where establishment-level data, say for components of an area health service, were not available separately at a central authority was not grounds for treating such a group of establishments as a single establishment unless such data were not available at any level in the health care system.
	Non-residential health services are classified in terms of separately administered organisations rather than in terms of the number of sites at which care is delivered. Thus, domiciliary nursing services would be counted in terms of the number of administered entities employing nursing staff rather than in terms of the number of clinic locations used by the staff.
	Establishments can cater for a number of activities and in some cases separate staff and financial details are not available for each activity. In the cases it is necessary to classify the establishment according to its predominant residential activity (measured by costs) and to allocate all the staff and finances to that activity. Where non-residential services only are provided at one establishment, that establishment is classified according to the predominant non-residential activity (in terms of costs).
Context:	Health services:
	Type of establishment is required in order to aggregate establishment-level data into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis.
Relational and Rep	into meaningful summary categories (e.g. public hospitals, residential aged care
-	into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis.
Relational and Repu Datatype: Representational form:	into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis. resentational Attributes
Datatype:	into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis. resentational Attributes Alphanumeric
Datatype: Representational form:	into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis. resentational Attributes Alphanumeric Code
Datatype: Representational form: Representational layout:	into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis. resentational Attributes Alphanumeric Code AN.N.N
Datatype: Representational form: Representational layout: Minimum size:	into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis. resentational Attributes Alphanumeric Code AN.N.N 2
Datatype: Representational form: Representational layout: Minimum size:	into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis. resentational Attributes Alphanumeric Code AN.N.N 2

Identifying and Definitional Attributes

N8.2.2 Private (non-profit) domiciliary nursing service

Public domiciliary nursing service

N8.2.1

	N8.2.3	Private (profit) domiciliary nursing service
	R1.1	Public acute care hospital
	R1.2	Private acute care hospital
	R1.3.1	Veterans' Affairs hospital
	R1.3.2	Defence force hospital
	R1.3.3	Other Commonwealth hospital
	R2.1	Public psychiatric hospital
	R2.2	Private psychiatric hospital
	R3.1	Private charitable nursing home for the aged
	R3.2	Private profit nursing home for the aged
	R3.3	Government nursing home for the aged
	R3.4	Private charitable nursing home for young disabled
	R3.5	Private profit nursing home for young disabled
	R3.6	Government nursing home for young disabled
	R4.1	Public alcohol and drug treatment centre
	R4.2	Private alcohol and drug treatment centre
	R5.1	Charitable hostels for the aged
	R5.2	State government hostel for the aged
	R5.3	Local government hostel for the aged
	R5.4	Other charitable hostel
	R5.5	Other State government hostel
	R5.6	Other Local government hostel
	R6.1	Public hospice
	R6.2	Private hospice
<i>Guide for use:</i>	Establis	hments are classified into 10 major types subdivided into major groups:
2		esidential establishments (R)
	– n	on-residential establishments (N)
	R1 Acut	e care hospitals:
	services round-t necessar departm have act	hments which provide at least minimal medical, surgical or obstetric for inpatient treatment and/or care, and which provide he-clock comprehensive qualified nursing service as well as other ry professional services. They must be licensed by the State health nent, or controlled by government departments. Most of the patients ute conditions or temporary ailments and the average stay per on is relatively short.
	or surgi providii not prov	Is specialising in dental, ophthalmic aids and other specialised medical cal care are included in this category. Hospices (establishments ng palliative care to terminally ill patients) that are freestanding and do vide any other form of acute care are classified to R6.
	-	hiatric hospitals:
	psychia approve Insuran health a disorder	hments devoted primarily to the treatment and care of inpatients with tric, mental, or behavioural disorders. Private hospitals formerly ed by the Commonwealth Department of Health under the Health ce Act 1973 (Commonwealth) (now licensed/approved by each State uthority), catering primarily for patients with psychiatric or behavioural rs are included in this category.
		for the non-acute treatment of drug dependence, developmental and ual disability are not included here (see below). This code also excludes

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institutions mainly providing living quarters or day care.

R3 Nursing homes:

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile inpatients. They must be approved by the Commonwealth Department of Health and Family Services and/or licensed by the State, or controlled by government departments.

Private profit nursing homes are operated by private profit-making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated by or on behalf of a State or Territory government.

R4 Alcohol and drug treatment centres:

Freestanding centres for the treatment of drug dependence on an inpatient basis.

R5 Hostels and residential services:

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Only hostels subsidised by the Commonwealth are included. Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

R6 Hospices:

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

N7 Same-day establishments:

Includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

N8 Non-residential health services:

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

N8.1 Community health centres:

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

N8.2 Domiciliary nursing service:

Public or registered non-profit or profit-making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Verification rules: Collection methods: Related metadata:

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Organisation charac	teristic		
Data Set Specifications:		Start date	End date
NMDS - Alcohol and other d	rug treatment services	01/07/2002	30/06/2003
NMDS - Public hospital estal	blishments	01/07/1989	

Comments:

In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This data element is currently under review by the Organisational Units Working Group of the National Health Data Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Estimated date flag

Identifying and Definitional Attributes

Knowledgebase ID:	000431	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	An indication of whether	any componen	t of a reported date was estimated.
Context:	However, at times, the act birth or date of injury). Th a date that have been estin approximation of the date	tual date or par nis data elemen mated when a c e in question rat sist with record	requirement in data collections. t thereof is not known (e.g. date of t is designed to flag the part or parts of late provided is based on an ther than reporting of the actual date. linkage processes (for example when thage key).

Relational and Representational Attributes

Datatype:	Alphabetic
Representational form:	Code
Representational layout:	AAA
Minimum size:	1
Maximum size:	3

Data domain:	А	Date estimated from reported age
	D	Day value in date was estimated
	DM	Day and month values in date were estimated
	DMY	(All values (day, month, year) in date were estimated
	DY	Day and year values in date were estimated
	М	Month value (only) in date was estimated
	MY	Month and year values in date were estimated
	Null	Date not estimated
	Y	Year value (only) in date was estimated
Guide for use:		be used to record an estimated date for date of birth or data elements for r dates such as date of death.
Verification rules:		
Collection methods:		data element should be reported in conjunction with a reported date when part of the date represents an estimate rather than the actual or known
Related metadata:	is us	ed in conjunction with Date of birth vers 4

Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee

Start date	End date
01/01/2003	

Comments:

DSS – Health care client identification:

The use of a code V for a valid date could be useful in the determination of a positive identification of a health care client.

Extended wait patient

Identifying and Defi	Illional Allindules
Knowledgebase ID:	000400 Version No: 1
Metadata type:	Derived Data Element
Admin. status:	Current
	01/07/99
Definition:	A patient with the lowest level of clinical urgency for an awaited procedure who has been on the waiting list for elective surgery for more than one year.
Context:	Elective surgery: The numbers and proportions of patients with extended waits are measures of hospital performance in relation to patient access to elective hospital care.
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Data domain:	 Extended wait patient Other patient
Guide for use:	A patient is classified as an extended wait patient if the patient is clinical urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year.
<i>Guide for use:</i> <i>Verification rules:</i>	urgency category 3 at the time of admission or at a census time and has been
	urgency category 3 at the time of admission or at a census time and has been
Verification rules:	urgency category 3 at the time of admission or at a census time and has been
Verification rules: Collection methods:	urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year. is qualified by Clinical urgency vers 2 is derived from Waiting time at a census date vers 2
Verification rules: Collection methods:	urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year. is qualified by Clinical urgency vers 2
Verification rules: Collection methods:	urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year. is qualified by Clinical urgency vers 2 is derived from Waiting time at a census date vers 2 is derived from Waiting time at removal from elective surgery waiting list vers 2
Verification rules: Collection methods: Related metadata:	urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year. is qualified by Clinical urgency vers 2 is derived from Waiting time at a census date vers 2 is derived from Waiting time at removal from elective surgery waiting list vers 2
Verification rules: Collection methods: Related metadata: Administrative Attrib	urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year. is qualified by Clinical urgency vers 2 is derived from Waiting time at a census date vers 2 is derived from Waiting time at removal from elective surgery waiting list vers 2

Identifying and Definitional Attributes

Data Set Specifications:

NHIM Performance indicator

NMDS - Elective surgery waiting times

Comments: This data item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an 'Overdue patient' as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.

Start date

01/07/1999

End date

External cause – admitted patient

Identifying and Definitional Attributes Knowledgebase ID: 000053 Version No: 4 Metadata type: Data Element Current Admin. status: 01/07/98 Definition: Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect. Institutional health care: Context: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes.

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANN.NN
Minimum size:	3
Maximum size:	6
Data domain:	ICD-10-AM 3rd edition
Guide for use:	This code must be used in conjunction with an injury or poisoning codes and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM classification.
	An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code (data element Place of occurrence of external cause). External cause codes V01 to Y34 must be accompanied by an activity code (data element Activity when injured).
Verification rules:	As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.
Collection methods:	
Related metadata:	is used in conjunction with Activity when injured vers 2
	is used in conjunction with Additional diagnosis vers 4
	relates to the data element Diagnosis onset type vers 1
	supersedes previous data element External cause – admitted patient – ICD-9-CM code vers 3
	is used in conjunction with Place of occurrence of external cause vers 2
	is used in conjunction with Principal diagnosis vers 3

Administrative Attributes

Source document:	International Classification of Diseases – Tent Modification (3rd edition 2002) National Cent Sydney.		
Source organisation:	National Health Data Committee		
	National Centre for Classification in Health		
	National Data Standards for Injury Surveillan	ce Advisory Grou	ıp
Information model link:			
NHIM Injury event			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient car	re	01/07/1998	
NMDS - Injury surveillance		01/07/1998	

Comments:

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

External cause – human intent

Identifying and Definitional Attributes

Knowledgebase ID:	000382	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current 01/07/98		
Definition:			ne occurrence of the injury or
Context:	for injury control. This inf	formation is nec	oning according to factors important ressary for defining and monitoring identifying cases for in-depth research.

Relational and Representational Attributes

Datatype:	Nun	Numeric	
Representational form:	Cod	Code	
Representational layout:	NN		
Minimum size:	2		
Maximum size:	2		
Data domain:	01	Accident – injury not intended	
	02	Intentional self-harm	
	03	Sexual assault	
	04	Maltreatment by parent	
	05	Maltreatment by spouse or partner	
	06	Other and unspecified assault	
	07	Event of undetermined intent	
	08	Legal intervention (including police) or operations of war	
	09	Adverse effect or complications of medical and surgical care	
	10	Other specified intent	
	11	Intent not specified	
Guide for use:	Select the item which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. This item must always be accompanied by an External cause – non-admitted patient code. This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in emergency departments).		
Verification rules:			

Collection methods:

Related metadata:	is used in conjunction with Activity when injured vers 2		
	is used in conjunction with Bodily location of	main injury vers 1	
	supersedes previous data element External car	use – human inten	t vers 3
	is used in conjunction with Narrative descript	ion of injury event	vers 1
	is used in conjunction with Nature of main inj	ury – non-admitte	d patient vers 1
	is used in conjunction with Place of occurrence	e of external cause	of injury vers 5
Administrative Attrib	utes		
Source document:			
Source organisation:	National Health Data Committee		
	National Data Standards for Injury Surveilland	ce Advisory Group	2
Information model link:			
NHIM Injury event			
Data Set Specifications:		Start date	End date
NMDS - Injury surveillance		01/07/1998	

External cause – non-admitted patient

Identifying and Definitional Attributes

Knowledgebase ID:	000381	Version No: 4
Metadata type:	Data Element	
Admin. status:	Current 01/07/98	
Definition:	Event, circumstance or co poisoning or adverse effec	ndition associated with the occurrence of injury, ct.
Context:	for injury control. This inf	injury and poisoning according to factors important formation is necessary for defining and monitoring ry costing and identifying cases for in-depth research.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2

Data domain:	01	Motor vehicle – driver
	02	Motor vehicle – passenger or unspecified occupant
	03	Motorcycle – driver
	04	Motorcycle - passenger or unspecified
	05	Pedal cyclist or pedal cycle passenger
	06	Pedestrian
	07	Other or unspecified transport-related circumstance
	08	Horse-related (includes fall from, struck or bitten by)
	09	Fall – low (on same level or < 1 metre or no information on height)
	10	Fall – high (drop of 1 metre or more)
	11	Drowning, submersion - swimming pool
	12	Drowning, submersion – other than swimming pool (excludes drowning associated with water craft [07])
	13	Other threat to breathing (including strangling and asphyxiation)
	14	Fire, flames, smoke
	15	Hot drink, food, water, other fluid, steam, gas or vapour
	16	Hot object or substance, not otherwise specified
	17	Poisoning - drugs or medicinal substance
	18	Poisoning – other substance
	19	Firearm
	20	Cutting, piercing object
	21	Dog-related
	22	Animal-related (excluding Horse [08] and Dog [21])

	23	(deleted)
	24	Machinery in operation
	25	Electricity
	26	Hot conditions (natural origin) sunlight
	27	Cold conditions (natural origins)
	28	Other specified external cause
	29	Unspecified external cause
	30	Struck by or collision with person
	31	Struck by or collision with object
Guide for use:	poss eme circu it is seleo non-	data domain is for use in injury surveillance purposes only, when it is not sible to use a complete ICD-10-AM code (e.g. Non-admitted patients in rgency departments). Select the item which best characterises the unstances of the injury, on the basis of the information available at the time recorded. If two or more categories are judged to be equally appropriate ct the one that comes first in the code list. The External cause – -admitted patient group must always be accompanied by an External cause man intent code (see data element External cause – human intent).
Verification rules:		
Collection methods:		
Related metadata:	is us	sed in conjunction with Activity when injured vers 2
	is us	ed in conjunction with Bodily location of main injury vers 1
	is us	ed in conjunction with External cause – human intent vers 4
	supe	ersedes previous data element External cause - major external cause vers 3
	is us	ed in conjunction with Narrative description of injury event vers 1
		sed in conjunction with Nature of main injury – non-admitted patient vers 1
	is us	eed in conjunction with Place of occurrence of external cause of injury vers 5

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
	National Centre for Classification in Health		
	National Data Standards for Injury Surveilland	ce Advisory Grou	р
Information model link:			
NHIM Injury event			
Data Set Specifications:		Start date	End date
Comments:	This item has been developed to cater for the i wide range of settings where injury surveillan the capability of recording the complete ICD-1 code list has been derived from the ICD-10-AN Further information on the national injury sur obtained from the National Injury Surveillanc Adelaide.	nce is undertaken a 10-AM external car M external cause c veillance program	and do not have use codes. This lassification. n can be

Family name

Identifying and Definitional Attributes Knowledgebase ID: 000781 Version No: 1 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: That part of a name a person usually has in common with some other members of his/her family, as distinguished from her/his given names. Context: Relational and Representational Attributes Datatype: Alphabetic **Representational form:** Text Representational layout: A(40) Minimum size: 1 Maximum size: 40 Data domain: Text Guide for use: Verification rules: Collection methods: Mixed case should be used.

Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type.

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the health care establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the health care establishment. The person's preferred name may in fact be the name on their Medicare card. The Name type data element can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name? _

Are you known by any other family names that you would like recorded? If so, what are they? _____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an Alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the Family name field and leave the Given name field blank.

Registering an unidentified health care client:

The default for unknown family name, should be 'Unknown' in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of 'Unknown'.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias name type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (alias name) in addition to the person's Medicare card name.

Baby for adoption:

The word 'Adoption' should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to 'Adoption' in client registers (for names) should also be changed to 'Unknown'. Contact your State or Territory adoption information service for further information.

	Prefixes:
	Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the Family name field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.
	Ethnic names:
	The Centrelink publication, <i>Naming Systems for Ethnic Groups</i> , provides the correct coding for ethnic names.
	Misspelled family name:
	If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.
Related metadata:	relates to the data element Given name(s) vers 1
	relates to the data element concept Name vers 1
	relates to the data element Name context flag vers 1
	relates to the data element Name suffix vers 1
	relates to the data element Name title vers 1
	relates to the data element Name type vers 1

Administrative Attributes

Source document:	AS5017 Health care client identification, with adaptations.
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Source organisation:	Standards Australia			
Information model link:				
NHIM Person characteristic				
Data Set Specifications:			Start date	End date
DSS - Health care client ider	ntification		01/01/2003	

Fasting status

Identifying and Defir	nitior	al Attributes			
Knowledgebase ID:	0006	65	Version No: 1		
Metadata type:	Data	Element			
Admin. status:	Curr	ent			
	01/0	1/03			
Definition:		fasting status of the procedure.	atient at the time o	f an examination, t	est, investigation
Context:	Publ	ic health, health care	and clinical setting		
Relational and Repr	eser	ntational Attribu	utes		
Datatype:	Num	neric			
Representational form:	Code				
Representational layout:	Ν				
Minimum size:	1				
Maximum size:	1				
Data domain:	1 2 9	Fasting Non-fasting Not stated/inadequ	ataly described		
	2	Not stated/ madequ	latery described		
Guide for use:					
Verification rules:					
Collection methods:					
Related metadata:	is use	ed in conjunction wit	h Cholesterol-HDL	- measured vers 1	L
	is used in conjunction with Cholesterol-total – measured vers 1				
		es to the data element			
	is use	ed in conjunction wit	h Triglycerides – m	neasured vers 1	
Administrative Attributes					
Source document:					
Source organisation:	Natio	onal Diabetes Data Wo	orking Group		
	CV-D	ata Working Group			
Information model link:					
NHIM Service provision ev	ent				
Data Set Specifications:				Start date	End date
DSS – Cardiovascular disease	(clinic	cal)		01/01/2003	
DSS – Diabetes (clinical)				01/01/2003	
Comments:	In se	ttings where the mon	itoring of a person	's health is ongoin	g and where

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

First day of the last menstrual period

Knowledgebase ID:	000056	Version No: 1	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	Date of the first day of the mother's last menstrual period (LMP).		
Context:	Perinatal statistics:		
	The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.		

