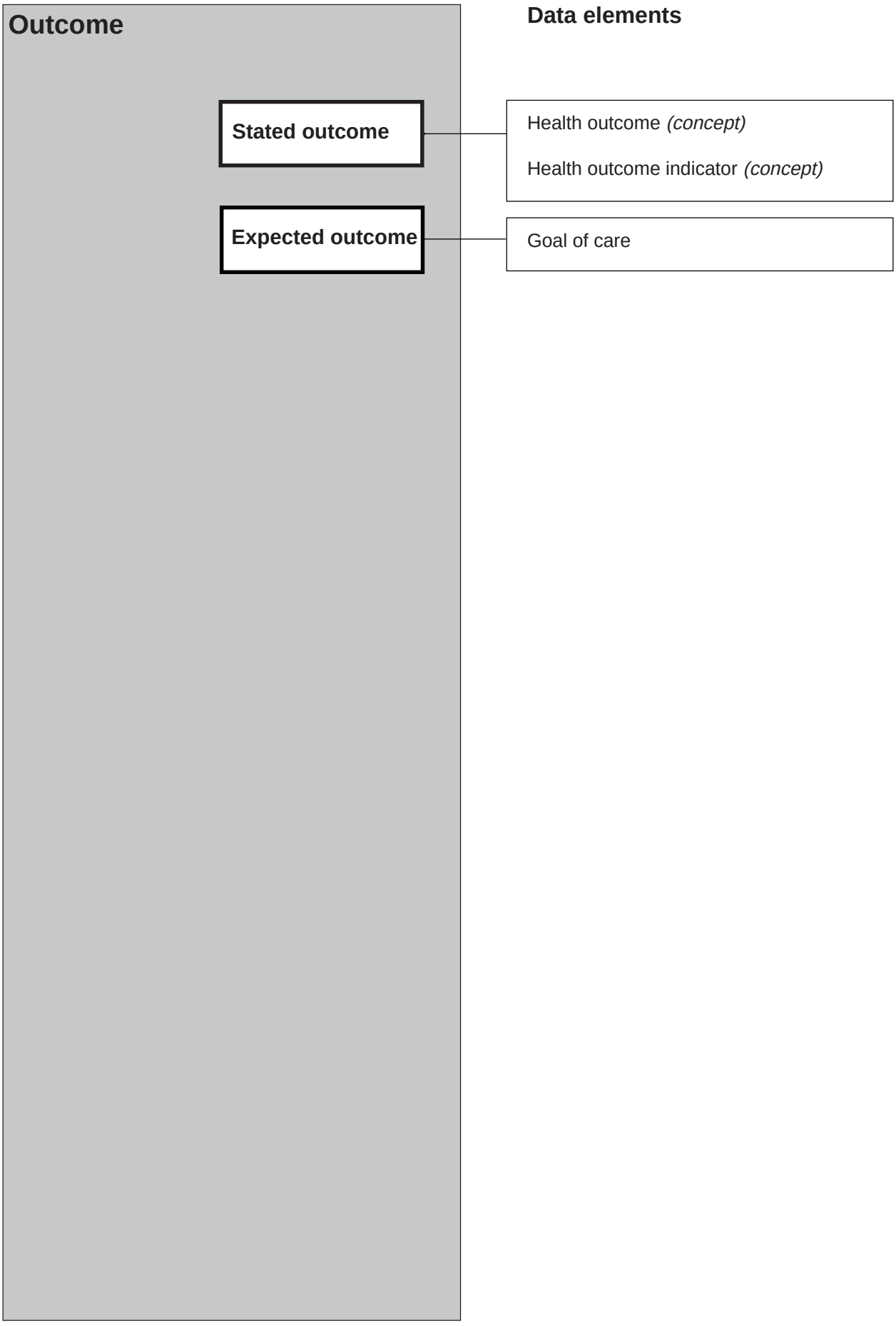
National Health Information Model entities



Health outcome

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000062 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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: Institutional and non-institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Information Management Group

National minimum data sets:

Comments:

Health outcome indicator

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000063 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A statistic or other unit of information which reflects, directly or indirectly, the effect of an intervention, facility, service or system on the health of its target population, or the health of an individual.

- A generic indicator provides information on health, perceived health or a specific dimension of health using measurement methods that can be applied to people in any health condition.

- A condition-specific indicator provides information on specific clinical conditions or health problems, or aspects of physiological function pertaining to specific conditions or problems.

Epidemiological terminology

- An association exists between two phenomena (such as an intervention and a health outcome) if the occurrence or quantitative characteristics of one of the phenomena varies with the occurrence or quantitative characteristics of the other.

- One phenomenon is attributable to another if there is a casual link between the phenomena. Attribution depends upon the weight of evidence for causality.

- Association is necessary (but not sufficient) for attribution. Associations may be fortuitous or causal. The term relationship is to be taken as synonymous with association.

Context: Institutional and non-institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Information Management Group

National minimum data sets:

Comments:

Goal of care

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000111 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, which outlines the overall aim of actions planned by a community service and relates to a person's health need. This goal reflects a total care plan and takes into account the possibility that a range of community services may be provided within a specified time frame.

Context: This item focuses on the broad goal which the person and services provider hope to achieve within an expected time period and takes into account the intervention or services provided by a range of community services.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

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 athome 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:

1. GOAL 1 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.

2. GOAL 2 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

Goal of care *(continued)*

Guide for use (cont'd): 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.

3. GOAL 3 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.

4. GOAL 4 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.

5. GOAL 5 refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

6. GOAL 6 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.

7. GOAL 7 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.

Goal of care *(continued)*

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 data: supersedes previous data element Nursing goal, version 1

relates to the data element Date of first contact, version 2

relates to the data element Nursing diagnosis, version 2

relates to the data element Nursing interventions, version 2

relates to the data element Date of last contact, version 2

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: Agencies who had previously implemented this item should note changes to the code set in data domain.