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Date		
Representational layout:	DDMMYYYY		
Minimum size:	8		
Maximum size:	8		
.			
Data domain:	Valid dates or 99999999 if first day is unknown		
Guide for use:	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).		
Verification rules:			
Collection methods:			
Related metadata:	is used in the calculation of Gestational age vers 1		
Administrative Attributes			
Source document:			
Source organisation:	National Perinatal Data Development Committee		

Source organisation:	National Perinatal Data Development Committee		
Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:	Start date	End date	
NMDS - Perinatal	01/07/1997		

Food supplies

Identifying and Definitional Attributes Knowledgebase ID: Version No: 1 000240 Metadata type: Data Element Admin. status: Current 01/07/89 Definition: The cost of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers. Context: Health expenditure: This is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level. **Relational and Representational Attributes** Numeric Datatype: Representational form: Currency \$999,999,999 Representational layout: 2

Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

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Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recurrent expenditure			
Data Set Specifications:		Start date	End date
NMDS – Public hospital establishments		01/07/1989	

Comments:

Minimum size: Maximum size:

Foot deformity

Identifying and Definitional Attributes			
Knowledgebase ID:	000819 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Presence of foot deformity on either foot. Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.		
Context:	Public health, health care and clinical settings.		
Relational and Repr	resentational Attributes		
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Yes, foot deformity present		
	2 No, foot deformity not present		
	9 Not stated/inadequately described		
Guide for use:	Record whether or not a foot deformity is present in the person.		
Verification rules:			
Collection methods:	Both feet to be examined for the presence of foot deformity.		
Related metadata:	relates to the data element Health professionals attended – diabetes mellitus vers 1		
	relates to the data element Foot lesion – active vers 1		
	relates to the data element Foot ulcer – history vers 1		
	relates to the data element Lower limb amputation due to vascular disease vers 1		
	relates to the data element Peripheral neuropathy – status vers 1		
	relates to the data element Peripheral vascular disease in feet – status vers 1		
Administrative Attributes			
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
Source organisation: Information model link:	National Diabetes Data Working Group		

NHIM Physical wellbeing

End date

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

Comments:

Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads. Foot deformities are frequently the result of diabetic motor neuropathy and diabetic foot disease is the most common cause of hospitalisation in people with diabetes.

Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45–74 years and sevenfold over 75 years. In people with diabetes, amputations are 15 times more common than in people without diabetes and 50% of all amputations occur in people with diabetes (Epidemiology of the diabetic foot; Report of the Diabetic Foot and Amputation Group). All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Specialised foot clinics appear to decrease further episodes of foot ulceration and decrease hospital admissions for amputations.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- feet should be examined every 6 months or at every visit if high-risk foot or active foot problem
- refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present
- ensure that patients with 'high-risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems
- to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of Peripheral neuropathy
- assessment outcome, peripheral vascular disease, or foot deformity or history of previous ulceration.

References:

Lesley V Campbell, Antony R Graham, Rosalind M Kidd, Hugh F Molloy, Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27-42.

Reiber GE. Epidemiology of the diabetic foot. In: Levin ME, O'Neal LW, Bowker JH, editors. The diabetic foot. 5th ed. St Louis: Mosby Year Book, 1993; 1–5.

Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes Care 1983; 6: 87–91.

Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Foot lesion – active

Identifying and Definitional Attributes			
Knowledgebase ID:	000820 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether an individual has an active foot lesion other than an ulcer on either foot. The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.		
Context:	Public health, health care and clinical settings.		
Relational and Repr	esentational Attributes		
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Yes, foot lesion present		
	2 No, foot lesion not present		
	9 Not stated/inadequately described		
Guide for use:	Record whether or not a current active foot lesion other than ulceration is present on either foot in the person.		
Verification rules:			
Collection methods:	Assess whether the individual has an active foot lesion on either foot.		
Concerton methous,			
Related metadata:	relates to the data element Foot deformity vers 1		
	relates to the data element Foot ulcer - current vers 1		
	relates to the data element Foot ulcer – history vers 1		
	relates to the data element Lower limb amputation due to vascular disease vers 1		
	relates to the data element Peripheral neuropathy – status vers 1		
	relates to the data element Peripheral vascular disease in feet - status vers 1		
Administrative Attrib	utoo		
Administrative Attrib			
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
0			
Source organisation:	National Diabetes Data Working Group		
Information model link:			
NHIM Physical wellbeing			

ntifyi d Dafiniti Attribut Ide

Comments:

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

Early detection and appropriate management of the 'high-risk foot' and active foot problems can reduce morbidity, hospitalisation and amputation in people with diabetes.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers or other problems that may result in the need for amputation. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus foot examination:

- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer
- Ask the patient about current foot problems, neuropathic symptoms, rest pain and intermittent claudication.

Foot ulcer – current

Information model link:NHIMPhysical wellbeingData Set Specifications:

DSS - Diabetes (clinical)

Identifying and Definitional Attributes			
Knowledgebase ID:	000821 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether an individual has a current foot ulcer on either foot.		
Context:	Public health, health care and clinical settings.		
Relational and Repr	esentational Attributes		
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Yes, foot ulcer present		
	2 No, foot ulcer not present		
	9 Not stated/inadequately described		
Guide for use:	Record whether or not a foot ulcer is present on either foot in the person.		
Verification rules:			
Collection methods:	Assess whether the individual has a current foot ulcer on either foot.		
Related metadata:	relates to the data element Health professionals attended – diabetes mellitus vers 1		
	relates to the data element Foot deformity vers 1		
	relates to the data element Foot lesion – active vers 1		
	relates to the data element Foot ulcer – history vers 1		
	relates to the data element Lower limb amputation due to vascular disease vers 1		
	relates to the data element Peripheral neuropathy - status vers 1		
	relates to the data element Peripheral vascular disease in feet – status vers 1		
Administrative Attrib	utes		
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
Source organisation:	National Diabetes Data Working Group		

Comments:	Foot ulcer is usually situated on the edge of the foot or toes because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.
	Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.
	Assessment
	 Ask the patient about previous or current foot problems, neuropathic symptoms, rest pain and intermittent claudication.
	• Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.

- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

The development of ulcers of the feet and lower extremities is a special problem in the diabetic patient, and appears to be due primarily to abnormal pressure distribution secondary to diabetic neuropathy.

Diabetic foot ulceration is a serious problem and the lack of pain does not mean that the ulcer can be ignored or neglected. The absence of pain is very common in people with diabetes due to peripheral neuropathy.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Early detection and appropriate management of the 'high-risk foot' and current foot ulceration can reduce morbidity, hospitalisation and amputation in people with diabetes.

References:

The Diabetic Foot Vol. 3 No. 4 Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Foot ulcer – history

Identifying and Defir	nitional Attributes	
Knowledgebase ID:	000822 Version No: 1	
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Whether or not person has a previous history of foot ulceration on either foot.	
Context:	Public health, health care and clinical settings.	
Relational and Repr	esentational Attributes	
Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Yes, history of foot ulceration	
	2 No, no history of foot ulceration	
	9 Not stated/inadequately described	
Guide for use:	Record whether or not the person has a history of foot ulceration.	
Verification rules:		
Collection methods:	Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.	
Related metadata:	relates to the data element Health professionals attended – diabetes mellitus vers 1	
	relates to the data element Foot deformity vers 1	
	relates to the data element Foot lesion – active vers 1	
	relates to the data element Foot ulcer - current vers 1	
	relates to the data element Lower limb amputation due to vascular disease vers 1	
	relates to the data element Peripheral neuropathy – status vers 1	
	relates to the data element Peripheral vascular disease in feet – status vers 1	
Administrative Attrib	utes	
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.	

Source organisation: National Diabetes Data Working Group *Information model link:*

NHIM Request for/entry into service event

Comments:

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

Past history of foot ulceration, peripheral neuropathy and foot deformities have been associated with increased risk of foot ulceration and lower limb amputation for patients who suffer from diabetes. The aim is to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, individuals with a 'high-risk foot' or a significant active foot problem should be examined every six months or at every visit.

Assessment

- Ask patient about previous foot problems, neuropathic symptoms, rest pain and intermittent claudication.
- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

Formal community support access status

Knowledgebase ID: 000660 Version No: 1 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: Identifies a person who is currently accessing a formal community support service or services. Context: Personal and social support and clinical settings: This data element provides information about the use of formal community support services by clients. **Relational and Representational Attributes** Datatype: Numeric Representational form: Code Representational layout: Ν 1 Minimum size: Maximum size: 1 Data domain: 1 Currently accessing 2 Currently not accessing 9 Not known/inadequately described Code 1 The person is currently accessing at least one paid community support Guide for use: service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc.). Code 2 The person is not currently accessing any paid community support service or services. Code 9 The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding. Verification rules: Collection methods: **Related metadata:** relates to the data element Carer availability vers 3 relates to the data element Living arrangement vers 1 is used in conjunction with Service contact date vers 1

Identifying and Definitional Attributes

Administrative Attributes

Source document:			
Source organisation:	CV-Data Working Group		
Information model link:			
NHIM Request for/entry into service event			
Data Set Specifications:		Start date	End date
DSS - Cardiovascular disease (clinical)		01/01/2003	

Full-time equivalent staff

Knowledgebase ID:	000252	Version No: 2
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.	
	for the supply of labour (e maintenance). In the form	hrough an agency are included where the contract is e.g. nursing) rather than of products (e.g. photocopier er case, the contract would normally specify the d and could be reported as full-time equivalent units.
Context:	Health expenditure:	
	establishments. Inclusion	e resource use and activity of public hospital of these data, classified by staffing category, allows of labour and analysis of staffing inputs against
Relational and Representational Attributes		
Datatype:	Numeric	
Representational form:	Quantitative value	
Representational layout:	NNNNN	
Minimum size:	1	
Maximum size:	5	

Identifying and Definitional Attributes

Data domain:	Calculated number of staff (full-time equivalents) for each of the staffing categories listed in the Guide for use.
Guide for use:	 Staffing categories: C1.1 Salaried medical officers C1.2 Registered nurses C1.3 Enrolled nurses C1.4 Student nurses C1.5 Trainee/pupil nurses C1.6 Other personal care staff C1.7 Diagnostic and health professionals C1.8 Administrative and clerical staff
	C1.9 Domestic and other staff
	The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary-time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each. (Salary costs should be apportioned on the same basis.)

Verification rules:	
Collection methods:	
Related metadata:	supersedes previous data element Total full-time equivalent staff vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recurrent expenditure			
Data Set Specifications:		Start date	End date
NMDS – Public hospital establishments		01/07/1997	7
NMDS - Community mental health establishments01/07/1998		3	

Comments:

This metadata item was amended during 1996-97. Until then, both average and end-of-year counts of full-time equivalent staff were included, and the end-of-year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Funding source for hospital patient

Identifying and Definitional Attributes

Knowledgebase ID:	0006	32 Version No: 1
Metadata type:	Data	Element
Admin. status:	Curr	ent
	01/0	7/01
Definition:	-	ected principal source of funds for an admitted patient episode or admitted patient service event.
Context:	Adm	nitted patient care.
	Hos	pital non-admitted patient care.
Relational and Repr	eser	ntational Attributes
Datatype:	Nun	neric
Representational form:	Code	2
Representational layout:	NN	
Minimum size:	2	
Maximum size:	2	
Data domain:	01	Australian Health Care Agreements
Duta aomani.	02	Private health insurance
	03	Self-funded
	04	Worker's compensation
	05	Motor vehicle third party personal claim
	06	Other compensation (e.g. public liability, common law, medical negligence)
	07	Department of Veterans' Affairs
	08	Department of Defence
	09	Correctional facility
	10	Other hospital or public authority (contracted care)
	11	Reciprocal health care agreements (with other countries)
	12	Other
	99	Not known
Guide for use:		major funding source should be recorded if there is more than one source nding. The final payment class recorded by the hospital should be used.
	Australian Health Care Agreements (category 1) should be recorded as the funding source for admitted patients who elect to be treated as public patients. However, overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as public patients (as detailed at www.health.gov.au/haf/docs/visthlth/2000hlth.htm#rhca) should be recorded as Reciprocal health care agreement (category 11).	
		funded (category 3) includes funded by the patient, by the patient's family iends, or by other benefactors.
	Vete	artment of Veterans' Affairs (category 7) should be used for Department of rans' Affairs patients (as defined in the data element Department of rans' Affairs patient).

	Compensable patients (as defined in the data element Compensable status), should be recorded as Worker's compensation (category 4), Motor vehicle third party personal claim (category 5) or Other compensation (category 6), as appropriate.
	Overseas visitors for whom travel insurance is the major funding source should be recorded as Other (category 12).
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Admitted patient vers 3
	relates to the data element Admitted patient election status vers 1
	relates to the data element concept Non-admitted patient service event vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Insurance/benefit characteristic			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient care		01/07/2001	
NMDS - Admitted patient pa	lliative care	01/07/2001	
1		, ,	

Geographical location of establishment

Identifying and Definitional Attributes			
000260	Version No:	2	
Data Element			
Current			
01/07/97			
Geographical location of the establishment. For establishments with more than one geographical location, the location is defined as that of the main administrative centre.			
Health services:			
5	1	01	
	000260 Data Element Current 01/07/97 Geographical location of t one geographical location administrative centre. Health services: To enable the analysis of s	000260Version No:Data ElementCurrent01/07/97Geographical location of the establishmentone geographical location, the location isadministrative centre.	

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNNNN
Minimum size:	5
Maximum size:	5
Data domain:	Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0)
Guide for use:	The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA) for service delivery outlet.
	The ASGC is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.
	The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA.
	In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1
	supersedes previous data element Geographic location vers 1

Administrative Attributes

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

Source organisation:	National Health Data Committee		
Information model link:			
NHIM Address element			
Data Set Specifications:		Start date	End date
NMDS - Alcohol and other drug treatment services		01/07/2002	30/06/2003
NMDS – Public hospital establishments		01/07/1997	
NMDS - Community mental	health establishments	01/07/1998	

Comments:

The geographical location does not provide direct information on the geographical catchment area or catchment population of the establishment.

Geographical location of service delivery outlet

identifying and Den	Indian Allindules		
Knowledgebase ID:	000823	Version No: 1	
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	Geographical location of delivered.	a site from which a health/community service is	
Context:	Alcohol and other drug t	reatment services:	
	2	the accessibility of service provision in relation to haracteristics of the population of a geographic area.	
Deletional and Depresentational Attributes			

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNNNN
Minimum size:	5
Maximum size:	5
Data domain:	Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0).
	Statistics, Cat. No. 1210.0).
Guide for use:	The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA) for service delivery outlet.
	The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.
	The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA.
	In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Service delivery outlet vers 1
	is composed of State/Territory identifier vers 3

Administrative Attributes

Source document:	Australian Standard Geographical Classification (ABS Cat. No. 1216.0)	
Source organisation:	Intergovernmental Committee on Drugs NMDS WG	
Information model link:		
NHIM Address element		
Data Set Specifications:	Start date End dat	te

Gestational age

identifying and Dem	nuonal Auroules		
Knowledgebase ID:	000059	Version No: 1	
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/96		
Definition:	menstrual period. Gestati weeks (e.g. events occurr	is measured from the first day of the last normal onal age is expressed in completed days or completed ing 280 to 286 completed days after the onset of the last are considered to have occurred at 40 weeks of	
	The World Health Organization identifies the following categories:		
	 Pre-term: less than 	37 completed weeks (less than 259 days) of gestation	
	 Term: from 37 com 293 days) of gestat 	pleted weeks to less than 42 completed weeks (259 to ion	
	– Post-term: 42 comp	pleted weeks or more (294 days or more) of gestation.	
Context:	Perinatal.		

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Gestational age vers 1

Administrative Attributes

Source document:			
Source organisation:	National Perinatal Data Development Commi	ttee	
Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:		Start date	End date

Gestational age

identifying and Dem			
Knowledgebase ID:	000060	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	The estimated gestational clinical assessment.	age of the baby	in completed weeks as determined by
Context:	Perinatal statistics:		
	outcome of pregnancy an Although the date of the erroneous, estimation of g	d an important r LMP may not be gestational age b	imate gestational age, which is a key risk factor for neonatal outcomes. r known, or may sometimes be ased on clinical assessment may also gestational age are required for

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	Number representing the number of completed weeks
	99 Not stated/unknown.
Guide for use:	This is derived from clinical assessment when accurate information on the date of the last menstrual period (LMP) is not available for this pregnancy.
	Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.
Verification rules:	
Collection methods:	
Related metadata:	is calculated using First day of the last menstrual period vers 1
	relates to the data element concept Gestational age vers 1
Administrative Attrib	outes
Source document:	International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992
Source organisation:	National Perinatal Data Development Committee
Information model link:	

Start date	End date
01/07/1997	

NMDS - Perinatal

NHIM Physical wellbeing *Data Set Specifications:*

Given name(s)

Identifying and Definitional Attributes Knowledgebase ID: Version No: 1 000782 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: The person's identifying name(s) within the family group or by which the person is socially identified. Context: Relational and Representational Attributes Datatype: Alphabetic **Representational form:** Text Representational layout: A(40) 0 Minimum size: Maximum size: 40 Data domain: Text Health care establishments may record given names (first and other given *Guide for use:* names) in one field or several fields. This data element definition applies regardless of the format of data recording. A full history of names is to be retained. Verification rules: Collection methods: Given name(s) should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre-) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data. It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nickname or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may change his or her name under the Change of Name Act. A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the health care establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Name type data element can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection: What is the given name you would like to be known by? Are you known by any other given names that you would like recorded?

If so, what are they?

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Do not delete or overwrite a previous given name:

Whenever a person informs the establishment of a change of given name (e.g. prefers to be know by their middle name), the former name should be recorded according to the appropriate Name type.

Example – Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred Given name and record 'Mary' as the Medicare card Given name.

Example – The establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred Given name.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record 'Unknown' in the Given name field and use alias name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of 'Unknown'.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the (preferred) Given name field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a family name and a given name: they have only one name by which they are known. If the person has only one name, record it in the Family name field and leave the Given name blank.

Multiple given names (middle, second, third etc.names):

All of the person's given names should be recorded in the Given name field, leaving a space between each name.

Record complete information:

If the person has many given names and all of them cannot fit in the field, record as many names in full as possible, in preference to recording initials.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as Alias names as appropriate.

Example – The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred Given name and 'Jennifer' as her Medicare card name.

Example – The person's given name is 'Giovanni' but he prefers to be called 'John'. Record 'John' as the preferred Given name and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included.

- hyphen (e.g. Anne-Maree, Mary-Jane)

Hyphenated names shall be entered with the hyphen. Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces e.g. Jean Claude

If the person has recorded a given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way. - e.g. Oscar Peter, Wendy Hilda

Leave a single space between the person's first name and each of their middle names.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the (preferred) Given name field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred Given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple birth. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first-born baby, and 'Twin 2 of Fiona' in the Given name field of the second-born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman numerals (I, II, III).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin
 - Use Twin i.e. Twin 1 of Fiona
- Triplet
 - Use Trip i.e. Trip 1 of Fiona
 - Quadruplet
 - Use Quad i.e. Quad 1 of Fiona
- Quintuplet

Use Quin i.e. Quin 1 of Fiona

- Sextuplet

Use Sext i.e. Sext 1 of Fiona

- Septuplet

Use Sept i.e. Sept 1 of Fiona

These names should be recorded under the newborn Name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name. Record their current name as the preferred Given name and record their previously recorded given name as an Alias name.

Ethnic names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Appendix A Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Related metadata:	relates to the data element Family name vers 1
	relates to the data element Name vers 1
	relates to the data element Name context flag vers 1
	relates to the data element Name suffix vers 1
	relates to the data element Name title vers 1
	relates to the data element Name type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification, with adaptation.

Source organisation:	Standards Australia		
Information model link:			
NHIM Person characteristic			
Data Set Specifications:		Start date	End date
DSS - Health care client ident	ification	01/01/2003	

Glycosylated haemoglobin (HbA1c) – measured

Identifying and Defir Knowledgebase ID:	nitional Attributes 000824	Version No: 1		
Metadata type:	Data Element			
Admin. status:	Current			
	01/01/03			
Definition:	A person's measured glyce	osylated haemoglo	bin (HbA1c) level	
Context:	Public health, health care a	and clinical settings	3.	
Relational and Repr	esentational Attribu	ites		
Datatype:	Numeric			
Representational form:	Quantitative value			
Representational layout:	NN.N			
Minimum size:	3			
Maximum size:	4			
Data domain:	Measured in % to 1 decima	*		
	99.9 Not stated/inadequa	tely described		
Guide for use:	Record the absolute result	of the test (%).		
Verification rules:				
Collection methods:	Test is performed in accred	lited laboratories.		
	• A single blood sample required.	is sufficient and n	o preparation of t	he patient is
	Measure HbA1c ideal (HPLC)	ly using High Perfo	ormance Liquid C	hromatography
Related metadata:	relates to the data element normal range vers 1	Glycosylated haen	noglobin (HbA1c)	- upper limit of
Administrative Attrib	utes			
Source document:	National Diabetes Outcom dictionary.	es Quality Review	Initiative (NDOQ	PRIN) data
Source organisation: Information model link: NHIM Service provision ev	National Diabetes Data W ent	orking Group		
Data Set Specifications:			Start date	End date
DSS - Diabetes (clinical)			01/01/2003	
Comments	The HhAlc along with reg	ular blood glucose	monitoring is the	hest way to see

Comments: The HbAlc along with regular blood glucose monitoring is the best way to see the overall picture of blood glucose levels.

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. The level of HbA1c is proportional to the level of glucose in the blood over a period of approximately two months, because glucose attaches to the haemoglobin (red blood cells) and remains there for the life of the red blood cell, approximately 120 days. The HbA1c gives an average of the blood glucose level over the past 6– 8 weeks and therefore haemoglobin A1c is accepted as an indicator of the mean daily blood glucose concentration over the preceding two months.

HbA1c is formed by the non-enzymatic glycation of the N-terminus of the B-chain of haemoglobin Ao. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions used as a standard for assessing overall blood glucose control.

HbA1c results vary between laboratories; use the same laboratory for repeated testing

When reporting, record absolute result of the most recent HbA1c level in the last 12 months.

Research studies in the United States have found that for every 1% reduction in results of HbA1c blood tests, the risk of developing micro vascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40%.

The maintenance of good glycaemic control (in diabetes Type 1 and Type 20, significantly reduces progression of diabetes-related complications such as retinopathy, nephropathy and neuropathy, as indicated in the 'Diabetes Control and Complications Trial' (DCCT 1993) and the 'United Kingdom Prospective Diabetes Study' (UKPDS 1997).

The target proposed by the Australian Diabetes Society for glycosylated haemoglobin (HbA1c) is 7.0% or less and a doctor may order this test about every 3–6 months.

References:

Koening, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. Diabetes 259 (1976): 230–232.

Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. N. Eng. J. Med. 310 (1984): 341–346.

Glycosylated haemoglobin (HbA1c) – upper limit of normal range

Identifying and Defi	nitional Attributes
Knowledgebase ID:	000825 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
Aumin. Stutus.	01/01/03
Definition:	Laboratory standard for the value of glycosylated haemoglobin (HbA1c) that is the upper boundary of the normal reference range.
Context:	Public health, health care and clinical settings.
Relational and Repr	resentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN.N
Minimum size:	3
Maximum size:	4
Data domain:	Measured in % 99.9 Not stated/inadequately described
Guide for use:	Record the upper limit of the HbA1c normal reference range from the laboratory result.
Verification rules:	
Collection methods:	This value is usually notified in patient laboratory results and may vary for different laboratories.
Related metadata:	relates to the data element Glycosylated haemoglobin (HbA1c) – measured vers 1
Administrative Attrib	outes
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Source organisation:	National Diabetes Data Working Group
Information model link:	
NHIM Service provision ev	rent
Data Set Specifications:	Start date End date
DSS – Diabetes (clinical)	01/01/2003
Comments:	The upper limit of normal range is the laboratory standard for the maximum level of HbA1c, which is still in normal range.

These figures vary between laboratories.

HbA1c results vary between laboratories; use the same laboratory for repeated testing.

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions and is used as a standard for assessing overall blood glucose control. The target is to achieve an HbA1c within 1% of the upper limit of normal or achieve control as near to this target as possible without producing unacceptable hypoglycaemia as recommended from the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

If HbA1c is 2% above the upper limit of normal, explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise and review management:

- review and adjust treatment
- consider referral to diabetes educator
- consider referral to dietitian
- consider referral to endocrinologist or physician or diabetes centre.

Goal of care

Identifying and Definitional Attributes

Knowledgebase ID: Metadata type:	000111 Data Element	Version No:	2
Admin. status:	Current 01/07/98		
Definition:	provider and recipient, will community service and re	hich outlines th lates to a perso nto account the	of care, negotiated by the service the overall aim of actions planned by a n's health need. This goal reflects a possibility that a range of community ied time frame.
Context:		0	h the person and services provider period and takes into account the

intervention or services provided by a range of community services.

Relational and Representational Attributes

Datatype: Representational form: Representational layout: Minimum size: Maximum size:	Num Code NN 2 2	
Data domain:	01	Well person for preventative/maintenance/health promotion program
	02	Person will make a complete recovery
	03	Person will not make a complete recovery, but will rehabilitate to a state where formal on-going service is no longer required
	04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home
	05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die
	06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time
	07	For assessment only/not applicable
Guide for use:	01	service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.
	02	describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long-term health problems who are normally independent in their management.
		Goal 2 service recipient includes:
		- post-surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;
		 persons recovering from an acute illness and referred from the general practitioner or other community-based facility;

- persons with disability or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.
- 03 refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.
- 04 refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.
- 05 refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.
- 06 includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.
 - Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in Goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.
- 07 service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.
- *Verification rules:* Only one option is permissible and where Code 7 is selected, Code 9 must be used in Nursing interventions.
- **Collection methods:** At time of formal review of the client, the original Goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the Date of first contact with community nursing service and Date of last contact and in this format provides a focussing effect at the time of planning for care.
- Related metadata:relates to the data element Date of first contact vers 2
relates to the data element Date of last contact vers 2
relates to the data element Nursing diagnosis vers 2
supersedes previous data element Nursing goal vers 1
relates to the data element Nursing interventions vers 2

Administrative Attributes

Source document: Source organisation:	Australian Council of Community Nursing Services
Information model link:	
NHIM Expected outcome Data Set Specifications:	Start date End date
Comments:	Agencies who had previously implemented this item should note changes to

the code set in data domain.

Group sessions

Identifying and Definitional Attributes				
Knowledgebase ID:	000210	Version No: 1		
Metadata type:	Derived Data Element			
Admin. status:	Current			
	01/07/89			
Definition:	The number of groups of patients/clients receiving services. Each group is to count once, irrespective of size or the number of staff providing services.			
Context:	The resources required to provide services to groups of patients are different from those required to provide services to an equivalent number of individuals. Hence services to groups of non-admitted patients or outreach clients should be counted separately from services to individuals.			
Relational and Repr	esentational Attrib	utes		
Datatype:	Numeric			
Representational form:	Quantitative value			
Representational layout:	NNNNN			
Minimum size:	1			
Maximum size:	6			
Data domain:	Coloulated average of ano			
Data aomain:	Calculated number of gro	sessions		
Guide for use:				
Verification rules:				
Collection methods:	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.			
Related metadata:				
Administrative Attrib	outes			
Source document:				
Source organisation:	National minimum data s	set working parties	3	
Information model link:				
NHIM Service provision event				
Data Set Specifications:			Start date	End date
NMDS – Public hospital establishments 01/07/1989				
Comments:	This data element is deriv in the <i>National Health</i> D ways by hospitals and/or of individual consultation	<i>Data Dictionary,</i> b outpatient depart	ut which are record ments. Examples in	ded in various

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of individual consultations/visits, diagnostic tests, etc.

Health labour force

Identifying and Defi	nitional Attributes		
Knowledgebase ID:	000061	Version No: 1	
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/95		
Definition:	 All those in paid employment, unpaid contributing family workers, and unpaid volunteers: whose primary employment role is to achieve a health outcome for either individuals or the population as a whole, whether this is in clinical, research, education, administrative or public health capacities employed in the health industry defined by the Australian Bureau of Statistics using the Australian and New Zealand Standard Industrial Classification, other than those already included. The health labour force consists of all those persons included in the health work force plus all those persons not currently employed in the health work force who are seeking employment therein. Health professionals registered in Australia but working overseas are excluded from the national health labour force. Health professionals registered in a particular State or Territory but working solely in another State or Territory. 		
Context:	Health labour force statis	tics and public hospital establishments.	
Relational and Repr Datatype: Representational form: Representational layout: Minimum size: Maximum size: Data domain:	esentational Attrib	utes	
Guide for use: Verification rules:			
Collection methods:			
Related metadata:	relates to the data elemen vers 1	t Profession labour force status of health professional	
Administrative Attributes			
Source document:			
Source organisation:	National Health Labour H	Force Data Working Group	

Identifying and Definitional Attributes

Source organisation:	National Health Labour Force Data Working Group		
Information model link:			
NHIM Labour characteristic			
Data Set Specifications:		Start date	End date

Health outcome

dentifying and Demilional Allibutes				
Knowledgebase ID:	000062	Version No: 1		
Metadata type:	Data Element Concept			
Admin. status:	Current			
	01/07/97			
Definition:	A change in the health of an individual, or a group of people or a population, which is wholly or partially attributable to an intervention or a series of interventions.			
Context:	Admitted patient and nor	n-admitted patient care.		
Relational and Representational Attributes				
Datatype:				
Representational form:				

Identifying and Definitional Attributes

Minimum size: Maximum size: Data domain: Guide for use: Verification rules: Collection methods:

Representational layout:

Related metadata:

Administrative Attributes

Source document:			
Source organisation:	National Health Information Management G	roup	
Information model link:			
NHIM Stated outcome			
Data Set Specifications:		Start date	End date

Health outcome indicator

Identifying and Definitional Attributes Knowledgebase ID: 000063 Version No: 1 Metadata type: Data Element Concept Admin. status: Current 01/07/97 Definition: A statistic or other unit of information which reflects, directly or indirectly, the effect of an intervention, facility, service or system on the health of its target population, or the health of an individual. A generic indicator provides information on health, perceived health or a specific dimension of health using measurement methods that can be applied to people in any health condition. A condition-specific indicator provides information on specific clinical • conditions or health problems, or aspects of physiological function pertaining to specific conditions or problems. Epidemiological terminology An association exists between two phenomena (such as an intervention and a health outcome) if the occurrence or quantitative characteristics of one of the phenomena varies with the occurrence or quantitative characteristics of the other. One phenomenon is attributable to another if there is a casual link between the phenomena. Attribution depends upon the weight of evidence for causality. Association is necessary (but not sufficient) for attribution. Associations ٠ may be fortuitous or causal. The term relationship is to be taken as synonymous with association. Context: Admitted patient and non-admitted patient care. **Relational and Representational Attributes** Datatype:

Representational form: Representational layout: Minimum size: Maximum size: Data domain: Guide for use: Verification rules: Collection methods: **Related metadata:**

Administrative Attributes

Source accument:		
<i>Source organisation:</i> National Health Information Management Group		
Information model link:		
NHIM Stated outcome		
Data Set Specifications:	Start	date End date

C 1 1

Health professionals attended – diabetes mellitus

Identifying and Define	nitional Attributes		
Knowledgebase ID:	000804	Version No: 1	
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The health professionals relation to issues arising	that a person has attended in the last 12 months in from diabetes mellitus.	
Context:	Diabetes (clinical) specific data element.		
Relational and Repr	esentational Attrib	outes	
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	N(NNNN)		
Minimum size:	1		
Maximum size:	5		
Data domain:	1 Diabetes educator		
	2 Dietitian		
	3 Ophthalmologist		
	4 Optometrist		
	5 Podiatrist		
	8 None of the above		
	9 Not stated/inadeq	uately described	
Guide for use:	Record a code sequential	ly for each health professional attended.	
		ided several health professionals in the last 12 months, code can be recorded sequentially.	
		as attended a diabetes educator and a podiatrist in the ode recorded would be 15.	
	Example 2: If all have be	en seen, the code recorded would be 12345.	
Varification miles			
Collection methods:	Verification rules: Collection methods: The person should be asked about each type of health professional in successive questions, as follows: Have you attended any of the following health professionals in relation to diabetes mellitus in the last 12 months?		
	Diabetes educator	YesNo	
	Dietitian	YesNo	
	Ophthalmologist	YesNo	
	Optometrist	Yes No	
	Podiatrist	YesNo	
	The appropriate code should be recorded for each health professional attended.		
	If the person answers 'Ne should be applied.	O' to all the health professionals specified, then code 8	

Identifying and Definitional Attributes

	Code 9 should only be used in situations questions.	s where it is not practic	cable to ask the	
Related metadata:	relates to the data element Occupation of	of person vers 2		
Administrative Attrib	outes			
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.			
Source organisation: Information model link:	National Diabetes Data Working Group			
NHIM Request for/entry in	nto service event			
Data Set Specifications:		Start date	End date	
DSS – Diabetes (clinical)		01/01/2003		
Comments:	The health professional occupations are assigned the following codes at the occupation level of the Australian Standard Classification of Occupations, Second Edition, Australian Bureau of Statistics, 1997, Catalogue No. 1220.0			
	Diabetic educator 2512-13			
	Dietitian 2393-11			
	Ophthalmologist 2312-19			
	Optometrist 2384-11 Podiatrist 2388-11			
	Management of diabetes requires a team approach, comprising selected health			
	professionals, to provide services specific to the individual with diabetes.			
	All patients with diabetes require diet therapy in conjunction with exercise and/or medication to achieve optimal control of blood glucose, body weight and blood lipids. In insulin treated diabetics, diet management aims to restrict variations in the timing, size or composition of meals that could result in hypoglycaemia or postprandial hyperglycaemia. Based on the Healthy Eating Pyramid, meals should be low in saturated fat, and rich in high-fibre carbohydrates with low glycaemic index (GI). Saturated fats have to be replaced with monounsaturated and polyunsaturated fats.			
	According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, a comprehensive ophthalmological examination should be carried out:			
	 at diagnosis and then every 1–2 years for patients whose diabetes onset was at age 30 years or more 			
	 within five years of diagnosis and then every 1–2 years for patients whose diabetes onset was at age less than 30 years. 			
	Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:			
	 foot examination to be performed every 6 months or at every visit if high-risk foot or active foot problem 			
	 refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present 			
	problems, especially ulceration, a	 to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of peripheral neuropathy, peripheral vascular disease, or foot deformity and history of previous ulceration 		
	 ensure that patients with 'high-risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems. 			

Height – measured

Knowledgebase ID:	000362	Version No: 2	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	A person's measured height.		
	In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.		
Context:	Public health, health care and clinical settings:		
	Stature is a major indicator of general body size and of bone length and of nutritional and health status of the individual and the community at large. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all-cause mortality, coronary heart disease mortality in middle-aged men, and of less favourable gestational outcomes in women (Marmot et al. 1984, Kramer 1988).		
Measurements of height should be assessed in relation to childre adolescents' age and pubertal status.			
	the height of an individua weight, is of unique value body mass index which re	tic and environmental factors all exert an influence on al, hence this variable, together with its related variable in health surveillance. It enables the calculation of equires the measurement of height and weight (body as sex and date of birth for children and adolescents.	

Identifying and Definitional Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN.N
Minimum size:	3
Maximum size:	4
Data domain:	Measurement in centimetres to one decimal place
	999.9 Not able to be measured
Guide for use:	
Verification rules:	
Collection methods:	Measurement protocol:
	Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.
	The measurement of height requires a vertical metric rule, a horizontal headboard, and a non-compressible flat even surface on which the subject stands. The equipment may be fixed or portable, and should be described and reported.
	The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm.

Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject stands on a platform scale is not recommended.

Adults and children who can stand:

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems). The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board. To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base-board.

The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement. If the two measurements disagree by more than 0.5 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured height is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over-reporting (Armitage & Berry 1994). For example, a mean value of 172.25 cm would be rounded to 172.2 cm, while a mean value of 172.35 cm would be rounded to 172.4 cm.

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5–1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the

	date be recorded when the change is made from supine to standing height measure.
	Validation and quality control measures:
	All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level. Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.
	Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.
Related metadata:	supersedes previous data element Adult height - measured vers 1
	is used in the calculation of Body mass index vers 2
Administrative Att	ributes
Source document:	The measurement protocol described below are those recommended by the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996), and the World Health Organization (WHO Expert

Source organisation:	International Society for the Advancement of Kinanthropometry World Health Organization
	The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing.
T. C	

Committee 1995), which was adapted from Lohman et al. (1988).

Information model link:

NHIM Physical characteristic

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

Comments:

This data element applies to persons of all ages. It is recommended for use in population surveys and health care settings.

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

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

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be

presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men, women, children and adolescents although the range will depend on the population.

Ht < 70 cm 70 cm = Ht < 75 cm 75 cm = Ht < 80 cm ... in 5 cm categories 185 cm = Ht < 190 cm Ht => 190 cm

Height - self-reported

Knowledgebase ID:	000363	Version No: 2	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	A person's self-reported height.		
Context:	Public health and health care:		
	Stature is a major indicator of general body size and of bone length and of nutritional and health status of the individual and the community at large. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all cause mortality and coronary heart disease mortality in middle aged men (Marmot et al. 1984) and of less favourable gestational outcomes in women (Kramer 1988). Self-reported or parentally reported height for children and adolescents should be used cautiously if at all. It enables the calculation of body mass index which requires the measurement of height and weight (body mass) for adults.		

Identifying and Definitional Attributes

Datatume	Numeric	
Datatype:		
Representational form:	Quantitative value	
Representational layout:	NNN	
Minimum size:	2	
Maximum size:	3	
Data domain:	Measurement in centimetres to the nearest centimetre	
	888 Unknown	
	999 Not stated/inadequately described	
Guide for use:		
Verification rules:		
Collection methods:	The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported. The data collection form should include a question asking the respondent what their height is. For example, the Australian Bureau of Statistics' National Health Survey 1995 included the question 'How tall are you without shoes?'. The data collection form should allow for both metric (to the nearest 1 cm) and imperial (to the nearest 0.5 inch) units to be recorded.	
	If practical, it is preferable to enter the raw data into the database before conversion of measures in imperial units to metric. However if this is not possible, height reported in imperial units can be converted to metric prior to data entry using a conversion factor of 2.54 cm to the inch.	
	Rounding to the nearest 1 cm will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 cm. The following rounding conventions are desirable to reduce systematic over-reporting (Armitage & Berry 1994):	

	nnn.x where x < 5 – round down, e.g. 172.2	cm would be rour	adad to 172 cm	
	nnn.x where $x > 5$ – round up, e.g. 172.7 cm			
	nnn.x where $x = 5$ – round to the nearest ev			
	rounded to 172 cm, while 173.5 cm would b			
Related metadata:	supersedes previous data element Adult he	eight – self-reported	d vers 1	
	is used in the calculation of Body mass inde	ex vers 2		
Administrative Attrib	outes			
Source document:				
Source organisation:				
Information model link:				
NHIM Physical characteris	tic			
Data Set Specifications:		Start date	End date	
Comments:	This data element is recommended for pers recommended for use in population survey height.			
	It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.			
	National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.			
	Presentation of data:			
	Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.			
	For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.			
	For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140–190 cm.			
	Ht < 140 cm			
	140 cm = Ht < 145 cm			
	145 cm = Ht < 150 cm			
	in 5 cm categories			
	185 cm = Ht < 190 cm			
	Ht => 190 cm			
	On average, height tends to be overestimated when self-reported by respondents. Data for Australian men and women aged 20–69 years in 1989 indicated that men overestimated by an average of 1.1 cm (sem of 0.04 cm) and women by an average of 0.5 cm (sem of 0.05 cm) (Waters 1993). The extent of overestimation varied with age.			

Hip circumference – measured

Knowledgebase ID: 000370 Version No: 2 Metadata type: Data Element Admin. status: Current 01/07/03 Definition: A person's hip circumference measured at the level of maximum posterior extension of the buttocks. In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used. Context: Public health and health care: Its main use is to enable the calculation of adult Waist-to-hip ratio which requires the measurement of hip circumference and waist circumference.

Identifying and Definitional Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN.N
Minimum size:	3
Maximum size:	4
Data domain:	Measurement in centimetres to the nearest 0.1 cm
Dulu uomum.	999.9 Not able to be measured
	555.5 Not able to be measured
Guide for use:	As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to collect this item for those aged under 18 years.
Verification rules:	
Collection methods:	Measurement protocol:
	The data collection form should allow for up to three measurements of hip circumference to be recorded in centimetres to 1 decimal place. The data collection form should also have the capacity to record any reasons for the non-collection of hip circumference data.
	The measurement of hip circumference requires a narrow (< 7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.
	The subject should wear only non-restrictive briefs or underwear, a light smock over underwear or light clothing. Belts and heavy outer clothing should be removed. Hip measurement should be taken over one layer of light clothing only.
	The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the

	two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.
	The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement.
	All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the data base as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured hip circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.
	It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting. For example, a mean value of 102.25 cm would be rounded to 102.2 cm, while a mean value of 102.35 cm would be rounded to 102.4 cm.
	Validation and quality control measures:
	Steel tapes should be checked against a 1-metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.
	Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.
	Extreme values at the lower and upper end of the distribution of measured hip circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.
	Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.
Related metadata:	supersedes previous data element Adult hip circumference – measured vers 1 is used in the calculation of Waist-to-hip ratio vers 2
Administrative Attrib	outes
Source document:	The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995).
Source organisation:	World Health Organization (see also Comments)
Information model link:	
NHIM Physical characteris	tic
Data Set Specifications:	Start date End date
Comments:	This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.
	More recently it has emerged that waist circumference alone, or in combination

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the

errors in waist-to-hip ratio measurements.

Waist-to-hip ratio is therefore no longer a commonly used measure.

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

Presentation of data:

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

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

For some reporting purposes, it may be desirable to present hip circumference data in categories. It is recommended that 5 cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation

Hospital

Identifying and Definitional Attributes

Knowledgebase ID:	000064	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	<i>min. status:</i> Current 01/07/94	
Definition:	A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.	
Context:	Admitted patient care, ad	mitted patient palliative care, admitted patient mental

health care and public hospital establishments.

Relational and Representational Attributes

relates to the data element Establishment sector vers 3

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Service delivery sett	ing		
Data Set Specifications:		Start date	End date
Comments:	A hospital thus defined may be located at or multicampus hospital. A multicampus hosp between sites as ward transfers.	1 5	5
	For the purposes of these definitions, the ter managed and staffed by the hospital.	m hospital include	es satellite units
	This definition includes but is not limited to	hospitals as reco	onised under

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

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

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

Hospital boarder

Identifying and Defin	nitional Attributes		
Knowledgebase ID:	000065	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/94		
Definition:	A person who is receiving hospital does not accept a		accommodation but for whom the or treatment and/or care.
Context:	Admitted patient care.		
Relational and Repr	esentational Attrib	utes	
Datatype:			
Representational form:			
Representational layout:			
Minimum size:			
Maximum size:			
Data domain:			
Guide for use:	A boarder thus defined is register a boarder.	not admitted t	o the hospital. However, a hospital may
			nnot be boarders. They are admitted be either a qualified or unqualified
Verification rules:			
Collection methods:			
Related metadata:			
Administrative Attrib	outes		

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recipient role			
Data Set Specifications:		Start date	End date

Comments:

Hospital census

Identifying and Defir	nitional Attributes		
Knowledgebase ID:	000066	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/01/95		
Definition:	A point in time count by a currently on a waiting list	-	its admitted patients and/or patients
Context:	Admitted patient care.		
Relational and Repr	esentational Attribution	utes	
Datatype:			
Representational form:			
Representational layout:			
Minimum size:			
Maximum size:			
Data domain:			
Guide for use:			
Verification rules:			
Collection methods:			
Related metadata:	relates to the data element	t Census date v	rers 2
	relates to the data elemen	t Waiting time	at a census date vers 2

Identifying and Definitional Attributes

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Surveillance/monitoring event Data Set Specifications:

Start date End date

Comments:

Hospital insurance status

Identifying and Definitional Attributes

identifying and Dem					
Knowledgebase ID:	0000	75	Version No:	3	
Metadata type:	Data	Element			
Admin. status:	Curre	ent			
	01/07	7/97			
Definition:	Hospital insurance under one of the following categories:				
	-	Registered insuran registered under th	-		
	_	General insurance company under a g similar to those ava	guaranteed renew	vable policy provid	
	-	No hospital insura	nce or benefits co	overage under the a	above.
Context:	To as	sist in analysis of uti	lisation and heal	th care financing.	
Relational and Repr	resen	tational Attrib	utes		
Datatype:	Num	eric			
Representational form:	Code				
Representational layout:	Ν				
Minimum size:	1				
Maximum size:	1				
Data domain:	1	Hospital insurance			
	2	No hospital insurar	nce		
	9	Unknown			
Guide for use:		ns covered by insura no hospital insuran		of ancillary service	s only are included
	The 'unknown' category should not be used in primary collections but can be used to record unknown insurance status in databases.				
		tem is to determine od of payment for th	-	-	surance, not their
Verification rules:					
Collection methods:					
Related metadata:	super	sedes previous data	element Insuran	ce status vers 2	
Administrative Attrib	outes				
Source document:					
Source organisation:	Natio	nal Health Data Cor	nmittee		
Information model link:					
NHIM Insurance/benefit cl	haracter	ristic			
Data Set Specifications:				Start date	End date
				01 /05 /1005	20 10(12000

NMDS - Admitted patient care

01/07/1997

30/06/2000

Comments:	Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the <i>Health Legislation (Private Health Insurance Reform) Amendment Act</i> 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 <i>National Health Act</i> 1953. All hospital tables offered by registered private health insurers since 29 May 1995 have been referred to as 'Applicable Benefits

 $\label{eq:and_action} Arrangements' \ and \ marketed \ under \ the \ insurer's \ own \ product \ name.$

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Hospital waiting list

Knowledgebase ID: Version No: 2 000067 Metadata type: Data Element Concept Admin. status: Current 01/07/02 Definition: A register which contains essential details about patients who have been assessed as needing elective hospital care. Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours. Patients on waiting lists for elective hospital care can be 'ready for care' or 'not ready for care' (as defined in Patient listing status). Context: Admitted patient care.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element concept Elective care vers 1
	relates to the data element Patient listing status vers 3
	relates to the data element Waiting list category vers 3

Administrative Attributes

Source document: Source organisation: Information model link: NHIM Assessment event Data Set Specifications:

Start date End date

Comments:

Hospital-in-the-home care

Identifying and Definitional Attributes

Identifying and Dem	
Knowledgebase ID:	000633 Version No: 1
Metadata type:	Data Element Concept
Admin. status:	Current
	01/07/01
Definition:	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
Context:	Admitted patient care.
Relational and Repr	resentational Attributes
Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	The criteria for inclusion as hospital-in-the-home include but are not limited to:
	 without hospital-in-the-home care being available patients would be accommodated in the hospital
	 the treatment forms all or part of an episode of care for an admitted patient (as defined in the Admitted patient data element concept)
	 the hospital medical record is maintained for the patient
	 there is adequate provision for crisis care.
	Selection criteria for the assessment of suitable patients include but are not limited to:
	 the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment
	 the patient does not require continuous 24-hour assessment, treatment or observation
	 the patient agrees to this form of treatment
	 the patient's place of residence is safe and has carer support available;
	 he patient's place of residence is accessible for crisis care
	 the patient's place of residence has adequate communication facilities and access to transportation.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Admitted patient vers 3
	relates to the data element concept Episode of care vers 1
	× ×

Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee

Information model link:NHIMService provision eventData Set Specifications:

Comments:

Start date End date

Hours on-call (not worked) by medical practitioner

, ,			
Knowledgebase ID:	000393	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	The number of hours in a available to provide advic		edical practitioner is required to be ny emergencies etc.
Context:	Health labour force:		
	Used in relation to issues working conditions etc.	of economic ac	tivity, productivity, wage rates,
	Used to develop capacity	measures relat	ing to total time available.
	Assists in analysis of hum	an resource rec	quirements and labour force modelling.
	equivalents (FTE) (see ent	ry for FTE). Of urs) and knowi	he work status and to compute full-time ten the definition for full-time or FTE ng total hours and numbers of

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	3
Maximum size:	3
D. (. L	
Data domain:	Total hours, expressed as 000, 001 etc. 999 Not stated / inadequately described
	999 Not stated / inadequately described
Guide for use:	Data element relates to each position (job) held by a medical practitioner.
Verification rules:	Value must be less than 169 (except for 999).
Collection methods:	There are inherent problems in asking for information on number of hours on-call not worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours on-call not worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
Related metadata:	supersedes previous data element Hours worked vers 1 relates to the data element Hours worked by medical practitioner in direct patient care vers 2 relates to the data element Total hours worked by a medical practitioner vers 2

Administrative Attributes

Source document:

Source organisation:	National Health Labour Force Data Working Group
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Information model link:NHIMLabour characteristicData Set Specifications:NMDS - Health labour force

Comments:

 Start date
 End date

 01/07/1997

Hours worked by health professional

Knowledgebase ID:	000313	Version No: 2		
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/97			
Definition:	Hours worked is the amount of time a person spends at work in a week in employment/self-employment. It may apply to hours actually worked in a week or hours usually worked per week, and the National Health Labour Force Collection collects hours usually worked. It includes all paid and unpaid overtime less any time off.			
	It also:			
	 includes travel to h 	nome 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.			
	Force Collection asks for h	rked, for some professions the National Health Labour nours worked in each of the main job, second job and for each of these is the amount of time spent at work in		
Context:	Health labour force:			
	rates, working conditions total time available. Assist labour force modelling. U and to compute full-time or definition for full-time or	tion to issues of economic activity, productivity, wage etc. Used to develop capacity measures relating to ts in analysis of human resource requirements and sed to determine full-time and part-time work status equivalents (FTE) (see entry for FTE). Often the FTE differs (35, 37.5 and 40 hours) and knowing total lividuals allows for variances in FTE.		

Identifying and Definitional Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	3
Maximum size:	3
Data domain:	Total hours, expressed as 000, 001 etc. 999 Not stated/inadequately described
Guide for use:	
Verification rules:	Value must be less than 127 (except for 999).
Collection methods:	There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related metadata: supersedes previous data element Hours worked vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Labour Force Data Working	Group	
Information model link:			
NHIM Labour characteristic	2		
Data Set Specifications:		Start date	End date
NMDS - Health labour force		01/07/1997	

Comments:

It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Hours worked by medical practitioner in direct patient care

Knowledgebase ID:	000392	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	provision to patients inc	orked in a week by a medical practitioner on service cluding direct contact with patients, providing care, lling, and providing other related services such as ptions and phone calls.
Context:	Health labour force:	
	working conditions etc.	s of economic activity, productivity, wage rates, Used to develop capacity measures relating to total analysis of human resource requirements and labour

Identifying and Definitional Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	3
Maximum size:	3
Data domain:	Total hours, expressed as 000, 001 etc.
	999 Not stated/inadequately described
Guide for use:	Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked for all jobs.
Verification rules:	Value must be less than 127 (except for 999).
Collection methods:	There are inherent problems in asking for information on number of hours usually worked per week in direct patient care, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked in direct patient care are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
Related metadata:	relates to the data element Hours on-call (not worked) by medical practitioner vers 2
	supersedes previous data element Hours worked vers 1
	relates to the data element Total hours worked by a medical practitioner vers 2

Administrative Attributes

Source document:			
Source organisation:	National Health Labour Force Data Working	Group	
Information model link:			
NHIM Labour characteristic	c		
Data Set Specifications:		Start date	End date
NMDS - Health labour force		01/07/1997	

Comments: It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Hypertension – treatment

Identifying and Define	nitional Attributes		
Knowledgebase ID:	000826 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether an individual is currently treated for hypertension (high blood pressure) using antihypertensive medication.		
Context:	Public health, health care and clinical settings.		
Relational and Repr	resentational Attributes		
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Yes, currently being treated for hypertension using antihypertensive medication		
	2 No, not currently being treated for hypertension using antihypertensive medication		
	9 Not stated/inadequately described		
Guide for use:	Record whether or not on treatment for hypertension.		
	Only record yes if on an antihypertensive medication for their blood pressure.		
Verification rules:			
Collection methods:	Ask the individual if he/she is currently treated with anti-hypertensive medications. Alternatively obtain the relevant information from appropriate documentation.		
Related metadata:	relates to the data element Blood pressure – diastolic measured vers 1		
	relates to the data element Blood pressure – systolic measured vers 1		
	relates to the data element Cardiovascular medication - current vers 1		
	relates to the data element Date of birth vers 4		
Administrative Attrib	outes		
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
Source organisation: Information model link: NHIM Physical wellbeing	National Diabetes Data Working Group		

Identifying and Definitional Attributes

Data Set Specifications:		Start date	End date	
DSS – Diabetes (clinical)		01/01/2003		
Comments:	Hypertension is probably the most important public health problem in developed countries. It is common, asymptomatic, readily detectable, usually easily treatable, and often leads to lethal complications if left untreated.			
	Elevated blood pressure (Hypertension) is a recognised risk for microvascular and macro vascular complications of diabetes (coronary, cerebral and peripheral).			
	Hypertension is elevated arterial blood pres (130 to 139/85 to 89 mm Hg) and values abo hypertension. Lower levels of target blood p specific groups, e.g. in diabetics aim for bloo 135/80 mm Hg.	ove these are defin pressure should be	ed as aimed for in	
	Many diabetics fail to control high blood pre- high blood pressure, 29% were unaware tha only slightly more than half were receiving treatment. Numbers of studies have shown pressure is at least as important as good con reduction of cholesterol in preventing the co	t they had high bl hypertensive med that good manage trol of blood gluco	ood pressure and ications as ment of blood ose and the	
	Antihypertensives – Australian Medicines F blood control in diabetes usually requires cc (Australian Diabetes society) Therapeutic G	mbination therap	y as stated by	
	People taking antihypertensives are also end changes, such as quit smoking, lose weight a The level of blood pressure should generally four occasions prior to initiating antihyperte	and have regular p / be established or	physical activity. at least two to	
	Systematic reviews of studies that have repordiabetes and hypertension indicate that comrequired and may be more beneficial than metherapy to control hypertension has not been the special report published in the American inhibitor therapy alone doesn't achieve good therapy should be implemented. (Heart Centeral Cente	bination therapy in nonotherapy. In the n advocated much n Journal of Kidne d blood pressure c	is frequently e past multi-drug , but according to y Diseases, if ACE	
	References:			
	Pahor M, Psaty BM, Furberg CD. Treatment diabetes. Lancet 1998; 351:689–90.	of hypertensive p	atients with	
	Tight blood pressure control and risk of mac complications in type 2 diabetes: UKPDS 38. Group (erratum appears in Br Med J 1999; 3	. UK Prospective I		
	Br Med J 1998; 317:703–13. Grossman E, Mes Pressel SL, Cutler JA, Savage PJ, Applegate diuretic-based antihypertensive treatment o older diabetic patients with isolated systolic	WB, Black H, et al n cardiovascular c	. Effect of	
	Systolic Hypertension in the Elderly Program JAMA 1996; 276:1886–92. Hypertension in d 2002).			
	American Journal of Preventive Medicine 20	002;21.		

Hypoglycaemia – severe

Identifying and Definitional Attributes

Knowledgebase ID:	000827	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:		as had severe hypoglycaemia, which is defined as assistance from another party.
Context:	Public health, health care	and clinical settings:
	51 65	l as an abnormally low level of glucose in the blood, ood glucose level falls to values low enough to cause

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Yes, has had severe hypoglycaemia requiring assistance from another party	
	2 No, has not had severe hypoglycaemia requiring assistance from another party	
	9 Not stated/inadequately described	
Guide for use:	Record whether or not the person has a history of severe hypoglycaemia requiring assistance.	
Verification rules:		
Collection methods:	Ask the individual if he/she has had a severe hypoglycaemia requiring assistance. Alternatively obtain the relevant information from appropriate documentation.	
Related metadata:	relates to the data element Glycosylated haemoglobin (HbA1c) – measured vers 1	
	relates to the data element Glycosylated haemoglobin (HbA1c) – upper limit of normal range vers 1	
Administrativo Attrib	utes	

Administrative Attributes

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

Information model link:		
NHIM Physical wellbeing		
Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	

Comments:

When reporting:

• Record whether the individual has had severe hypoglycaemia requiring assistance from another party in the last 12 months. The medications used in the treatment of diabetes may cause the blood glucose value to fall below the normal range and this is called hypoglycaemia.

Most hypoglycaemic reactions, however, do not cause long term problems, but the risks of permanent injury to the brain are greater in children under the age of 5 years, the elderly with associated cerebrovascular disease and patients with other medical conditions such as cirrhosis and coeliac disease. The serious consequences of hypoglycaemia relate to its effects on the brain. Rarely hypoglycaemia may cause death.

It is important to know how to recognise and react when someone is unconscious from hypoglycaemia. These people should be placed on their side and the airway checked so that breathing is unhampered and nothing should be given by mouth as food may enter the breathing passages. Treatment needs to be given by injection – either glucagon (a hormone which raises the blood glucose by mobilising liver stores) or glucose itself. Glucagon should be given by injection (usually intramuscular) at a dose of 0.5 units (or mg) in children under the age of 5 years and 1.0 units (or mg) for all older age groups.

All diabetic patients at risk of developing hypoglycaemia should have glucagon at home. Their families need to be shown how to administer it in times of severe hypoglycaemia.

Reference:

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

Report of the Health Care Committee Expert Panel on Diabetes; Commonwealth of Australia 1991; ISBN 0644143207.

Indicator procedure

lacitarying and De		
Knowledgebase ID:	000073	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	An indicator procedure is associated with long wait	s a procedure which is of high volume, and is often ting periods.
Context:	Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision. It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful. Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.	

Identifying and Definitional Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	NN		
Minimum size:	2		
Maximum size:	2		
Data domain:	01	Cataract extraction	
	02	Cholecystectomy	
	03	Coronary artery bypass graft	
	04	Cystoscopy	
	05	Haemorrhoidectomy	
	06	Hysterectomy	
	07	Inguinal herniorrhaphy	
	08	Myringoplasty	
	09	Myringotomy	
	10	Prostatectomy	
	11	Septoplasty	
	12	Tonsillectomy	
	13	Total hip replacement	
	14	Total knee replacement	
	15	Varicose veins stripping and ligation	
	16	Not applicable	

Guide for use:	These procedure terms are defined by the ICD-10-AM (2002) codes which are listed in comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance.		
	These are planned procedures for the ware performed during hospitalisation.	aiting list, not what is a	actually
Verification rules:	Zero filled, right justified.		
Collection methods:			
Related metadata:	supersedes previous data element Indicator procedure - ICD-9-CM code		
	is used in conjunction with Procedure ve	ers 5	
	supplements the data element Waiting li	ist category vers 3	
Administrative Attrib	utes		
Source document:	International Classification of Diseases – Modification (3rd edition 2002) Nationa Sydney.		
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Service provision ev	ent		
Data Set Specifications:		Start date	End date
NMDS – Elective surgery wai	iting times	01/07/2002	
Comments:	The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures. The following is a list of ICD-10-AM codes, for the indicator procedures:		
	Cataract extraction: 42698-00 [195] 42702-00 [195] 42702-01 [1 42702-03 [196] 42698-02 [197] 42702-04 [1 42702-06 [198] 42702-07 [198] 42698-04 [1 42731-01 [200] 42698-05 [200] 42702-10 [2 42719-00 [201] 42731-00 [201] 42719-02 [2 42702-11 [200] 42719-00 [201] 42722-00 [2	.95] 42698-01 [196] 427 .97] 42702-05 [197] 426 .99] 42702-08 [199] 427 .00] 42734-00 [201] 427 .01] 42791-02 [201] 427	02-02 [196] 98-03 [198] 02-09 [199] 88-00 [201]
	Cholecystectomy: 30443-00 [965] 30454-01 [965] 30455-00 [9 30448-00 [965] 30449-00 [965]	965] 30445-00 [965] 304	46-00 [965]
	Coronary artery bypass graft: 38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672] 38497-04 [673] 38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674] 38503-00 [674] 38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676] 38500-03 [677] 38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679] 90201-01 [679] 90201-02 [679] 90201-03 [679]		
	Cystoscopy: 36812-00 [1088] 36812-01 [1088] 36836-00	[1097]	
	Haemorrhoidectomy: 32138-00 [949] 32132-00 [949] 32135-00 [9	949] 32135-01 [949]	
	Hysterectomy: 35653-00 [1268] 35653-01 [1268] 35653-02 35670-00 [1268] 35667-00 [1268] 35664-00 35756-00 [1269] 35673-00 [1269] 35673-01 35756-01 [1269] 35756-02 [1269] 35667-01 90450-01 [989] 90450-02 [989]	[1268] 35657-00 [1269] [1269] 35753-00 [1269]	35750-00 [1269] 35753-01 [1269]

Myringotomy:

Prostatectomy:

36869-01 [1162] Septoplasty:

Tonsillectomy:

32514-00 [737]

41672-02 [379] 41679-03 [379]

41789-00 [412] 41789-01 [412]

49333-00 [1492] 49345-00 [1492]

Varicose veins stripping and ligation:

Total hip replacement:

Total knee replacement:

Inguinal herniorrhaphy: 30614-03 [990] 30615-00 [997] 30609-03 [990] 30614-02 [990 30609-02 [990]

41626-00 [309] 31626-01 [309] 41632-00 [309] 41632-01 [309]

49521-03 [1519] 49524-00 [1519] 49524-01 [1519] 49527-00

41527-00 [313] 41530-00 [313] 41533-01 [313] 41542-00 [315] 41635-10 [313]

37203-00 [1165] 37203-01 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01 [1166] 37200-00 [1166] 37200-01 [1166] 37203-05 [1166] 37203-06 [1166] 37200-03 [1167] 37200-04 [1167] 37209-00 [1167] 37200-05 [1167] 90407-00 [1168] 36839-03 [1162]

49318-00 [1489] 49319-00 [1489] 49324-00 [1492] 49327-00 [1492] 49330-00 [1492]

49518-00 [1518] 49519-00 [1518] 49521-00 [1519] 49521-01 [1519] 49521-02 [1519]

32508-00 [727] 32508-01 [727] 32511-00 [727] 32504-01 [728] 32505-00 [728]

Myringoplasty:

Indigenous status

Knowledgebase ID:	000001	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	Aboriginal or Torres Stra	iit Islander origi Commonwealth	er a person identifies as being of n. This is in accord with the first two of a definition. See Comments for the
Context:	Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area.		
	identify as being of Abor wishing to determine the services or rights will nee	iginal or Torres eligibility of in ed to make their for these purpos	ovide information about people who Strait Islander origin. Agencies dividuals for particular benefits, own judgements about the suitability ses, having regard to the specific med.

Identifying and Definitional Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Aboriginal but not Torres Strait Islander origin		
	2 Torres Strait Islander but not Aboriginal origin		
	3 Both Aboriginal and Torres Strait Islander origin		
	4 Neither Aboriginal nor Torres Strait Islander origin		
	9 Not stated/inadequately described		
Guide for use:	This data element is based on the Australian Bureau of Statistics' (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS web site as indicated below in the Source document section.		
	The classification for 'Indigenous status' has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:		
	Indigenous:		
	 Aboriginal but not Torres Strait Islander origin 		
	 Torres Strait Islander but not Aboriginal origin 		
	 both Aboriginal and Torres Strait Islander origin 		
	300		

	Non-indigenous:
	 neither Aboriginal nor Torres Strait Islander origin
	Not stated/inadequately described:
	This category is not to be available as a valid answer to the questions but is intended for use:
	 primarily when importing data from other data collections that do not contain mappable data
	 where an answer was refused
	 where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.
	Only in the last two situations may the tick boxes on the questionnaire be left blank.
Verification rules:	
Collection methods:	The standard question for Indigenous status is as follows:
	[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?
	(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)
	No
	Yes, Aboriginal
	Yes, Torres Strait Islander□
	This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject.
	When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.
	This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.
	The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:
	If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).
	If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander origin'.
	If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander origin' (i.e. disregard the 'No' response).
	This approach may be problematical in some data collections, for example when data are collected by interview or using screen-based data capture systems. An additional response category:
	Yes, both Aboriginal and Torres Strait Islander \Box
	may be included if this better suits the data collection practices of the agency concerned.

Related metadata: supersedes previous data element Indigenous status vers 3

Administrative Attributes

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

Source organisation:	Australian Bureau of Statistics
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	0
Inform	ation model link:
NHIM	Social characteristic

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

Comments:

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

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

There are three components to the Commonwealth Definition:

- descent
- self-identification
- community acceptance.

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

Indirect health care expenditure

Identifying and Defir	nitional Attributes		
Knowledgebase ID:	000326	Version No: 1	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	Expenditures on health care that cannot be directly related to programs operated by a particular establishment (that is, can only be indirectly related to particular establishments). To be provided at the State level but disaggregated into patient transport services, public health and monitoring services, central and statewide support services, central administrations and other indirect health care expenditure.		
Context:	Health expenditure:		
	care expenditure and assi establishments in differer which support services an	iate financial reporting in relation to indirect health ist in understanding differences in costs for similar at States and regions, due to differences in the extent to and other services to residents/inpatients and ents may be provided by the establishment itself or by	
Relational and Repr	esentational Attrib	utes	
Datatype:	Numeric		
Representational form:	Currency		
Representational layout:	\$999,999,999		
Minimum size:	2		
Maximum size:	12		
Data domain:	Australian dollars to the 1	nearest whole dollar	
Guide for use:	Record values up to hund	lreds of millions of dollars.	
	Indirect health care exper following categories:	nditure is to be reported separately for each of the	
	1 Patient transport se	ervices:	
	(or ambulance) for service	profit organisations which provide patient transport es associated with inpatient or residential episodes at s within the scope of this data set.	
	establishments (for examp This category includes cer example, Queensland Am	atient transport services provided by other types of ple, public hospitals) as part of their normal services. ntralised and statewide patient transport services (for nbulance Transport Brigade) which operate ual inpatient establishments.	
	2 Public health and n	nonitoring services:	
	statewide or national pub programs concerned prim	profit services and organisations with centralised, blic health or monitoring services. These include narily with preventing the occurrence of diseases and d includes such activities as mass short X ray.	

Identifying and Definitional Attributes

mitigating their effect, and includes such activities as mass chest X-ray

campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical

services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council.

Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.

3 Central and statewide support services:

Public or registered services which provide central or statewide support services for residential establishments within the scope of this data set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross.

4 Central administrations:

Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (for example, the Department of Veterans' Affairs).

5 Other:

Any other indirect health care expenditure as defined above not catered for in the above categories. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information.

Verification rules: Collection methods: Related metadata:

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recurrent expenditure			
Data Set Specifications:		Start date	End date
NMDS - Public hospital estab	lishments	01/07/1989	

Comments:

Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the State level and were also concerned at the lack of uniformity between States. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Individual/group session

Identifying and Definitional Attributes Knowledgebase ID: Version No: 1 000235 Metadata type: Data Element Admin. status: Current 01/07/89 A group is defined as two or more patients receiving services at the same time Definition: from the same hospital staff. However, this excludes the situation where individuals all belong to the same family. In such cases, the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual. Context: Required to distinguish between those occasions of service on an individual patient basis and those servicing groups of patients. This distinction has

Relational and Representational Attributes

resource implications.

Datatype:	Alphanumeric		
Representational form:	Code		
Representational layout:	ANN.N		
Minimum size:	5		
Maximum size:	5		
Data domain:	A12.1 A12.2	Individual sessions Group sessions	
Guide for use:			
Verification rules:			
Collection methods:			
Related metadata:			

Administrative Attributes

Source document:		
Source organisation:		
Information model link:		
NHIM Service provision event		
Data Set Specifications:	Start date	End date
NMDS – Public hospital establishments	01/07/1989	

Comments:

Infant weight, neonate, stillborn

Identifying and Definitional Attributes 000010 Knowledgebase ID: Version No: 3 Metadata type: Data Element Admin. status: Current 01/07/97 Definition: The first weight of the live-born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth. Weight is an important indicator of pregnancy outcome, is a major risk factor Context: for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants. This item is required to generate Australian national diagnosis related groups.

Relational and Representational Attributes

•	
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNN
Minimum size:	4
Maximum size:	4
Data domain:	Measured weight in grams
Guide for use:	For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.
	In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.
	Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000 g and age is less than 365 days.
Verification rules:	For the provision of State and Territory hospital data to Commonwealth agencies, this field must be consistent with diagnoses and procedure codes for valid grouping.
Collection methods:	
Related metadata:	is used in the derivation of Diagnosis related group vers 1
	supersedes previous data element Stillborn, live born baby, infant weight vers 2

Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee

Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:	Start date	End date	
NMDS – Admitted patient care	01/07/1997		
NMDS – Perinatal	01/07/1997		

Initial visit – diabetes mellitus

Knowledgebase ID: Version No: 1 000828 Metadata type: Data Element Admin. status: Current 01/01/03 Whether this is the initial visit of the patient to a health professional for diabetes Definition: or a related condition after diagnosis has been established. Context: Public health, health care and clinical settings. Diabetes mellitus specific data element. Relational and Representational Attributes Datatype: Numeric **Representational form:** Code Ν Representational layout: Minimum size: 1 Maximum size: 1 Data domain: 1 Yes, this is the initial visit of the patient for diabetes or a related condition after diagnosis 2 No, this is not the initial visit of the patient for diabetes or a related condition after diagnosis 9 Not stated/inadequately described Guide for use: Record whether or not this is the first visit of the patient to this health professional. Verification rules: Collection methods: **Related metadata:** relates to the data element Glycosylated haemoglobin (HbA1c) - measured vers 1 Administrative Attributes Source document: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Source organisation: National Diabetes Data Working Group Information model link: NHIM Request for/entry into service event Data Set Specifications: Start date End date 01/01/2003 DSS - Diabetes (clinical) Comments: Used to compare findings or parameters (e.g. blood glucose control) of newly

Identifying and Definitional Attributes

referred individuals with that of those previously seen.

Injecting drug use status

Identifying and Definitional Attributes

Knowledgebase ID:	000432	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	,	on as a method of administering drugs. Includes lar and subcutaneous forms of injection.
Context:	Alcohol and other drug tr	reatment services:
	The data element is import associated with injecting c	ortant for identifying patterns of drug use and harms drug use.

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Cod	e	
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	Last injected three months ago or less	
	2	Last injected more than three months ago but less than or equal to twelve months ago.	
	3	Last injected more than twelve months ago.	
	4	Never injected	
	9	Not stated/inadequately described	
Guide for use:			
Verification rules:			
Collection methods:	To b	e collected on commencement of treatment with a service.	
		clients whose treatment episode is related to the alcohol and other drug use nother person, this data element should not be collected.	
Related metadata:	is qu	alified by Client type - alcohol and other drug treatment services vers 3	
	supe	rrsedes previous data element Injecting drug use vers 1	
	relates to the data element Method of use for principal drug of concern vers 1		
		es to the data element Other drug of concern vers 2	
	relat	es to the data element Principal drug of concern vers 2	

Administrative Attributes

Source	document:	
Source	organisation:	Intergovernmental Committee on Drugs NMDS WG
Inform	ation model link:	
NHIM Request for/entry into service event		

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

Comments:This data element is used in conjunction with the data element Commencement
of treatment for reporting the NMDS - Alcohol and other drug treatment
services, and has been developed for use in clinical settings. A code that refers
to a three-month period to define 'current' injecting drug use is required as a
clinically relevant period of time.

The data element may also be used in population surveys that require a longer timeframe, for example to generate 12-month prevalence rates, by aggregating codes 1 and 2. However, caution must be exercised when comparing clinical samples with population samples.

Intended length of hospital stay

Knowledgebase ID: 000076 Version No: 2 Metadata type: Data Element Admin. status: Current 01/07/01 The intention of the responsible clinician at the time of the patient's admission Definition: to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date. Context: Admitted patient care: To assist in the identification and casemix analysis of planned same-day patients, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.

Identifying and Definitional Attributes

Relational and Representational Attributes

NHIM Planning event

Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Data domain:	 Intended same-day Intended overnight
Guide for use:	
Verification rules:	
Collection methods:	The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.
Related metadata:	is used in the derivation of Diagnosis related group vers 1 supersedes previous data element Intended length of hospital stay vers 1
Administrative Attrib	outes
Source document: Source organisation: Information model link:	National Health Data Committee

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

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

Intended place of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000077	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	The intended place of bir	th at the onset of labour.
Context:	Perinatal care:	
	risk factors for outcome of	e birth in birth centres or at home usually have different compared to those who plan to give birth in hospitals. red to hospital after the onset of labour have increased adverse outcomes.

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1	Hospital
	2	Birth centre, attached to hospital
	3	Birth centre, free-standing
	4	Home
	8	Other
	9	Not stated
0.110		
Guide for use:		
Verification rules:		
Collection methods:		
Related metadata:	is qualified by Actual place of birth vers 1	
	is qua	alified by Method of birth, version 1
	is qua	alified by Onset of labour, version 2

Administrative Attributes

Source document:	
Source organisation:	National Perinatal Data Development Committee
Information model link:	
NHIM Planning event	
Data Set Specifications:	Start date End date
Comments:	The development of a definition of a birth centre is currently under

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

Intensive care unit

Identifying and Definitional Attributes Knowledgebase ID: Version No: 1 000078 Metadata type: Data Element Concept Admin. status: Current 01/07/96 An intensive care unit (ICU) is a designated ward of a hospital which is Definition: specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems. Context: Admitted patient care.

Relational and Representational Attributes

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

Administrative Attributes

Source document:			
Source organisation:	National Intensive Care Working Group		
Information model link:			
NHIM Service delivery setti	ng		
Data Set Specifications:		Start date	End date

Comments:

There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards. The five types of ICU are briefly described below:

Adult intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services, and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.

- Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines).
- Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for less than a 24-hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.
- Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care; and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.
- Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature.

Definitions for high-dependency unit and coronary care unit are under development.

Inter-hospital contracted patient

Identifying and Defi	nitional Attributes	
Knowledgebase ID:	000079	Version No: 2
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	provided under an arrang (contracting hospital) and	admitted patient whose treatment and/or care is gement between a hospital purchaser of hospital care a provider of an admitted service (contracted he activity is recorded by both hospitals.
Context:	Admitted patient care:	
	hospitals. This item is use	ving services that have been contracted between d to eliminate potential double-counting of hospital patterns of health care delivery and funding and
Relational and Representational Attributes		
Datatype:	Numeric	

Identifying and Definitional Attributes

Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Data domain:	1 Inter-hospital contracted patient from public sector hospital
	2 Inter-hospital contracted patient from private sector hospital
	3 Other
	9 Not reported
Guide for use:	A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.
Verification rules:	
Collection methods:	All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity. This data element will be derived as follows.
	If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital (Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records the contracted activity within the patient's record for the episode of care). Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital. Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

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

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recipient role			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient ca	re	01/07/2000	

Interest payments

identifying and Dem	IIIIOIIai AIIIIDUIES		
Knowledgebase ID:	000245	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	(e.g. interest on bank over	rdraft) provided lude the cost of	tablishment in respect of borrowings d the establishment is permitted to equity capital (i.e. dividends on te establishments.
Context:	Health expenditure:		
	private sector. Private pro operations either by loan	ofit-making esta borrowings (de can be signific	et because of its significance for the blishments will seek to fund their bt capital) or raising shares (equity ant, although the cost of the latter (that of profits.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Currency
Representational layout:	\$999,999,999
Minimum size:	2
Maximum size:	12
Data domain:	Australian dollars, rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Recurrent expenditure			
Data Set Specifications:		Start date	End date
NMDS – Public hospital establishments		01/07/1989	

Comments: The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.

Labour force status

identifying and Dem	Informati Antibules		
Knowledgebase ID:	000670	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	force (employed/unemployed/unemployed/unemployed) determined by a person's	oyed) or not in status in relatio	ntly has in being either in the labour the labour force. The categories are on to current economic activity (which to work in a specified reference
Context:	Clinical settings:		
	activity) of a person and is needs of individuals and i unemployed people was l death from cardiovascular	s a key element families. In all s higher than tha r disease, lung A 1998; 168: 178	socio-economic status (economic in assessing the circumstances and social classes, the mortality rate of t of the employed, particularly for cancer, accidents and suicide (Mathers –182). It is one of a group of items that r force characteristics.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:		
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Employed	
	2 Unemployed	
	3 Not in the labour force	
	4 Not stated/inadequately described	
Guide for use:	Definitions for these categories are:	
	Employed:	
	Employed persons comprise all those aged 15 years and over who, during the reference week:	
	 (a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers'); 	
	(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker');	
	(c) were 'Employees' who had a job but were not at work and were:	
	 on paid leave 	
	 on leave without pay, for less than four weeks, up to the end of the reference week 	
	 stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week 	

- on strike or locked out
- on workers' compensation and expected to be returning to their job
- receiving wages or salary while undertaking full-time study;
- (d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

Unemployed:

Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:

- (a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then;
- (b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown.

Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

Not in the labour force:

Persons not in the labour force are those persons who, during the reference week, were not in the categories employed or unemployed, as defined. They include persons who were keeping house (unpaid), retired, voluntarily inactive, permanently unable to work, persons in institutions (hospitals, gaols, sanatoriums, etc.), trainee teachers, members of contemplative religious orders, and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Verification rules:	
Collection methods:	For information about collection, refer to the Australian Bureau of Statistics' (ABS) web site: www.abs.gov.au/

Related metadata: is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document:	AIHW: 2000 National Community Ser Catalogue No. HWI 27. Canberra: AIF 000526 V2). Standards for Social, Labo	HW. (Data element 'Lab	our force status'
Source organisation:	Australian Bureau of Statistics		
Information model link:			
NHIM Labour characteris	tic		
Data Set Specifications:		Start date	End date
DSS – Cardiovascular disease (clinical)		01/01/2003	
Comments:	This definition is based on the ABS standard definition of labour force status. It is generally measured at the point of coming into contact with (or completion of		

assistance by) a community services agency.

Laterality of primary cancer

Knowledgebase ID: 000774 Version No: 1 Metadata type: Data Element Admin. status: Current 01/07/02 Laterality describes which side of a paired organ is the origin of the primary Definition: cancer. Each side of a paired organ is considered separately and described as lateral when occurring unless a physician determines that it is bilateral. A paired organ is one in which there are two separate organs of the same kind, one on either side of the body (e.g. kidney, breast, ovary, testis and lung). Context: This information is collected for the purpose of differentiating the site of the primary cancer. For example, a woman may present with a primary cancer in the left breast. She may return at a later stage with a new primary cancer in the right breast.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric	
01	Code	
Representational form:		
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Left	
	2 Right	
	3 Bilateral (Note: Bilateral cancers are very rare)	
	9 Not known	
	Null Not applicable	
Guide for use:	The valid International Classification of Diseases for Oncology values for the variable are provided in the list below:	
	1 Left:	
	Origin of primary site is on the left side of a paired organ	
	Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)	
	2 Right:	
	Origin of primary site is on the right side of a paired organ	
	3 Bilateral:	
	Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3))	

	9 Unknown: It is unknown whether, for a paired organ the left or right side of the body.	e origin of the canc	er was on the
Verification rules:			
Collection methods:	This information should be obtained from the patient's medical record, or the patient's med	I I C	
Related metadata:	is qualified by Primary site of cancer vers 1		
Administrative Attrib	utes		
Source document:	International Classification of Diseases for On	ncology, Second Ed	lition
Source organisation: Information model link:	World Health Organization		
NHIMAssessment eventData Set Specifications:		Start date	End date

Length of non-admitted patient emergency department service episode

Identifying and Defin	nitional Attributes
Knowledgebase ID:	000829 Version No: 1
Metadata type:	Derived Data Element
Admin. status:	Current
	01/07/03
Definition:	The amount of time, measured in minutes, between when a patient presents at an emergency department for an emergency department service episode, and when the non-admitted component of the emergency department service episode has concluded.
Context:	Emergency department care.
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	MMMMM
Minimum size:	5
Maximum size:	5
Data domain: Guide for use:	Count in minutes to the nearest minute A non-admitted patient Emergency department service episode ends when
	either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.
Verification rules:	
Collection methods:	
Related metadata:	is calculated using Date patient presents vers 2
	relates to the data element concept Emergency department – public hospital vers 1
	relates to the data element concept Non-admitted patient emergency department service episode vers 1
	relates to the data element Patient presentation at emergency department vers 1
	is calculated using Time patient presents vers 2
Administrative Attrib	outes
Source document:	
Source organisation:	National reference group for non-admitted patient data development, 2001–02
I	• •

Information model link:			
NHIM Exit/leave from service event			
Data Set Specifications:	Start date	End date	
NMDS - Non-admitted patient emergency department care	01/07/2003		

Length of stay

Identifying and Defi			
Knowledgebase ID:	000119	Version No:	3
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	should be allocated a leng overnight stay patient is o	gth of stay of one calculated by sul f separation and	in patient days. A same-day patient e patient day. The length of stay of an btracting the date the patient is deducting total leave days. Total he length of stay.
Context:	Admitted patient care.		
Relational and Rep	resentational Attrib	utes	
Datatype:	Numeric		
Representational form:	Quantitative value		
Representational layout:	NNN		
Minimum size:	1		
Maximum size:	3		
Data domain:	Count of the number of p	atient days	
Guide for use:	Formula:		
	LOS (incl. leave days) = S	eparation date -	Admission date - Total leave days
	The calculation is inclusiv	ve of admission a	and separation dates.
Verification rules:			
Collection methods:			
Related metadata:	is calculated using Admis	ssion date vers 4	
	supersedes previous data	0	
	is calculated using Separa	ation date vers 5	
	is calculated using Total l	eave days vers 3	3
Administrative Attrik	outes		
Source document:			
Source organisation:	National Health Data Con	nmittee	

NHIM Performance indicator

Information model link:

Data Set Specifications:

Start date End date

Comments:

Perinatal length of stay data elements include leave days and so are not included in this data element.

Length of stay (antenatal)

Identifying and Define	nitional Attributes
Knowledgebase ID:	000635 Version No: 1
Metadata type:	Derived Data Element
Admin. status:	Current
	01/07/01
Definition:	The length of stay of a patient measured in days calculated from the admission date of mother to the date of birth of the baby. Total contracted days are included in the length of stay. Leave days are included.
Context:	Perinatal
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	1
Maximum size:	3
Data domain:	Calculated number of days
Data domain: Guide for use:	Calculated number of days Formula:
	Formula:
	Formula: Antenatal LOS = baby's Date of birth - mother's Admission date
	Formula: Antenatal LOS = baby's Date of birth - mother's Admission date Antenatal length of stay refers only to the admission associated with the birth. The calculation is inclusive of the day of admission of the mother and the day of
Guide for use:	Formula: Antenatal LOS = baby's Date of birth - mother's Admission date Antenatal length of stay refers only to the admission associated with the birth. The calculation is inclusive of the day of admission of the mother and the day of
<i>Guide for use:</i> <i>Verification rules:</i>	Formula: Antenatal LOS = baby's Date of birth - mother's Admission date Antenatal length of stay refers only to the admission associated with the birth. The calculation is inclusive of the day of admission of the mother and the day of
Guide for use: Verification rules: Collection methods:	Formula: Antenatal LOS = baby's Date of birth - mother's Admission date Antenatal length of stay refers only to the admission associated with the birth. The calculation is inclusive of the day of admission of the mother and the day of birth of the baby and includes any leave days.
Guide for use: Verification rules: Collection methods:	Formula: Antenatal LOS = baby's Date of birth - mother's Admission date Antenatal length of stay refers only to the admission associated with the birth. The calculation is inclusive of the day of admission of the mother and the day of birth of the baby and includes any leave days.
Guide for use: Verification rules: Collection methods:	Formula: Antenatal LOS = baby's Date of birth - mother's Admission date Antenatal length of stay refers only to the admission associated with the birth. The calculation is inclusive of the day of admission of the mother and the day of birth of the baby and includes any leave days. is calculated using Admission date vers 4 is calculated using Date of birth vers 4

Identifying and Definitional Attributes

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Performance indicat	or		
Data Set Specifications:		Start date	End date

Length of stay (including leave days)

identifying and Dem	IIIIOIIal Allibules	
Knowledgebase ID:	000636	Version No: 1
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	allocated a length of stay	tient measured in days. A same-day patient should be of one day. Total contracted days are included in the lays are included in length of stay calculation.
Context:	All admitted patient care of a stay in hospital.	situations where it is required to know the total length
Relational and Repr	esentational Attrib	utes

Identifying and Definitional Attributes

ľ

Datatype:	Numeric
Representational form:	
Representational layout:	NNN
Minimum size:	1
Maximum size:	3
Data domain:	Calculated number of days
Guide for use:	Formula:
	LOS (incl. leave days) = Separation date - Admission date
	The calculation is inclusive of admission and separation dates.
Verification rules:	
Collection methods:	
Related metadata:	is calculated using Admission date vers 4
	relates to the data element Length of stay (antenatal) vers 1
	relates to the data element Length of stay (postnatal) vers 1
	relates to the data element Perinatal period vers 1
	is calculated using Separation date vers 5

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Performance indicat	or		
Data Set Specifications:		Start date	End date

Length of stay (postnatal)

Identifying and Defi	nitional Attributes
Knowledgebase ID:	000637 Version No: 1
Metadata type:	Derived Data Element
Admin. status:	Current
	01/07/01
Definition:	The length of stay of a patient measured in days calculated from the Date of birth of baby to Separation date of mother. Total contracted days are included in the length of stay. Leave days are included.
Context:	Perinatal.
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	1
Maximum size:	3
Data domain:	Calculated number of days
0.11.6	
<i>Guide for use:</i>	Formula for the mother:
Guide for use:	Formula for the mother: LOS (post-natal) = mother's Separation date - baby's Date of birth
Guide for use:	
Guide for use:	LOS (post-natal) = mother's Separation date - baby's Date of birth
Guide for use:	LOS (post-natal) = mother's Separation date - baby's Date of birth Formula for the baby:
Guide for use: Verification rules: Collection methods:	LOS (post-natal) = mother's Separation date - baby's Date of birth Formula for the baby: LOS (post-natal) = baby's Separation date - baby's Date of birth Both calculations are inclusive of those dates and any leave days are included.
Verification rules:	LOS (post-natal) = mother's Separation date - baby's Date of birth Formula for the baby: LOS (post-natal) = baby's Separation date - baby's Date of birth Both calculations are inclusive of those dates and any leave days are included.
Verification rules: Collection methods:	LOS (post-natal) = mother's Separation date - baby's Date of birth Formula for the baby: LOS (post-natal) = baby's Separation date - baby's Date of birth Both calculations are inclusive of those dates and any leave days are included. Excludes transfers, home births and other non-hospital births.
Verification rules: Collection methods:	LOS (post-natal) = mother's Separation date - baby's Date of birth Formula for the baby: LOS (post-natal) = baby's Separation date - baby's Date of birth Both calculations are inclusive of those dates and any leave days are included. Excludes transfers, home births and other non-hospital births.
Verification rules: Collection methods:	LOS (post-natal) = mother's Separation date - baby's Date of birth Formula for the baby: LOS (post-natal) = baby's Separation date - baby's Date of birth Both calculations are inclusive of those dates and any leave days are included. Excludes transfers, home births and other non-hospital births.

Identifying and Definitional Attributes

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Performance indicat	or		
Data Set Specifications:		Start date	End date

Listing date for care

Identifying and Definitional Attributes

Knowledgebase ID:	000082	Version No: 4
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.	
Context:	Hospital non-admitted pa	tient care.
	Community health care.	
	Elective surgery (admittee	l patient care).

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral. For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list.
Verification rules:	
Collection methods:	
Related metadata:	supersedes previous data element Listing date for care vers 3
	is used in conjunction with Patient listing status vers 3
	is used in conjunction with Scheduled admission date vers 2
	is used in the calculation of Waiting time at a census date vers 2
	is used in the calculation of Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Request for/entry into service event			
Data Set Specifications:		Start date	End date
NMDS - Elective surgery waiting times		01/07/1994	

Comments:

The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil State/Territory, local and national reporting requirements.

Live birth

Identifying and Defir	nitional Attributes			
Knowledgebase ID:	000083	Version No: 1		
Metadata type:	Data Element Concept			
Admin. status:	Current			
	01/07/94			
Definition:	A live birth is defined by the expulsion or extraction from of the pregnancy, which, a evidence of life, such as bed definite movement of the has been cut or the placent considered live born.	om the mother of a offer such separation eating of the heart, voluntary muscles	a baby, irrespective of on, breathes or show , pulsation of the un s, whether or not the	of the duration vs any other nbilical cord, or e umbilical cord
Context:	Perinatal.			
Relational and Repr	esentational Attribu	utes		
Datatype:				
Representational form:				
Representational layout:				
Minimum size:				
Maximum size:				
Data domain:				
Guide for use:				
Verification rules:				
Collection methods:				
Related metadata:	relates to the data element	Status of the baby	y vers 1	
Administrative Attrib	utes			
Source document:	International Classification Revision, Vol. 1, WHO 199		Related Health Prob	vlems, 10th
Source organisation:	National Health Data Con	nmittee		
	National Perinatal Data D	evelopment Comr	nittee	
	National Perinatal Data A	dvisory Committe	e	
Information model link:				
NHIM Birth event				
Data Set Specifications:			Start date	End date
Comments:				

Living arrangement

Identifying and Definitional Attributes

Knowledgebase ID:	000629	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Whether a person usually	resides alone or with others.
Context:	living arrangements for a support, both physically a	clinical setting: It is important to record the type of person in order to develop a sense of the level of and emotionally, to which a person may have access. ives alone is a significant determinant of risk.

Relational and Representational Attributes

Datatuna	Num	
Datatype:		
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1	Lives alone
	2	Lives with others
	9	Not stated/inadequately described
Guide for use:	the f	item does not seek to describe the quality of the arrangements but merely act of the arrangement. It is recognised that this item may change on a ber of occasions during the course of an episode of care.
Verification rules:		
Collection methods:		
Related metadata:	relat	es to the data element Carer availability vers 3
	relat	es to the data element Formal community support access status vers 1
	is us	ed in conjunction with Service contact date vers 1

Administrative Attributes

Source document:			
Source organisation:	CV-Data Working Group		
Information model link:			
NHIM Functional wellbeing			
Data Set Specifications:		Start date	End date
DSS - Cardiovascular disease (clinical)		01/01/2003	

Comments:

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

Lower limb amputation due to vascular disease

Identifying and Defi	nitional Attributes
Knowledgebase ID:	000830 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/01/03
Definition:	Amputation of toe, forefoot or leg (above or below knee), due to vascular disease.
Context:	Public health, health care and clinical settings.
Relational and Rep	resentational Attributes
Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Data domain:	1 Lower limb amputation – occurred in the last 12 months
Data aomain.	 Lower limb amputation - occurred prior to the last 12 months Lower limb amputation - occurred prior to the last 12 months
	3 Lower limb amputation – occurred both in and prior to the last 12 months
	4 No history of lower limb amputation due to vascular disease
	9 Not stated/inadequately described
Guide for use:	
Verification rules:	
Collection methods:	Ask the individual if he/she has had an amputated toe or forefoot or leg (above or below knee), not due to trauma or causes other than vascular disease. If so determine when it was undertaken; within or prior to the last 12 months (or both). Alternatively obtain this information from appropriate documentation.
Related metadata:	relates to the data element Health professionals attended – diabetes mellitus vers 1
	relates to the data element Foot deformity vers 1
	relates to the data element Foot lesion – active vers 1
	relates to the data element Foot ulcer – current vers 1
	relates to the data element Foot ulcer – history vers 1
	relates to the data element Peripheral neuropathy – status vers 1
	relates to the data element Peripheral vascular disease in feet – status vers 1
Administrative Attrib	outes

. : 1 : . اء ا c: ما :مىلىلە م .

Source organisation: National Diabetes Data Working Group

dictionary.

Source document:

330

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data

Information model link:		
NHIM Physical wellbeing		
Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	

Comments:

In people with diabetes, amputations are 15 times more common than in people without diabetes, and 50% of all amputations occur in people with diabetes (The Lower Limb in People With Diabetes; 1997/98 Australian Diabetes Society).

Diabetic foot disease is the most common cause of hospitalisation in people with diabetes. Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45–74 years and sevenfold in population aged over 75 years. As stated by Duffy and authors the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

References:

Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. Military Medicine, 155: 575–579.

Edmonds M, Boulton A, Buckenham T et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27–42.

Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Colagiuri S, Colagiuri R, Ward J. National Diabetes Strategy and Implementation Plan. Canberra: Diabetes Australia, 1998.

Main language other than English spoken at home

Knowledgebase ID:	000638	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current 01/07/01		
Definition:	spoken by a person in his	/her home (or i on a regular bas	e main language other than English most recent private residential setting is, to communicate with other residents rs.
Context:	disadvantage in terms of cultural difficulties. In co spoken English and Cour	their ability to a njunction with I ntry of birth, thi nguage indicate	ying those people most likely to suffer access services due to language and/or Indigenous status, Proficiency in s data element forms the minimum ors recommended by the Australian
	ethnicity and also as usef retention. The availability community services to eff groups that need those se	ul for the study v of such data m fectively target rvices. It may b	are regarded as an indicator of 'active' of inter-generational language aay help providers of health and the geographic areas or population e used for the investigation and as interpreter/translation services.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype: Representational form: Representational layout: Minimum size: Maximum size:	Numeric Code NNNN 4 4
Data domain:	Valid ABS codes
Guide for use:	At the most detailed level the ABS classification comprises four-digit codes based on a hierarchical structure. It includes codes for indigenous Australian languages and sign language. Generally for output purposes, four-digit language codes are grouped into language regions, either at two-digit or one-digit level.
	Example 1:
	The Lithuanian language has a code of 3102.
	3 denotes that it is an Eastern European language
	1 denotes that it is a Baltic language
	02 denotes the specific language.
	Example 2:
	The Pintupi Aboriginal language has a code of 8217.
	8 denotes that it is an Australian Indigenous language
	2 denotes that the language is Central Aboriginal
	17 denotes the specific language.

	Note that the code 9900 should be used where language is Not stated/inadequately described.
	Persons not in private residential settings should respond for 'at home' as the most recent private residential setting in which that person has resided.
	The reference in the title to 'at home' may cause offence to homeless persons and should be shortened to 'Main language other than English spoken' where applicable.
Verification rules:	
Collection methods:	It is recommended that data be collected at the 2- or 4-digit level. Data collected at the 4-digit level will obviously provide more detailed information than that collected at the 2-digit level, but may be more difficult to collect. Recommended question:
	Do you speak a language other than English at home?
	No (English only)?
	Yes, Italian?
	Yes, Greek?
	Yes, Cantonese?
	Yes, Mandarin?
	Yes, Arabic?
	Yes, Vietnamese?
	Yes, German?
	Yes, Tagalog (Filipino)?
	Yes, Other (please specify)
Related metadata:	relates to the data element Country of birth vers 3
	relates to the data element Proficiency in spoken English vers 1
Administrative Attrib	utes
Source document:	Standards for Statistics on Cultural and Language Diversity, 1999, Australian Bureau of Statistics, Cat. No. 1289.0
Source organisation:	Australian Bureau of Statistics
Information model link:	
NHIM Social characteristic	
Data Set Specifications:	Start date End date

Comments: Data may be collected at any level but is most accurate at the 4-digit level.

Main treatment type for alcohol and other drugs

Identifying and Defin	nitional Attributes
Knowledgebase ID:	000639 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
	01/07/01
Definition:	The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern.
Context:	Alcohol and other drug treatment services.
Relational and Repr	esentational Attributes
Datatype:	Numeric
Representational form:	Code
Representational layout:	Ν
Minimum size:	1
Maximum size:	1
Data domain:	1 Withdrawal management (detoxification)
	2 Counselling
	3 Rehabilitation
	4 Pharmacotherapy
	5 Support and case management only
	6 Information and education only
	7 Assessment only
	8 Other
Guide for use:	To be completed at assessment or commencement of treatment.
	The main treatment type is the principal activity, as judged by the treatment provider, that is necessary for the completion of the treatment plan for the principal drug of concern. The Main treatment type for alcohol and other drugs is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.
	For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.
	Code 1 refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.
	Code 2 refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in code 3.
	Code 3 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration.

Identifying and Definitional Attributes

	Rehabilitation activities can occur in residential or non-residential settings.
	Code 4 refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, LAAM and specialist methadone treatment). Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal.
	Code 5 refers to support and case management offered to clients (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.
	Code 6 refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.
	Code 7 refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.
Verification rules:	
Collection methods:	Only one code to be selected.
Related metadata:	relates to the data element Other treatment type for alcohol and other drugs vers 1

Administrative Attributes

SWG			
Information model link:			
NHIM Service provision event			
Start date	End date		
01/07/2001			
	Start date		

Major diagnostic category

Knowledgebase ID:	000088	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/93		
Definition:	possible principal diagno a single body system or a care. Each category is par	ses fall. The dia etiology, broadl titioned accordi l. This prelimin	ally exclusive categories into which all gnoses in each category correspond to ly reflecting the speciality providing ing to whether or not a surgical ary partitioning into major diagnostic red group is assigned.
	principal diagnosis as the A hierarchy of all exception major diagnostic category Australian refined diagno	initial variable ons to the prince has been create osis related grou oth a major diag	groups departs from the use of in the assignment of some groups. ipal diagnosis-based assignment to a ed. As a consequence, certain ups are not unique to a major diagnostic mostic category and an Australian herated per patient.
Context:		diagnostic cate group is a requ	egory to accompany each Australian uirement of the latter as diagnosis

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2

Data domain:	Australian refined diagnosis related groups		
Guide for use:	Version effective 1 July each year		
Verification rules:			
Collection methods:			
Related metadata:	is derived from Additional diagnosis vers 4		
	is derived from Admission date vers 4		
	is derived from Date of birth vers 4		
	is used in the derivation of Diagnosis related group vers 1		
	is derived from Infant weight, neonate, stillborn vers 3		
	is derived from Principal diagnosis vers 3		

Administrative Attributes

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

Information model link:			
NHIM Physical wellbeing			
Data Set Specifications:	Start date	End date	
NMDS - Admitted patient care	01/07/1993		
NMDS - Admitted patient mental health care	01/07/1997		

Comments:

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

Marital status

Identifying and Definitional Attributes Knowledgebase ID: 000089 Version No: 3 Metadata type: Data Element Current Admin. status: 01/07/01 Current marital status of the person. Definition: Context: Marital status is a core data element in a wide range of social, labour and demographic statistics. Its main purpose is to establish the living arrangements of individuals, to facilitate analysis of the association of marital status with the need for and use of services and for epidemiological analysis. The Australian Bureau of Statistics (ABS) has defined registered marital status based on a legal concept and social marital status, a social, marriage-like arrangement (i.e. de facto marriage).

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
.		
Data domain:	1 Never married	
	2 Widowed	
	3 Divorced	
	4 Separated	
	5 Married (including de facto)	
	6 Not stated/inadequately described	
Guide for use:	The category Married (including de facto) should be generally accepted as applicable to all de facto couples, including of the same sex.	
Verification rules:		
Collection methods:	While marital status is an important factor in assessing the type and extent of support needs, such as for the elderly living in the home environment, marital status does not adequately address the need for information about social support and living arrangements and other data elements need to be formulated to capture this information.	
Related metadata:	supersedes previous data element Marital status vers 2	
Administrative Attrib	outes	
· · ·		

Source organisation:	Australian Bureau of Statistics
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Information model link:			
NHIM Social characteristic			
Data Set Specifications:	Start date	End date	
NMDS - Admitted patient mental health care	01/07/2001		
NMDS - Community mental health care	01/07/2001		

Comments:

ABS standards identify two concepts of marital status:

- registered marital status-defined as whether a person has, or has had, a legally registered marriage
- social marital status-based on a persons living arrangements (including de-facto marriages), as reported by the person.

ABS recommends that the social marital status concept be collected when information on marital status is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection and only in areas of consent if necessary. Most community services data collections ask clients to self-report their marital status. Hence, the operative concept is one of social marital status.

Maternal medical conditions

Knowledgebase ID: 000090 Version No: 2 Metadata type: Data Element Admin. status: Current 01/07/98 Definition: Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome. Context: Perinatal statistics: Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the foetus and perinatal morbidity.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANN.NN
Minimum size:	3
Maximum size:	6
Data domain:	ICD-10-AM (3rd edition) disease codes
Guide for use:	Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.
Verification rules:	Conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM
Collection methods:	
Related metadata:	is used in conjunction with Complications of pregnancy vers 2
	supersedes previous data element Maternal medical conditions – ICD-9-CM code vers 1

Administrative Attributes

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

Medical and surgical supplies

Identifying and Definitional Attributes					
Knowledgebase ID:	000239	Version No:	1		
Metadata type:	Data Element				
Admin. status:	Current				
	01/07/89				
Definition:	The cost of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.				
Context:	Health expenditure:				
	expenditure and national	-level data on m	is is a significant element of non-salary nedical and surgical supplies is of wide range of persons and		

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Currency		
Representational layout:	\$999,999,999		
Minimum size:	2		
Maximum size:	12		
Data domain:	Australian dollars. Rounded to nearest whole dollar.		
Guide for use:	Record values up to hundreds of millions of dollars.		
Verification rules: Collection methods: Related metadata:	relates to the data element Establishment type vers 1		

Administrative Attributes

Source document:					
Source organisation:	National Health Data Committee				
Information model link:					
NHIM Recurrent expenditure					
Data Set Specifications:		Start date	End date		
NMDS – Public hospital establishments		01/07/1989			
NMDS - Public hospital establishments		01/07/1989			

Medicare card number

Identifying and Definitional Attributes

Knowledgebase ID:	000091	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:		d by the Health Insurance Commission to eligible re scheme, that appears on a Medicare card.
Context:	Medicare utilisation statis	tics.
	Persons eligible for Medic	are services

Relational and Representational Attributes

Relational and Representational Attributes			
Datatype:	Numeric		
Representational form:			
Representational layout:	N(11)		
Minimum size:	11		
Maximum size:	11		
Data domain:	Full Medicare card number for an individual (i.e. family number plus person (individual reference) number).		
Guide for use:	As a person can be identified on more than one Medicare card this is not a unique identifier for a person.		
	The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.		
	Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.		
Verification rules:			
Collection methods:			
Related metadata:	supersedes previous data element Medicare number vers 1		
Administrative Attrib	utes		
Source document:	AS5017 Health care client identification		
Source organisation: Information model link:	Standards Australia		

NHIM Recipient role Data Set Specifications:

 Start date
 End date

 01/01/2003

Comments:

The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person.

Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card.

Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related.

A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents.

Medicare eligibility status

Identifying and Definitional Attributes

Identifying and Defir	nitional Attributes		
Knowledgebase ID:	000414 Version No: 1		
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	The patient's eligibility for Medicare as specified under the Commonwealth <i>Health Insurance Act</i> 1973.		
Context:	Admitted patient care: To facilitate analyses of hospital utilisation and policy relating to health care financing.		
Relational and Repr	esentational Attributes		
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Eligible		
	2 Not eligible		
	9 Not stated/unknown		
Guide for use:	An eligible person includes a person who resides in Australia and is one of the following:		
	 an Australian citizen 		
	 a permanent resident 		
	 a New Zealand citizen 		
	 a temporary resident who has applied for permanent residency and who has either an authority to work in Australia or an immediate family member who is an Australian citizen or permanent resident 		
	 a person, or class of persons, who has been declared eligible for Medicare for the purposes of the <i>Health Insurance Act 1973</i>. 		
	Other persons, as temporary residents, who are fully eligible for Medicare include:		
	 a person who is a head or member of a diplomatic mission or consular post or is a member of such a person's family, where there is a Reciprocal Health Care Agreement in place between Australia and the country they represent (currently United Kingdom, Republic of Ireland, the Netherlands, Malta, Italy, Sweden and Finland) – with the exception of New Zealand diplomats. 		
	Other persons, as visitors or temporary residents, who are eligible for Medicare, in certain circumstances, include:		
	 persons who are visiting Australia and are eligible persons because there is a Reciprocal Health Care Agreement in place between Australia and their usual country of recidence (currently United Kingdom Republic of 		

their usual country of residence (currently United Kingdom, Republic of Ireland, the Netherlands, Malta (eligibility limited to 6 months), Italy

	(eligibility limited to 6 months), Sweden, Finland and New Zealand – it should be noted that the RHCA with New Zealand and the Republic of Ireland limits the access to medical services for their residents to that of public patients in public hospitals) – with the exception of New Zealand diplomats.
	With respect to hospital services, persons covered by an RHCA (except RHCA diplomats as they have full Medicare eligibility) are eligible only as public patients in a public hospital and are ineligible persons if they are admitted as a private patient in either a public or a private hospital;
	It should also be noted that some patients can be both an 'eligible person' and either personally or a third party liable for the payment of charges for hospital services received; for example:
	– prisoners
	 patients with Defence Force personnel entitlements
	 compensable patients
	 Department of Veterans' Affairs beneficiaries
	 nursing home type patients.
	Newborn babies take the eligibility status of the mother.
Verification rules:	
Collection methods:	Commencing with Version 9.0 of the Dictionary, three separate data elements are recorded in the Dictionary:
	 admitted patient accommodation status
	 Medicare eligibility status
	 compensable status.
	This is because each element relates to a separate concept and requires separate information to be reported. These three data elements replace the previous data elements Patient accommodation eligibility status and Compensable status.
Related metadata:	supersedes previous data element Patient accommodation eligibility status vers 2

Administrative Attributes

Source document:				
Source organisation:				
Information model link:				
NHIM	Insurance/benefit characteristic			
Data Set Specifications:				
NMDS - Admitted patient care				

Mental health legal status

····				
Knowledgebase ID:	000092	Version No:	5	
Metadata type:	Data Element			
Admin. status:	Current			
	01/07/00			
Definition:	Whether a person is treated on an involuntary basis under the relevant State or Territory mental health legislation, at any time during an episode of care for an admitted patient or treatment of a patient/client by a community-based service during a reporting period.			
	, j i i	under mental h	e detained in hospital or compulsorily nealth legislation for the purpose of reatment or care.	
Context:	Mental health care:			
	treatment provisions unde Australian hospitals and c community-based residen mental health services wh	er State and Ter community hea tial services. Fo lich provide psy gal status inform	trends in the use of compulsory critory mental health legislation by lth care facilities, including 24-hour or those hospitals and community ychiatric treatment to involuntary nation is an essential data element	

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 Involuntary patient		
	2 Voluntary patient		
	3 Not permitted to be reported under legislative arrangements in the jurisdiction		
Guide for use:	Code 3. This code is to be used for reporting to the NMDS – Community mental health care, where applicable.		
	Approval is required under the State or Territory mental health legislation in order to detain patients for the provision of mental health care or for patients to be treated compulsorily in the community.		
	Code 1 involuntary status should only be used by facilities which are approved for this purpose. While each State and Territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity. Each State/Territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.		

	The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care.
	Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.
Verification rules:	
Collection methods:	Admitted patients: to be collected if the patient is involuntary at any time during the episode of care.
	Patients in 24-hour staffed community-based residential services: to be collected if the patient is involuntary at any time during the stay in the residence.
	Non-admitted patients: to be collected if the patient is involuntary at any time during a specified collection period.
Related metadata:	supersedes previous data element Mental health legal status vers 4
Administrative Attrib	utes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Legal characteristic			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient care		01/07/2000	
NMDS - Admitted patient mental health care		01/07/2000	
NMDS - Community mental h	01/07/2000		

End date

Start date

01/07/1997

Method of birth

Knowledgebase ID: 000093 Version No: 1 Metadata type: Data Element Admin. status: Current 01/07/96 The method of complete expulsion or extraction from its mother of a product of Definition: conception. Context: Perinatal statistics: The method of delivery may affect the health status of the mother and the baby at birth and during the postpartum period. Relational and Representational Attributes Datatype: Numeric Representational form: Code **Representational layout:** Ν Minimum size: 1 Maximum size: 1 Data domain: 1 Spontaneous vaginal 2 Forceps (assisted vaginal birth) 3 Vaginal breech 4 Caesarean section 5 Vacuum extraction 8 Other 9 Not stated Guide for use: In a vaginal breech with forceps to the after coming head, code as vaginal breech. Verification rules: Collection methods: **Related metadata:** is used in conjunction with Presentation at birth vers 1 Administrative Attributes Source document: Source organisation: National Perinatal Data Development Committee Information model link: NHIM Birth event

Identifying and Definitional Attributes

Comments:

NMDS - Perinatal

Data Set Specifications:

Method of use for principal drug of concern

Identifying and Definitional Attributes Knowledgebase ID: 000433 Version No: 1 Data Element Metadata type: Admin. status: Current 01/07/00 Definition: The client's usual method of administering the Principal drug of concern as stated by the client. Context: Alcohol and other drug treatment services: Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	Ingests	
	2	Smokes	
	3	Injects	
	4	Sniffs (powder)	
	5	Inhales (vapour)	
	6	Other	
	9	Not stated/inadequately described	
Guide for use:	Code 1 Refers to eating or drinking as the method of administering the Principal drug of concern.		
Verification rules:			
Collection methods:	Collect only for Principal drug of concern.		
	To be collected on commencement of treatment with a service.		
Related metadata:	relates to the data element Injecting drug use status vers 2		
	relate	s to the data element Principal drug of concern vers 2	
Administrative Attrib	utes		

Source adeament.				
Source organisation:	Intergovernmental Committee on Drugs NMDS WG			
Information model link:				
NHIM Lifestyle characteristic				
Data Set Specifications:		Start date	End date	
NMDS - Alcohol and other drug treatment services		01/07/2001		
Comments:				

Microalbumin – units

Identifying and Definitional Attributes

Knowledgebase ID:	000832	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The units used for measur methodology.	ring microalbur	nin dependent upon laboratory
Context:	Public health, health care	and clinical set	tings:
	sign of kidney damage. M	licroalbuminur d diabetic neph	ropathy. Incipient diabetic

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:	1 mg/L (milligrams per litre)		
	2 $\mu g/\min$ (micrograms per minute)		
	3 mg/24hr (milligrams per 24-hour period)		
	4 albumin/creatinine ratio		
	9 Not stated/inadequately described		
Guide for use:	Record the units used for the microalbumin normal reference range.		
Verification rules:			
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.		
	Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.		
	Report the methodology used by the laboratory.		
	As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.		
Related metadata:	relates to the data element Microalbumin – upper limit of normal range vers 1		
	relates to the data element Microalbumin/protein – measured vers 1		

Administrative Attributes

Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
Source organisation:	National Diabetes Data Working Group		
Information model link:			
NHIM Surveillance/monitoring event			
Data Set Specifications:		Start date	End date
DSS - Diabetes (clinical)		01/01/2003	
Comments:	Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.		surements are
	Incipient diabetic nephropathy is suspected v	when microalbum	inuria is detecte

Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Identifying and Definitional Attributes				
Knowledgebase ID:	000833 Version No: 1			
Metadata type:	Data Element			
Admin. status:	Current			
	01/01/03			
Definition:	Laboratory standard for the value of Microalbumin that is the upper boundary of the normal reference range.			
Context:	Public health, health care and clinical settings.			
Relational and Repr	resentational Attributes			
Datatype:	Numeric			
Representational form:	Quantitative value			
Representational layout:	NNN.N			
Minimum size:	3			
Maximum size:	5			
Data domain:	Measured value or			
	999.9 Not stated/inadequately described			
Guide for use:	Record the upper limit of the microalbumin normal reference range for the Laboratory			
Verification rules:				
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.			
	Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.			
Related metadata:	is qualified by Microalbumin - units vers 1			
	relates to the data element concept Microalbumin/protein – measured vers 1			
Administrative Attrib	outes			
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.			
Source organisation:	National Diabetes Data Working Group			
Information model link:				
NHIM Surveillance/monite	oring event			
Data Set Specifications:	Start date End date			
DSS – Diabetes (clinical)	01/01/2003			

Idoptifyi d Dofiniti Attribut

Comments:Microalbuminuria is a strong predictor of macrovascular disease and diabetic
nephropathy. Incipient diabetic nephropathy can be detected by urine testing
for microalbumin. Incipient diabetic nephropathy is suspected when
microalbuminuria is detected in two of three samples collected over a 6-month
period in patients in whom other causes of an increased urinary albumin
excretion have been excluded.Diagnosis of microalbuminuria is established if 2 of the 3 measurements are
abnormal. A small amount of protein (albumin) in the urine (microalbuminuria)
is an early sign of kidney damage.If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with ACE inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantitate albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin/protein – measured

Identifying and Definitional Attributes

Knowledgebase ID:	000831 Version No: 1
Metadata type:	Data Element
Admin. status:	Current
Tumm. status.	01/01/03
Definition:	A person's measured total microalbumin in a spot test, 24 hour or timed collection.
Context:	Public health, health care and clinical settings.
Relational and Repr	resentational Attributes
Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNN.N
Minimum size:	3
Maximum size:	6
Data domain:	Measured in different units dependant upon laboratory methodology
	9999.9 Not stated/inadequately described
Guide for use:	Record the result expressed as the absolute amount of albumin (mg/L) or as albumin excretion rate (AER: μ g/min or mg/24hr) or albumin/creatinine ratio.
Verification rules:	
Collection methods:	Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.
	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.
	As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.
	Test for albuminuria by measuring microalbumin in timed or first morning urine sample.
	The results considered elevated are:
	 spot urine 30 to 300mg/L
	– timed urine (24 hr collection) 20 to 200 μ g /min.
Related metadata:	relates to the data element Microalbumin – units vers 1
	relates to the data element Microalbumin – upper limit of normal range vers 1
Administrative Attrib	
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Source organisation: National Diabetes Data Working Group

Information model link:		
NHIM Assessment event		
Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	

Comments:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a 6-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes.
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Minutes of operating theatre time

Identifying and Definitional Attributes Knowledgebase ID: 000094 Version No: 1 Metadata type: Derived Data Element Admin. status: Current 01/07/89 Total time spent by a patient in operating theatres during current episode of Definition: hospitalisation. Context: Admitted patient care. Relational and Representational Attributes Datatype: Numeric Quantitative value Representational form: Representational layout: MMMM Minimum size: 4 4 Maximum size: Data domain: Calculated number of minutes Guide for use: Verification rules: Right justified, zero filled Collection methods: Related metadata: Administrative Attributes Source document: National Health Data Committee Source organisation: Information model link: NHIM Service provision event

Comments:

Data Set Specifications:

This item was recommended for inclusion in the *National Health Data Dictionary* by Hindle (1988a, 1988b) to assist with diagnosis related group costing studies in Australia.

Start date

End date

This data element has not been accepted for inclusion in the NMDS – Admitted patient care.

Mode of admission

Identifying and Definitional Attributes Knowledgebase ID: 000385 Version No: 4 Metadata type: Data Element Admin. status: Current 01/07/99 Describes the mechanism by which a person begins an episode of care. Definition: Context: To assist in analyses of intersectoral patient flow and health care planning. Relational and Representational Attributes Numeric Datatype: Representational form: Code Representational layout: Ν Minimum size: 1 1 Maximum size: Data domain: 1 Admitted patient transferred from another hospital 2 Statistical admission - episode type change 3 Other Guide for use: Code 2: use this code where a new episode of care is commenced within the same hospital stay. Code 3: use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital). Verification rules: Collection methods: Related metadata: supplements the data element Mode of separation vers 3 supersedes previous data element Source of referral to acute hospital or private psychiatric hospital vers 3

Administrative Attributes

NHIM Request for/entry into service event		
2		
9		

Mode of separation

Knowledgebase ID: 000096 Version No: 3 Metadata type: Data Element Admin. status: Current 01/07/00 Definition: Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable). Context: Required for outcome analyses, for analyses of intersectoral patient flows and to assist in the continuity of care and classification of episodes into diagnosis related groups. **Relational and Representational Attributes** Datatype: Numeric Representational form: Code Representational layout: Ν Minimum size: 1 1 Maximum size: Data domain: 1 Discharge/transfer to an(other) acute hospital 2 Discharge/transfer to a nursing home 3 Discharge/transfer to an(other) psychiatric hospital 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals and hostels recognised by the Commonwealth Department of Health and Ageing, unless this is the usual place of residence) 5 Statistical discharge – type change 6 Left against medical advice/discharge at own risk 7 Statistical discharge from leave 8 Died 9 Other (includes discharge to usual residence, own accommodation or welfare institution (includes prisons, hostels and group homes providing primarily welfare services)) Guide for use: Code 4: In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of code 1. Verification rules: Collection methods: **Related metadata:** is used in the derivation of Diagnosis related group vers 1 is supplemented by the data element Source of referral to acute hospital or private psychiatric hospital vers 3 is supplemented by the data element Source of referral to public psychiatric hospital vers 3

Identifying and Definitional Attributes

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM Exit/leave from service event			
Data Set Specifications:		Start date	End date
NMDS - Admitted patient care		01/07/2000	
NMDS - Admitted patient mental health care		01/07/1997	
NMDS - Admitted patient palliative care		01/07/2000	

Comments:

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

Morphology of cancer

Knowledgebase ID: 000775 Version No: 1 Metadata type: Data Element Admin. status: Current 01/07/02 Definition: The morphology of a cancer refers to the histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour). The designation is based on a microscopic diagnosis of morphology by the pathologist (Esteban, Whelan, Laudico & Parkin 1995). Context: This information is collected for the purpose of: _ classifying tumours into clinically relevant groupings on the basis of both their morphology (cell type) and their degree of invasion or malignancy as indicated by the behaviour code component (the last digit of the morphology code) monitoring the number of new cases of cancer for planning treatment services.

Identifying and Definitional Attributes

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	NNNNN		
Minimum size:	5		
Maximum size:	5		
Data domain:	The current version of the International Classification of Diseases for Oncology (ICDO).		
Guide for use:	ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.		
	In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.		
	Record morphology codes in accordance with ICDO coding standards. Use the 5th digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:		
	0 Benign		
	1 Uncertain whether benign or malignant		
	 borderline malignancy 		
	 low malignant potential 		
	2 Carcinoma in situ		
	– intraepithelial		
	– non-infiltrating		
	– non-invasive		
	3 Malignant, primary site		
	6 Malignant, metastatic site		
	 malignant, secondary site 		
	9 Malignant, uncertain whether primary or metastatic site		
	360		

Verification rules:	
Collection methods:	Cancer registry use:
	In cancer registries morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.
	Hospital morbidity use:
In hospitals, the morphology code is modified for use with ICD-10-AM. morphology code consists of histologic type (4 digits) and behaviour coc (1 digit) ranging from 8000/0 to 9989/9. The '/' between the fourth and digits is not supplied.	
Related metadata:	
Administrative Attrib	utes
Source document:	International Classification of Diseases for Oncology, Second Edition (ICDO-2)
	New South Wales Inpatient Statistics Collection Manual, 2000/2001
Source organisation:	World Health Organization.
	New South Wales Health Department.
	State and Territory Cancer Registries.
Information model link:	

NHIM Assessment event **Data Set Specifications:**

Start date End date

Mother's original family name

Identifying and Definitional Attributes Knowledgebase ID: 000793 Version No: 1 Metadata type: Data Element Admin. status: Current 01/01/03 Definition: The original family name of the person's mother as reported by the person. Context: **Relational and Representational Attributes** Alphabetic Datatype: Representational form: Text Representational layout: A(40) 0 Minimum size: Maximum size: 40 Data domain: Text Guide for use: May be used to confirm the identity of a person. Mixed case should be used (rather than upper case only). Verification rules: Collection methods: See relevant paragraphs in the collection methods section of the data element Family name. **Related metadata:** Administrative Attributes Source document: AS5017 Health care client identification Source organisation: Standards Australia Information model link:

NHIM Person characteristic		
Data Set Specifications:	Start date	End date
DSS - Health care client identification	01/01/2003	

Multi-disciplinary team status

Identifying and Defi	nitional Attributes		
Knowledgebase ID:	000434	Version No: 1	
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	there is at most one appo	sciplinary team patient service event intment and the patient is assessed a ractitioner, allied health practitioner	nd/or treated by
Context:	Hospital non-admitted pa	atient care.	
Relational and Repr	resentational Attrib	utes	
Datatype:	Numeric		
Representational form:	Code		
Representational layout:	Ν		
Minimum size:	1		
Maximum size:	1		
Data domain:		ti-disciplinary team patient service e 1 patient service event	vent
Guide for use:			
Verification rules:			
Collection methods:			
Related metadata:	is used in conjunction wit	h Individual/group session vers 1	
		h New/repeat status vers 1	
		h Non-admitted patient service even	
	,	h Non-admitted patient service even	
	is used in conjunction wit	h Non-admitted patient service type	e vers 1
Administrative Attrib	outes		
Source document:			
Source organisation:			
Information model link:			
NHIM Assessment event			
Data Set Specifications:		Start date	End date

Myocardial infarction – history

Identifying and Definitional Attributes

Knowledgebase ID:	000834 Version No: 1	
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Whether the individual has had a myocardial infarction.	
Context:	Public health, health care and clinical settings.	
Relational and Repr	esentational Attributes	
Datatype:	Numeric	
Representational form:	Code	
Representational layout:	Ν	
Minimum size:	1	
Maximum size:	1	
Data domain:	1 Myocardial infarction – occurred in the last 12 months	
	2 Myocardial infarction – occurred prior to the last 12 months	
	3 Myocardial infarction – occurred both in and prior to the last 12 months	
	4 No history of myocardial infarction	
	9 Not stated/inadequately described	
Guide for use:		
Verification rules:		
Collection methods:	Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both). Record if evidenced by ECG changes or plasma enzyme changes.	
	Alternatively obtain this information from appropriate documentation.	
Related metadata:	relates to the data element Blood pressure – diastolic measured vers 1	
	relates to the data element Blood pressure – systolic measured vers 1	
	relates to the data element Cholesterol-HDL – measured vers 1	
	relates to the data element Cholesterol-total – measured vers 1	
	relates to the data element Tobacco smoking status – diabetes mellitus vers 1	
	relates to the data element Triglycerides – measured vers 1	
Administrative Attrib	outes	
Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data	

Source document:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Source organisation:	National Diabetes Data Working Group
Information model link:	
NHIM Physical wellbeing	

Data Set Specifications: DSS – Diabetes (clinical)	<i>Start date</i> 01/01/2003	End date
Comments:	Myocardial infarction (MI) generally occurs as a result of a critical imbalance between coronary blood supply and myocardial demand. Decrease in coronary blood flow is usually due to a thrombotic occlusion of a coronary artery previously narrowed by atherosclerosis. MI is one of the most common	

diagnoses in hospitalised patients in industrialised countries.

The most widely used in the detection of MI are creatinine kinase (CK) and (CK-MB), aspartate aminotransferase (AST) and lactate dehydrogenase (LD). Characteristic ECG changes include ST elevation, diminution of the R wave and a Q wave development. A recent study on Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI study) indicated that in diabetic patients with AMI, mortality is predicted by age, previous heart failure, and severity of the glycometabolic state at admission, but not by conventional risk factors or sex (American Heart Association 1999).

Reference:

Long-Term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study Circulation. 1999;99: 2626–2632.

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